A Qualitative Investigation of the Nature of ‘Informal Supervision’ Among
Therapists-in-Training

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Submitted in partial fulfillment of the
requirement for the degree of
Doctor of Philosophy
under the Executive Committee
of the Graduate School of Arts and Sciences

COLUMBIA UNIVERSITY

2017

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ABSTRACT

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The primary aim of this study was to investigate the ways that beginning therapists utilize ‘informal supervision’, the process wherein therapists in training engage individuals who are not their formally assigned supervisors in significant conversations about their clinical work. Because the research literature on formal supervision does not adequately acknowledge the frequent use and significance of informal supervision, this study sought to provide a comprehensive, phenomenological understanding of why therapists in training seek informal supervision, what they get out of it, how informal supervision differs from formal supervision, and how it influences trainees’ clinical work and their developing therapeutic identity. Participants were 16 doctoral trainees in clinical and counseling psychology programs. Semi-structured interviews were conducted and analyzed using the Consensual Qualitative Research (CQR) method.

Eleven domains emerged from CQR analysis, and results suggest that informal supervision is a valid practice by which trainees in clinical and counseling doctoral programs in psychology develop clinical and professional competencies. The valuable practice of informal supervision was evident in a multiplicity of arenas: in seeking informal supervision, trainees received validation, reassurance, and emotional support. Additionally, trainees used informal supervision to openly and authentically discuss personal anxieties and self-doubt, strong countertransference reactions to patients, and salient clinical challenges and mistakes. Trainees who used informal supervision gained insight into their clinical work, explored diverse approaches to clinical interventions, and increased their capacity to access and use their personal

reactions to patients to further their clinical work. Results also revealed important differences between formal and informal supervision, specifically that informal supervision provides trainees with a unique and important space to discuss clinical interactions that lead them to feel emotionally dysregulated, overwhelmed, confused, concerned, upset, and drained – i.e., those aspects of experience that are often not disclosed or are carefully curated in their presentation to formal supervisors – so that they could better understand and use their countertransference reactions to influence their clinical work. Regarding the former, i.e., personal challenges of clinical work, trainees revealed their personal anxiety, self-doubt, uncertainty, and shame frequently and non-defensively in informal supervision. Lastly, results showed that participants' concerns about using informal supervision are considerable, and include anxiety about breaking APA's ethics codes regarding patient privacy and confidentiality

Recommendations are proposed for clinical practice and clinical training, including an 'ethical' proposal to integrate informal supervision as a primary avenue for trainees' clinical and personal development throughout their training, and thus legitimize its practice. Clear and innovative ethical guidelines regarding the use of informal supervision that are consistent with the APA's ethics codes are outlined, and future directions are discussed.

Table of Contents

LIST OF TABLES	iv
ACKNOWLEDGMENTS	v
DEDICATION	vii
CHAPTER I. INTRODUCTION AND LITERATURE REVIEW	1
Beginning Therapists' Distress	3
Formal Supervision	6
Informal Supervision: Furthering Clinical Work and Professional Development.....	10
The present study: Statement of the problem	12
Research Questions	13
CHAPTER II. METHOD	14
Participants.....	14
Measure.....	16
Informal Supervision Interview	17
Procedure	18
Data analysis	19
Research team	21
Coding data into domains and core ideas	24
Cross-analysis and frequency labels	25
Stability check.....	26

CHAPTER III. RESULTS	27
Preferred qualities of Informal Supervisor	27
Reasons for seeking informal supervision	29
What trainees get out of informal supervision	32
Tone of Informal Supervision	35
Topics and themes discussed in informal supervision	36
Comparisons between formal and informal supervision	39
Changes in use of informal supervision over time.....	42
Reasons for informal supervision with significant other	44
Reasons for informal supervision with one's therapist.....	46
Concerns about using informal supervision.....	48
Experience providing informal supervision.....	52
CHAPTER IV. DISCUSSION.....	56
Research question 1: With whom, how frequently, and why does informal supervision usually take place, and what tone typically characterizes these discussions?.....	56
Research question 2: What qualities/characteristics do beginning therapists' value most highly in their informal supervisors?	62
Research question 3: What do therapists in training get out of informal supervision?	64
Research question 4: What are the similarities and differences between informal and formal supervision? Is there something inherent in the formal supervisory relationship that contributes to trainees' wish/need to seek informal supervision?	67
Research question 5: When beginning therapists describe a specific case with an informal supervisor, what common themes, topics, and challenging issues emerge?	70
Research Question 6: Does trainees' use of informal supervision change over time?	72

Research question 7: Do beginning therapists have concerns about using informal supervision to further their development and clinical work, and do they think the psychology field needs new rules, ethical codes, or simply more openness about the practice of informal supervision?.....	73
Research question #8: Why do beginning therapists seek informal supervision from significant others and personal therapists?	76
Research question #9: To what extent is informal supervision reciprocal?.....	80
Limitations	83
Clinical Implications: Personal and Professional Development	86
Ethical Considerations	88
Proposal for Integrating Peer Supervision into Doctoral Programs.....	92
Future directions	93
REFERENCES	96
TABLES	100
APPENDICES	106
A. Informed Consent and Participants' Rights	106
B. Introductory Email to Participants	108
C. Informal Supervision Demographics Survey	109
D. Informal Supervision Semi-Structured Interview	112

List of Tables

TABLE 1: Cross-Analysis: The Phenomenon of ‘Informal Supervision’	100
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Acknowledgements:

I am grateful to my parents for their care and support throughout my doctoral studies. My parents' fierce and gentle love gives me nurturance and strength. Thank you for helping me to have perspective, reminding me to finish strong, and always live a balanced life. To my brother Gabriel, my confidante and partner in crime, your curiosity, interest, and participation in my clinical and academic work has been vital to my growth. You are my greatest source of ego strength. My sister Freda, with her sharp wit, brilliant insight, and generous spirit, has so often propped me up. Thank you.

There are no words to describe the profound respect I feel for my life partner, best friend, and rock, Rachel. With you, I dream, explore, and find endless depths of love and understanding. Your gentle and sharp humor makes working easy. And your unshaking belief in me gives me courage to be myself. Thank you my love.

I want to say a very special thank you to my mentors Barry Farber and Dinelia Rosa. Barry, you are my guy, the single most important and impactful voice in my development as a clinical psychologist. From you, I have gained infinite wisdom, learned to be more patient, to trust my clinical and written voice, and to appreciate my personal process of development. You are my model of personal and professional empathy, unconditional positive regard, thoughtfulness, and kindness. And we have fun. I am lucky – in you I have both a mentor and a friend. Dinelia, I am forever grateful for your guidance and support as I transitioned to working with Barry after my first year. When I felt lost and was most in need, you stepped up and provided me with a holding environment. You too are a foundational influence in my development as a clinician. From intake to fourth year clinical practicum, you challenged me to be curious, thoughtful, self-reflexive, and organized in my clinical work, and to value each and

every patient in his/her unique culture and context. I am a more intentional, bolder, and multi-culturally sensitive clinician and person because of you. Thank you.

Lexi Walther, Devlin Hughes, and Erika Bach, my lab-mates and co-researchers were vital and essential to this project and to my graduate school experience. Your dedication, creativity, insightfulness, and spirit to this project were invaluable. I feel fortunate to have worked with all of you. Thank you to Emily Lyman for your thoughtful auditing of our work, and for your mentorship and friendship. I want to extend a special thank you to Laura Smith for graciously and generously teaching me CQR analysis, and for being a helpful and kind committee member throughout my project.

To my cohort, very simply, I got lucky to be placed with you. I want to credit you as some of my most trusted and valuable teachers. Throughout our training, you challenged me to bring more of myself in to my work and to trust my personal reactions to patients. More importantly, you were an endless source of laughter and fun, and for that, I am deeply grateful.

DEDICATION

I dedicate my dissertation to Grandma Fran, my all-time biggest fan. I am a therapist, first and foremost, because of you. Your boundless curiosity, love of learning, capacity to live in life's questions, and non-verbal expressions of caring and emotional presence are alive in me and in my clinical work. I miss talking to you about psychotherapy. When I close my eyes, I hear your cackle loud and clear.

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Chapter 1: Introduction and Literature Review

As they learn to do the work of what Freud (1937) termed an “impossible profession,” beginning therapists are typically beset with multiple stressors, including a greater awareness of their own personal issues; the myriad difficulties and frustrations inherent to treatment per se; the confusion that may be attendant to learning diverse treatment options and forming a professional identity; the scrutiny and evaluation of multiple teachers and supervisors; and the awareness of disjunctions between their preferred personal style (e.g., informality; friendliness) and the assumptions of a more professional demeanor (Eckler-Hart, 1987; Farber, 1983, 2006; Gold, 2005; Hill, Sullivan, Knox, & Schlosser, 2007; Skovholt & Rønnestad, 2003). Trainees’ responsibilities and expectations—both internally and externally imposed—are considerable. Many beginning therapists feel distressed by the demands and challenges of clinical and supervisory work (Mehr & Ladany, 2010).

While formal, assigned supervision is a valuable source of instruction and support, there are still inherent limitations to this form of learning. Many of the problems of formal supervision have been well-documented: that beginning therapists regard their supervisors as powerful and sometimes intimidating authority figures; that formal supervisory evaluations impact trainees’ professional advancement and reputation; that supervisors are assigned to trainees by their training programs; and that formal supervision occurs only once weekly. The significant power differential and evaluative components inherent in the supervisor-supervisee relationship can lead trainees to feel anxious and incompetent when engaging in supervision. As a result, many supervisees do not disclose and/or manipulate clinical material during supervision, thus reducing opportunities for personal and professional development (Mehr, Ladany, & Caskie, 2010; Yourman & Farber, 1996). Supervisees who feel personally or professionally constricted by their

formally assigned supervisors' supervisory style may feel that their options to positively influence the supervisory relationship are limited because of their desire to fulfill the role of a "good supervisee". Taken together, these aspects of formal supervision increase the likelihood that trainees will seek out multiple, informal sources of supervision for therapeutic advice and emotional support in order to best understand and help their clients (Betcher & Zinburg, 1988; Farber & Hazanov, 2014). Because the current literature on supervision does not adequately acknowledge the presence and/or significance of informal supervision, there is a need for meaningful consideration of the nature, process, and consequences of seeking informal supervision during training for clinical practice.

The primary aim of this study is to investigate the ways that therapists in training utilize informal supervision – a practice that is seemingly both normative and somewhat secretive – to further their clinical work. Informal supervision may be defined in terms of the ways in which trainees engage individuals who are not their formally assigned supervisors in significant conversations about their clinical work. Informal supervision differs from clinical consultation – a process akin to informal supervision – in that clinical consultants "share some level of responsibility for the client who is the focus of the problem-solving process", whereas informal supervisors are not responsible for the trainee's client (Knoff, 1988, p. 245).

I begin by reviewing the extant theoretical and empirical literature on supervision that has shaped the research questions posed here about the nature of informal supervision and its potential to augment trainees' professional development. Next, I present a proposal for a research project that uses an open-ended, semi-structured interview to investigate the extent to which and to what end beginning therapists use informal supervision. Lastly, I propose implications for

integrating informal supervision as a primary tool for therapeutic advancement in doctoral training programs, including a discussion of ethics.

Beginning Therapists' Distress

Beginning therapists of various ages, professions, and theoretical orientations feel anxious and overwhelmed early in their careers (e.g., Orlinsky & Ronnestad, 2001), in part because psychotherapy is at its essence: “an undefined technique applied to unspecified problems with unpredictable outcomes” (Raimy, 1950, p. 150). Novice therapists are faced with the challenging task of meeting ambiguous standards, internally and externally imposed, while working under the scrutiny of teachers and supervisors (Ronnestad & Skovholt, 2003). Williams, Judge, Hill, and Hoffman (1997) found that trainees experienced anxiety and self-doubt related to their therapeutic skills and performance, ability to connect with clients, self-efficacy, role clarity, similarities to and differences from clients, and problematic personal reactions to clients. A clinical psychology doctoral trainee described her fears early in training:

I felt exposed and anxious and fairly insecure and freaked out in general. And I felt incompetent—like I didn't know what the hell I was doing, that I shouldn't be doing therapy at all ... When I first started I wasn't so concerned about whether I would be able to cure [patients]. I was more concerned about—can I get through the hour, not make a fool of myself, not get my supervisor mad at me, not get myself kicked out of the program (Eckler-Hart, 1987, p. 687).

Many trainees struggle to define and accept their new professional role, leading to feelings of insecurity and self-doubt (Ronnestad & Skovholt, 1995). Faced with the daunting task of engaging distressed clients, they worry that they do not know what to do in session and that their (felt) lack of clinical skills will prevent them from helping their clients. Even trainees who

have acquired satisfactory knowledge of clinical theory and technique feel inadequately prepared for the real world experience of establishing meaningful relationships with diverse clients presenting with a wide range of problems (Rønnestad & Skovholt, 2003, p. 361). For many trainees, it can feel disheartening to discover that their classroom education has limited applicability in preparing them to engage clients in meaningful ways. It can also be difficult for beginning therapists to adjust expectations and recognize that “clients serve as (their) primary teachers”, a reality documented in critical incidents (McCarthy & Skovholt, 1988) and international survey research (Orlinsky & Rønnestad, 2001). Moreover, trainees tend to blame themselves when they have difficulty establishing strong working alliances with hard-to-reach clients. This can be exacerbated by trainees’ tendency to overestimate the potential impact of their efforts. Beginning therapists’ self-worth is intimately tied to client improvement so that they are primed to feel as if they have failed if their clients do not show noticeable improvement early in therapy.

Therapists of all theoretical persuasions have difficulty creating a ‘good enough’ therapeutic frame consisting of clear boundaries and effective session management (Hill, 2007). Many beginning therapists wonder if they are self-aware enough in sessions (Hill, 2007). Additionally, trainees’ struggle to hold their patients’ and their own considerable anxiety while engaging with the interpersonal dynamics (transference and countertransference in psychodynamic terms) evoked in session. Beginning therapists also experience difficulty regulating their own emotions when relating to clients, at the same time that they monitor – and in the best of circumstances, directly acknowledge – differences related to their clients’ cultural identity, race/ethnicity, gender, sexual orientation, and age (Hill, 2007). Thus, many trainees worry that they will have difficulty establishing meaningful relationships to clients whose

backgrounds are significantly different from their own, and are unsure whether or not it is appropriate to voice such concerns to professors and formal supervisors.

Beginning therapists are also faced with the challenging task of learning how to provide therapy from multiple theoretical orientations. For instance, trainees often struggle with the intrinsically ambiguous nature of providing psychodynamic psychotherapy. Many are apprehensive about how to use the clinical interventions associated with this theoretical orientation (e.g., challenge, self-disclosure, and open-ended questions) appropriately and productively. Therapists operating from a cognitive-behavioral (CBT) orientation – with a more explicit focus on reducing symptoms and attaining measurable goals – worry that they are not skilled enough to effectively employ cognitive behavioral techniques. Integrative therapists, asked to flexibly apply psychodynamic, humanistic/existential, and/or CBT case formulation and technique to their therapeutic engagement, likely experience heightened anxiety, confusion, and self-doubt. These therapists may ask themselves, “I don’t even feel competent working from one theoretical orientation - how am I supposed to work from three”?

Lastly, trainees are often apprehensive of how their teachers and supervisors will judge their clinical style and therapeutic choices: “like an adolescent, the fragile and incomplete practitioner self-shifts through a series of moods: enthusiasm, insecurity, elation, fear, relief, frustration, delight, despair, pride, and shame. The novice self is fragile and, therefore, highly reactive to negative feedback” (Ronnestad & Skovholt, 2003, p. 6). Trainees tend to regard both as powerful authority figures: many teachers and virtually all clinical supervisors are experienced psychotherapists, their evaluations impact trainees’ professional advancement and reputation, and session-to-session supervisory feedback influences beginning therapists’ self-esteem and professional identity. Trainees balance internal doubts such as, ‘Am I capable of doing this

work?’ and ‘Is it acceptable to feel this way?’ with external expectations like ‘How much distress is normative’? and ‘If I expose myself by showing how overwhelmed I sometimes am, will I be validated or judged’? Moreover, as Farber (2006) has noted, fears of failing oneself and/or one’s supervisor may be particularly acute because clinical work is so inextricably tied to the therapist’s sense of self: “The work of the psychotherapist...draws so palpably upon an individual's skills as a caring, well-related human being. Thus, acknowledgement that one is struggling with the work all too often feels tantamount to admitting that one is struggling to be the human being one wants to be and should be” (p. 182).

Formal Supervision

Empirical literature that documents the inherent limitations of formal supervision – specifically that supervisees do not fully disclose important clinical material to their formal supervisors – suggests that trainees seek out informal supervision to bolster their personal and professional growth, and to validate their emotional distress. These studies have shown that trainee anxiety and fear of unfavorable supervisor evaluations are significantly related to greater nondisclosure and dishonesty, and more frequent manipulation of presented clinical material during supervision (Mehr, Ladany, & Caskie, 2010; Yourman, 2003; Yourman & Farber, 1996). Studies have also shown that supervisee nondisclosure may be nearly universal. In one study (Ladany, Hill, Corbett, & Nutt, 1996), over 97% of a sample consisting primarily of doctoral students in counseling and clinical psychology reported withholding at least some information from their supervisors. In Yourman and Farber’s study, 47% of clinical supervisees acknowledged telling their supervisor—at moderate to high levels of frequency—what he or she wanted to hear.

These studies showed that the professional and evaluative nature of the supervisor-supervisee relationship led trainees to be cautious as to what clinical material they chose to conceal from their supervisors (Inman, Schlosser, Ladany, Howard, Boyd, Altman, & Stein 2011). In one study, supervisees worried about their supervisors' reaction to their clinical choices, suggesting that they engaged in impression management to ensure that their supervisors viewed them in a positive light (Inman, 2011). Goffman (1959) noted that complex interpersonal situations induce individuals to "perform" — that is, to modify and mold how they present themselves to others — in efforts to fit the expectations and judgments of "the society in which (they are) presented" (p. 35). His observations apply to the ever-present but often unspoken tension between beginning therapists' desire to authentically represent to their clinical supervisors how they experience themselves when providing therapy and their inclination to project an ideal self. As Goffman noted: "errors and mistakes are often corrected before the performance takes place, while telltale signs that errors have been made and corrected are themselves concealed" (p. 43).

Ladany et al. (1996) found that most trainees' nondisclosures related to information regarding negative reactions to their supervisor, personal issues not directly related to supervision, clinical mistakes, evaluation concerns, negative reactions to clients, countertransference, client counselor attraction issues, positive reactions to the supervisor, supervision setting concerns, supervisor appearance, supervisee-supervisor attraction issues, and positive reactions to clients. That the content of trainee nondisclosures is multitudinous and far-reaching is not surprising. Yet when supervisees withhold important information from their formal supervisors, they sacrifice valuable opportunities to process important dynamics with their patients and supervisors that preclude professional learning and development.

The most common reasons trainees' cited for nondisclosures were perceived unimportance of the material, the personal nature of the nondisclosure, negative feelings about the nondisclosure, a poor alliance with the supervisor, deference to the supervisor, impression management, and, to a lesser extent, the supervisor's agenda, political suicide, pointlessness, and a belief that the supervisor was not competent (Ladany et al., 1996). That beginning therapists concealed personal information and negative feelings suggests that even though clients inevitably evoke negative and anxious feelings in their therapists, trainees are unsure whether or not their supervisors will validate them if they voice these reactions. Trainees may feel as though negative reactions to clients reflects poorly on their therapeutic abilities, and that supervisors may judge them as unempathic in their clinical work. By not revealing personal information about themselves, such as their religious beliefs or family make-up, trainees may protect themselves from feeling vulnerable and overexposed, but miss out on opportunities to understand the ways that their personal histories influence their interactions with clients. Trainees' fears that their disclosures may not fit with their supervisors' agendas suggests that beginning therapists may be more highly attuned to their supervisors' needs than their own, and thus withhold information that they believe their supervisors will not receive as useful or important. Understandably, trainees want to earn their supervisors' approval and demonstrate their competence, but to what end (Dodge, 1982)? Supervisees' nondisclosures related to a negative reaction to their supervisor reflects trainees' awareness of the power imbalance between themselves and their supervisors, and fears that processing negative reactions will damage their relationship with their supervisor, potentially harming their ability to engage in effective supervision, or alternatively, negatively impacting their standing as a 'good supervisee'.

Hahn (2001) found that in addition to mollifying trainees' considerable anxiety

(documented above), nondisclosures also help to lessen feelings of shame that beginning therapists inevitably experience in the context of supervision. As noted above, trainees are highly motivated to hide their feelings of inadequacy and self-doubt, as they fear that the more they reveal the more likely they are to be condemned for their inadequacies (Hanh, 2001).

Supervisees desire to be seen as autonomous and competent, and also worry that their supervisors may judge them as lacking in basic therapeutic and interpersonal skills. Even when supervisors provide a sufficient ‘holding environment’ (Winnicott, 1961), many supervisees expect their supervisors to scrutinize their imperfections.

Pine (1995) suggests that shame has a self-protective function and Nathanson (1992) identifies common reactions to experiencing shame: withdrawal, avoidance, attack on the self, and attack on others. This is consistent with Yourman’s (2003) description of shame as an emotion that causes individuals to want to hide from others. Withdrawal and avoidance, expressed via nondisclosures, may indeed be an adaptive coping mechanism for trainees, relieving them of distress and providing them with a sense of control. However, shame “interrupts affective communication and therefore limits empathy and intimacy” (Nathanson, 1992, p. 143). Nondisclosures may have unintended consequences, such as hampering the development of genuine relationships with supervisors that otherwise may engender more emotionally honest communication, in addition to felt comfort and support.

Importantly, supervisees tend to reveal to others, typically a peer or friend in the field, or significant other, the very same information that they withhold from their formal supervisors (Ladany et al., 1996). To their credit, supervisees recognize the importance of discussing these reactions in the context of a safer relationship, presumably one that had no bearing on their professional reputation or advancement. In a more recent study, Inman et al. (2011) found that

over 85% of nondisclosures were discussed with a professional peer, significant other, or personal friend. Again, rather than hold these distressing reactions to clients and supervisors, trainees discussed them in more informal settings. The reason and nature of these nondisclosures notwithstanding, trainees appear to seek clinical guidance and emotional support from other sources when they do not feel comfortable confiding in their formal supervisors.

Informal Supervision: Furthering Clinical Work and Professional Development

In an effort to address the significant gap in the research literature, Farber and Hazanov (2014) surveyed 146 beginning therapists via an online self-report questionnaire about their experiences with “informal supervision”. They asked trainees whom they were most likely to share clinical information with (e.g., colleagues in a training program, program faculty, friends, family members, one’s own psychotherapist, clergy, and significant others) what type of information they shared with these individuals, why they sought informal supervision, how helpful the advice/support of informal supervisors seemed, and whether or not trainees shared their experiences with informal supervisors with their formal supervisors and teachers. Their sample was predominantly female, Caucasian, and evenly distributed regarding preferred clinical orientation (e.g., psychodynamic; CBT; humanistic/existential); over 60% were currently in their own psychotherapy. Trainees were most likely to seek informal supervision from colleagues in their program, a significant other, and their own therapists. The most helpful sources of informal supervision were a colleague in one’s program, a colleague in the mental health field outside one’s program, and a faculty member in one’s program, while the least helpful were a friend, a sibling, and a religious/spiritual leader. The most commonly shared types of information were difficulties in treatment, the primary problems of the client, the gender of the client, and feelings about the client.

Trainees most commonly sought informal supervision because their preferred informal supervisor was smart and insightful, they needed (personal) reassurance, their preferred informal supervisor possessed knowledge about a specific aspect of a specific clinical case, and they needed more than one opinion on this case. Importantly, trainees rarely sought informal supervision because they disagreed with formal supervisors, felt intimidated by their supervisor, or felt that their supervisor was too judgmental. When asked what type of clinical situations caused trainees to want to seek informal supervision, out of 15 possible items, the most highly endorsed were feeling stuck, feeling one has made a clinical mistake, and feeling challenged by the work. Regarding the experienced usefulness of informal supervisions, beginning therapists found informal supervision to be highly helpful to both their clinical work and emotional well-being. Importantly, trainees tended not to share their informal supervisory experiences with their formal supervisors.

Farber and Hazanov's (2014) findings suggest that trainees seek informal supervision – particularly with colleagues in their programs – far more often than is commonly noted in the research literature, in training programs, and in formal supervisory settings. When beginning therapists felt particularly challenged by a patient, stuck, or felt as if they'd made a critical mistake, they sought informal supervision from individuals whom they regarded as smart and insightful, both for clinically astute knowledge and emotional validation/support (Farber & Hazanov, 2014). Importantly, “trainees are not denigrating their formal supervisors—indeed, they (the formal supervisors) are preferred and more often evoked in times of need—but these trainees are suggesting that beginning therapeutic work is sometimes overwhelmingly stressful, requiring more consultation and support, especially of the ad-hoc variety, than once-weekly supervision, even exceptionally good supervision, can provide” (Farber & Hazanov, 2014, p. 13).

A recent study by Golia and McGovern (2013) explored the ways that training programs might incorporate peer supervision into their current practices. Echoing Farber and Hazanov (2014), they found that peer supervision helps to normalize and lessen trainees' anxiety and feelings of inadequacy, while allowing budding clinicians to build confidence in clinical judgment and skills through conversations with peers. Trainees reported that discussing clinical material with their graduate school peers in the absence of a formal supervisor fostered a safer and less intimidating environment to explore and process difficult issues that emerged in clinical training.

The Present Study

The present study extends Farber and Hazanov's (2014) research, which showed that trainees discuss clinical material with informal sources more frequently than typically assumed by those who write about the supervisory process. In addition to investigating the secretive component of informal supervision, this study aims to capture -- through semi-structured interviews and qualitative data analysis (Consensual Qualitative Research; Hill, Knox, & Thompson, 2005; Hill, Thompson, & Williams, 1997) -- a broad and detailed phenomenological understanding of how, when, with whom, and under what circumstances beginning therapists utilize informal supervision. I want to understand the extent to which beginning therapists have considered whether the practice of informal supervision is consistent with APA ethics and rules regarding confidentiality, and what new rules or ethical codes they might propose for the psychology field regarding the use of informal supervision. Additionally, I am curious about how the practice of informal supervision contributes to trainees' clinical work and their burgeoning therapeutic identity, as well as the similarities and differences between the utility of formal and informal supervision.

Research Questions

- 1) With whom, how frequently, and why does informal supervision usually take place, and what tone typically characterizes these discussions?
- 2) What qualities/characteristics do beginning therapists value most highly in their informal supervisors?
- 3) What do therapists in training get out of informal supervision?
- 4) What are the similarities and differences between how trainees use informal and formal supervision, and is there something inherent in the formal supervisory relationship that contributes to trainees' wish/need to seek informal supervision?
- 5) When beginning therapists describe a specific case with an informal supervisor, what common themes, topics, and challenging issues emerge?
- 6) Does trainees' use of informal supervision change over time?
- 7) Do beginning therapists have concerns about using informal supervision to further their development and clinical work, and do they think the psychology field needs new rules, ethical codes, or simply more openness about the practice of informal supervision?
- 8) Why do beginning therapists seek informal supervision from significant others and personal therapists?
- 9) To what extent is informal supervision reciprocal?

Chapter 2: Method

Participants

Interview subjects were 16 therapists in training currently enrolled in clinical and/or counseling psychology doctoral programs throughout the United States. The number of participants, therefore, was within Hill et al.'s (1997) original manual and (2005) updated requirements for minimum sample size necessary for a Consensual Qualitative Research (CQR) analysis of approximately eight to fifteen participants.

Following Hill et al. (2005), participants had to be knowledgeable about the phenomenon of informal supervision, i.e., use informal supervision, to participate in the study. Thus, in order to be included in the study, the subjects had to have provided psychotherapy to clients for at least one year while actively enrolled in their training program. Recruitment was conducted by email. Emails were sent to the directors of clinical training of Clinical and Counseling Psychology Ph.D. programs throughout the United States, who then chose whether or not to forward the recruitment email to their students. Subjects were provided with a brief description of the research and what their participation would entail. Subjects currently on internship were not excluded from participation.

Eleven women and five men participated in the study, and the majority of participants identified as Caucasian. Regarding primary theoretical orientation, ten participants identified as psychodynamic, four as integrative, and two as cognitive-behavioral. Ten participants were currently enrolled in a Ph.D. program, and six were in a Psy.D. program. The average participant was just under 32 years-old, and the average subject was in the middle of her/his fourth year of training. On average, participants carried an active caseload of nearly seven patients, had treated 35 patients to date, and were receiving formal supervision from more than 3 supervisors. Thus

the therapists-in-training interviewed in this study were fairly experienced, as the average length of doctoral training is 5-7 years.

Participants were asked to select their primary informal supervisor, i.e., the supervisor from whom they seek informal supervision most frequently. Seven identified a peer/colleague in their program, 5 a colleague outside of their program, 3 a significant other, and 1 a personal therapist. While 75% of participants identified a peer/colleague in or outside of their program as their primary informal supervisor, all but one participant noted that they also sought informal supervision from peers/colleagues. Regarding how frequently trainees sought informal supervision each month from various groups of individuals, 94% of trainees sought informal supervision from a peer/colleague in their program at an average rate of 3.67 times per month, 75% from colleagues outside of their program at a rate of 2.81 times per month, 44% from their significant other at a rate of 5 times per month, 38% from a faculty member (not a supervisor) at a rate of 2.20 times per month, and 56% from their personal therapist at a rate of 1.5 times per month. The average length of a typical informal supervision session was almost 19 minutes. All but one of the participants were currently in their own personal therapy, while nearly 75% had a significant other. Table 1 presents participants' demographics.

Table 1
Participant Demographics (N = 16)

	n/mean	%/SD
Gender		
Female	11	69%
Male	5	31%
Race/ Ethnicity		
Asian/ Asian-American	1	6%
White/Caucasian	15	94%
Age	31.88	3.74
Type of Program		
Clinical	15	94%
Counseling	1	6%

Type of Degree		
Ph.D.	10	63%
PsyD	6	37%
Year in Program	4.43	1.02
Primary Theoretical Orientation		
Psychodynamic	10	63%
Cognitive-Behavioral	2	12%
Integrative	4	25%
Primary Informal Supervisor		
Colleague in program	7	44%
Significant other	3	19%
Personal therapist	1	6%
Colleague (outside program)	5	31%
# Clients in Caseload	6.88	3.28
# Clients Treated to Date	35.25	24.41
# Current Supervisors	3.69	3.28
Frequency of use of IS (#times per month)		
Colleague in program	3.67	94%
Colleague (outside program)	2.81	75%
Significant other	5.00	44%
Faculty member (not supervisor)	2.20	38%
Personal therapist	1.50	56%
Length of Typical IS session	18.75 (min)	11.62 (min)
Significant Other	11	
Currently in Therapy	15	

Measure

The interviewer collected information about selected socio-demographic and practice-related variables, including age, gender, primary and secondary theoretical orientation, type of

graduate program, current year in program, number of years in psychotherapy practicum training, number of clients in current caseload, total number of clients treated to date, number of supervisors subjects are currently working with on an ongoing basis, primary informal supervisor (e.g., colleague, personal therapist, etc.), # of times informal supervision was sought from various individuals per month, and whether or not participants had a significant other and were currently in personal therapy (see Table 1 above).

Informal Supervision Interview

The informal supervision semi-structured interview protocol (see appendix B) was developed specifically for this study in order to assess beginning therapists' perceptions of the nature, extent, implications of informal supervision in the context of their clinical work. Following Hill et al. (2005), the interview protocol builds on previous research (Farber & Hazanov, 2014).

This 11-question semi-structured interview begins with the following instruction set: "Thank you for agreeing to participate in our study. I am trying to learn about the ways in which informal supervision is experienced and used throughout clinical training. Informal supervision is defined as occurring when therapists in training engage individuals who are not their formally assigned supervisors in significant conversations about their clinical work. Towards this end, I'll be asking you about your experiences using informal supervision. I'd like to tape-record your answers. Do you have any questions about this study? Ok, let's begin."

These instructions were then followed by a series of open-ended questions covering a range of topics about trainees' experiences with informal supervision. Interview questions were based on the study's research questions, feedback from pilot interviews, and a meeting with a skilled and experienced qualitative researcher. The interview began with general questions so as

not to influence subjects' responses, and included questions specifically meant to evoke more specific and detailed aspects of the phenomenon (e.g., "Please describe similarities and differences between formal and informal supervision").

First, participants were asked general questions about their use of informal supervision. The following questions were posed: "Why do you consider _____ to be your primary informal supervisor? Why do you seek informal supervision? What do you get out of informal supervision?" "What is the tone like when you engage in informal supervision?"

Next, subjects were asked to describe the similarities and differences between informal and formal supervision. Then subjects gave a detailed example of a specific time that they used informal supervision, and they described how this use of informal supervision affected their clinical work. Trainees were then asked to reflect on how their use of informal supervision has changed since they entered their program.

The following questions asked about the degree to which informal supervision is reciprocal, e.g., if trainees have been called upon to provide informal supervision by a peer, and what that experience has been like for the participant. Next, subjects were asked if they have sought informal supervision from a significant other and/or personal therapist, and the ways in which that experience was similar to or different from receiving informal supervision from a peer or colleague. Lastly, individuals were asked their thoughts about the relationship between informal supervision and psychology's practices regarding ethics codes.

Transcripts of the interviews were analyzed using the coding system developed by Hill et al., 2005 (Consensual Qualitative Research; CQR).

Procedure

Data was collected through semi-structured interviews. Two pilot interviews were

conducted, and the interview protocol was further revised based on these pilot interviews. Sixteen participants who met study inclusion criteria and agreed to be interviewed via phone were then interviewed individually. The principal investigator conducted each interview, and every attempt was made to follow the script that was developed specifically for this study (see the Interview Protocol, appendix B). The interview was tape-recorded with participants' consent. Interviews ranged from approximately 38 to 57 minutes long, with most between 45-50 minutes. The participants were assured of full confidentiality, and informed that their identity would not be disclosed in any manner (see the Participant's Rights and Consent forms, appendix A). Participants were told of the nature and purpose of the study, debriefed at the conclusion of the interview, and informed that they may request study results that will be delivered via email.

Data Analysis

Two graduate-level students enrolled in the M.A. program in Clinical Psychology at Teachers College, Columbia University transcribed the participant's speech verbatim. These students were affiliated with the principal investigator's research lab but were otherwise not involved in or knowledgeable about this research project. They were presented with the interviews after they had been de-identified by the principal investigator.

Given the exploratory nature of the investigation, this study was well suited for a qualitative approach. A consensual qualitative research approach (CQR) was used to code and analyze the qualitative interview questions (Hill et al., 2005; Hill, Thompson, & Williams, 1997). CQR highlights the use of multiple researchers, reaching consensus as a team, and the systematic methodology of examining the representativeness of results across cases (Hill et al., 2007). According to Hill et al. (2005), a strong sample of approximately 15 participants is critical for effective CQR, given the emphasis of words and experiences in the CQR methodology.

Hill et al. (2005) highlight that the aim of CQR is “to faithfully represent how participants describe their experience” (p. 197). Hill et al. (1997) describe eight key components to CQR: 1) Data are gathered using open-ended questions so that participant responses are not constrained; 2) Participants describe the phenomenon through words rather than numbers; 3) A small number (~15) of participants are studied comprehensively; 4) The specific parts of the phenomenon are understood in the context of the whole case; 5) Results/conclusions are built from the data (inductively); a priori hypotheses are not tested; 6) All judgments are made by a primary team of three researchers who code the data independently and then argue to consensus, permitting a variety of opinions for each coding decision; 7) One or two auditors check the consensus judgments of the primary team to ensure that no important data is overlooked; 8) “The primary team continually goes back to the raw data to make sure that the results and conclusions are accurate and based on the data” (Hill et al., 1997, p. 523).

In terms of a philosophical stance, CQR is constructivist with some postpositivist elements (Hill et al., 2005): “We recognize that people construct their reality and that there are multiple, equally valid, socially constructed versions of ‘the truth’. We also look for commonalities of experience among participants, which is another form of constructed reality” (Hill et al., 2005, p. 197). The interviewer is seen as a “trustworthy reporter” who seeks to discover the participant’s true experience by learning from the participant about the phenomenon. The researcher influences the participant by asking follow-up questions to help the participant fully explore his/her experiences. According to Hill et al. (2005), “We believe that researcher biases are inevitable and should be discussed at length (constructivistic) so that they can be kept in check and not unduly influence the results (postpositivistic). As much as possible, we want to faithfully represent how participants describe their experiences rather than

communicate how we as researchers experience the world (postpositivistic)” (p. 197). The use of a consistent semi-structured interview protocol minimizes the impact of interviewer bias.

Research team. In this study, the CQR analysis team consisted of the primary researcher, a Caucasian, male, advanced doctoral student in clinical psychology who had, prior to data analysis, three years of experience providing psychotherapy to a wide range of ethnically-diverse patients in New York City. The second team member was a Caucasian American, female, second year clinical psychology master’s student, who at the time of data analysis was involved in a second qualitative research project which utilized CQR. The third team member was a Caucasian American, female, second year clinical psychology master’s student who, during data analysis, also worked as a clinical researcher at a local hospital. Both team members were accepted to clinical psychology doctoral programs at the time of data analysis. The auditor was a Caucasian American, female, advanced clinical psychology doctoral student, who was completing her clinical internship and was well-versed in the CQR auditing and procedure given that she was also finishing her own dissertation using CQR methodology at the time.

All three team members were new to the CQR method, and therefore, in accordance with Hill et al. (2005)’s description of thorough training, underwent several sessions of training prior to data analysis. The team studied Hill et al.’s (1997) training manual, Hill et al.’s (2005) CQR update, and numerous CQR exemplar studies. A knowledgeable CQR researcher served as auditor, and an experienced CQR researcher and faculty member served as mentor and consultant to ensure that the team carefully upheld CQR procedures.

Following Hill et al.’s (1997; 2005) guidelines, the three team members explored and discussed their individual expectations and biases regarding the potential nature of the results of the study, i.e., their values, beliefs, and expectations about the topic of informal supervision. This

meeting occurred prior to starting data analysis in order to minimize the effect of these personal expectations on the team's analysis of the data.

Expectations were defined as “beliefs that researchers have found based on reading the literature and thinking about developing research questions” (Hill et al., 1997, p. 538). The meeting revealed that the expectations of the team included the belief that since all participants used informal supervision, they would view informal supervision as an important tool in their clinical and professional development. As a result, they might be primed to highlight the more positive aspects of the phenomenon. Team members also assumed – given their knowledge of the research literature on formal supervision that showed that supervisee nondisclosure may be nearly universal (Ladany et al., 1996) – that participants would discuss aspects of their clinical work with informal supervisors that they felt uncomfortable talking about with their formal supervisors. To address this expectation, the research team devised a neutral interview question regarding comparisons between formal and informal supervision: “How are your conversations with your formal and informal supervisors similar to and different from each other?” The primary researcher, who used informal supervision throughout his clinical training, expected that participants would seek informal supervision for emotional support and validation when they felt distressed about their clinical work. As a result, he acknowledged his strong belief that participants would discuss the ways that they sought support and validation from informal supervisors throughout their clinical training. Similarly, he expected that trainees would seek informal supervision to talk about strong countertransference reactions to patients, as well as anxieties and self-doubt that arose in the context of working with challenging patients.

Biases were defined as “personal issues that make it difficult for researchers to respond objectively to the data” (Hill et al. 1997, p. 539). Potential biases included the fact that the

primary researcher had conducted therapy for three years as a trainee, and utilized informal supervision with peers and colleagues as a companion to formal supervision throughout his training. He had a vested interest in better understanding the phenomenon of informal supervision with the eventual hope of legitimizing its practice, since he felt that he had benefitted from it in various ways throughout his training, ranging from receiving validation and emotional support, discussing personal reactions to patients, gaining insight into his work, conceptualizing patients from multiple theoretical perspectives, sharing the true extent of his uncertainty and self-doubt in learning to provide psychotherapy, and utilizing the freedom that arises from discussing clinical work with a non-formally assigned supervisor to openly and authentically explore the most challenging aspects of clinical work. These biases were curbed by his nearly exclusive positive experiences in formal supervision, his deeply held belief that formal supervision is the primary and most valuable vehicle for learning to do clinical work, and his belief that all clinical material that he talked about in informal supervision should also be a topic of conversation in discussions with his formal supervisors. Given these feelings, the primary researcher was open about potential overestimation of the positive effects of informal supervision. With an awareness of this bias, the other team members indicated to the primary researcher throughout analysis if they believed him to disregard evidence to the contrary. The primary researcher was also challenged when others believed that his interpretation of more vague passages of the transcript relied too heavily upon his previous experiences providing therapy and seeking informal supervision.

Each of the other team members were women interested in clinical practice and research. Although they had never provided psychotherapy and therefore experienced formal supervision and/or sought informal supervision, they were well versed in clinical theory and the research

literature on formal supervision. This led them to voice beliefs that if they were to provide psychotherapy to patients, they would seek informal supervision to help cope with the stresses and demands of clinical work. As a result, during the process of analysis, the team discussed in the moment if any member appeared to apply her own imaginings of seeking informal supervision in interpreting participants' statements. The team challenged one another throughout the data analysis to remain objective when analyzing trainee participant responses.

Coding data into domains: Data analysis followed three steps: developing domains, constructing core ideas, and performing a cross-analysis (Hill, 2012; Hill et al., 1997). The first step of this CQR analysis involved coding data into domains. The research team created a working list of domains based on the content of the interview protocol and the pilot interviews. Once the interviews were transcribed, each primary team member independently (not in the presence of the team) read through each transcript and assigned each block of data (ranging from individual sentences to long paragraphs) to a domain or topic area for each individual interview. Domains are used to group information/data about similar topics, and have been referred to as “start lists”, or a conceptual framework to begin organizing the immense amount of data collected in qualitative research (Miles & Huberman, 1994). According to Hill et al. (1997), “domains change to fit the specific data set after the team feels that they have reached the most elegant way to segment the data” (p. 544). Some domains needed to be altered to better fit the data and some need to be deleted because no data fits into them. After the primary members independently coded all material in each individual interview into domains, they met to discuss and arrive at consensus about the best possible coding for each domain. The auditor once again reviewed the team's work and provided feedback on the representativeness of the core ideas. The now cored domains were adapted with consensus by the team to include the auditor's feedback,

including the domain titles and all of the excerpts from the interview (raw data) for each domain (Hill et al., 1997).

Cross-analysis. The second step consisted of creating core ideas to summarize the content (i.e., derive themes) of each domain for each interview: “each primary team member independently reads all of the raw data for a domain and then summarizes the ideas into core ideas” (Hill et al., 2007, p. 546). The coders aimed to capture the essence of what each interviewee said about the domain succinctly and with greater precision. This process was not interpretive; rather, the coders extracted the core ideas from the explicit meaning of the raw data. During this step, the coders were acutely aware of the possible influence of interpretive biases. As with the construction of domains, the researchers coded each interview. Core ideas within the domains were reviewed and the team argued to consensus to cluster them into categories. The auditor was again invited to examine the categories. After the primary researcher completed his data defense and received feedback from three faculty members who serve on his dissertation committee-- one of whom is an expert on CQR methodology--the primary researcher refined three categories to capture the data with greater precision. As a result, the categories *Validation and reassurance* and *Emotional support*, located under the domain *What trainees get out of informal supervision*, were combined to form one General category: *Emotional support and validation*. The category *Greater performative aspect to FS* was subsumed under the category *Differences resulting from power dynamic* under the domain *Comparisons between formal and informal supervision* to form one General category: *Differences resulting from power dynamic*. Lastly, two participant responses from the category *Stresses of working with challenging patients* were found to better fit under the category *Countertransference/personal reactions to patients* under the domain *Topics and themes discussed in informal supervision*. As a result, this category

frequency label changed from Typical to General.

Frequency labels. Lastly, a cross-analysis was performed in which categories were created that captured similarities in core ideas across the interviews. Hill et al. (1997) described this process as “discovery oriented ... (and) creative as team members try to determine similarities between cases and capture the essence of the phenomenon in words” (p. 550). Categories were characterized according to frequency, so that *General* results apply to all cases or all but one case. A category is considered *Typical* if it applies to at least half of the cases up to the cut-off for general. A category is considered variant if it applies to at least three cases but fewer than half of all cases. Lastly, a category is considered *Rare* if it applies to two-three cases in samples of 15 participants or greater (Hill et al., 2005). Therefore, in this study for the overall sample, general applied 15-16 cases, typical applied to 8-14 cases, variant applied to 3-7 cases, and rare applied to 2 cases.

Stability check. CQR incorporates a stability check to determine if additional cases would change the results. Two interviews chosen at random were set aside at the start of analyses and analyzed for the stability check to identify the presence of any new domains, core ideas, categories, or frequencies of categories. Stability of findings was achieved in this study per Hill et al. (1997), as frequency labels were consistent between these two interviews and the rest of the interviews.

Chapter III: Results

Analysis of the transcripts yielded 11 domains and cross-analysis of these domains determined between 3 and 9 categories. The results of the study are presented below according to the 11 domains that reflected participants' experiences with informal supervision, and are displayed as subsection headings. Categories within domains are represented with italics. As outlined by Hill et al. (2005) frequency labels were assigned to each category and reported. In this study for the full sample, general applied to 15-16 cases, typical applied to 9-14 cases, variant applied to 3-8 cases, rare applied to 2 cases, and miscellaneous applied to 1 case. Domains, categories, and their frequencies are presented in Table 3 (p. 130).

Preferred qualities of Informal Supervisor. The first domain encompassed overarching characteristics of participants' primary informal supervisor. This domain captured the unique personal characteristics that led participants to seek informal supervision from their primary informal supervisor. A typical category that emerged in this domain was *Open-minded, non-judgmental, and validating (Rogerian)*. In other words, the majority of participants valued these qualities in their primary informal supervisor. Many participants described their primary informal supervisor as some combination of "open, kind, supportive, and caring". One participant shared that his primary informal supervisor is "non-judgmental and values using one's heart and values to guide decision making in clinical work." Another participant emphasized that her primary informal supervisor possessed qualities that allowed her to feel safe expressing vulnerable emotions: "She is someone I can express anxiety to, complain about clients and our dynamics, and share my real feelings." A second typical category was *Thoughtful, curious, and gives good feedback*, as described by one participant: "He's insightful, a great listener, and really interested in what I have to say. He has a genuine interest in

psychology, is very psychologically-minded, and engaged”. A common theme amongst participants was that their primary informal supervisor gives valuable feedback and input, and is thoughtful and helpful. One participant in particular described her primary informal supervisor as, “curious. She has wonder about the work and shares in moments of awe with me.” The third typical category was that the primary informal supervisor shared a *Similar background/perspective* with the participant. Participants sought primary informal supervision from individuals who were also learning to do clinical work and who shared similar approaches to treatment. One participant shared: “She’s also in the program and going through the experience with me, so we have a lot of shared context that makes it easy and natural to communicate about my cases”, and another replied: “My informal supervisor is a friend from my cohort who I’m very close to. We see things the same way as clinicians.”

Five variant categories also arose in this domain. The first, *Experienced and knowledgeable psychotherapist*, reflected that many participants respected these qualities in their primary informal supervisor. Multiple participants sought out a primary informal supervisor who was a few years ahead in his/her respective program: “My informal supervisor is a couple of years ahead of me and finishing up her post-doc. She is more experienced than me and has a breadth of knowledge in the field.” Other participants noted that they valued their primary informal supervisor’s clinical expertise. A variant number of participants also believed that having a *Close relationship with my informal supervisor* was important. Participants noted that their primary informal supervisor knows them better than anyone else in their life, and one participant shared: “My primary informal supervisor is the person I’ve spoken to about clinical work the most, and someone who I know very well on a personal level, which makes it easy for me to ask questions.”

A variant number of participants also emphasized that their primary informal supervisor is *Challenging and direct* in their approach to informal supervision. One participant shared that her primary informal supervisor challenges her approach to case conceptualization and another noted that her primary informal supervisor provides direct feedback on the quality of her clinical work because “politics did not enter into the equation”. Another participant elaborated on the challenging and direct qualities of her informal supervisor: “She looks at things with realism and ruthlessness, and does not expend a lot of energy complimenting, reassuring, or building me up. She’s direct. She challenges me.” Another variant domain showed that participants’ primary informal supervisor had the quality of *Providing alternative perspectives*. One participant shared, “He was trained in a different theoretical position with a different perspective which was really useful,” and another said, “My informal supervisor’s training was slightly different and more psychodynamic, so she is able to offer a dynamic, interesting perspective.” A variant number of participants appreciated that their primary informal supervisor was *Available on demand/as needed*. These participants valued the ease with which they could seek informal supervision as needed. They either shared an office with their primary informal supervisor or felt authorized to call their informal supervisor on demand.

Reasons for seeking informal supervision. The second domain reflected broad, general reasons for and situations in which trainees sought informal supervision. Participants’ responses were typical for the category of *Liberty to speak honesty about the work*. One participant described the essence of this category:

I seek informal supervision to be fully honest. It is important to me to share the affective experience that comes with the work in order to metabolize it and loosen it up, letting go in a way that wouldn’t be appropriate in a more

formal context.

Many participants noted that because they did not feel evaluative pressures or fear of judgment from their informal supervisors, they were capable of talking about their clinical work, and specifically their doubts, fears, and concerns about the quality of their work with freedom, openness, and creativity. One participant's response best reflected this notion: "I seek informal supervision from him because there's a real liberty in talking to him that's absent from my formal supervision because I don't feel like I have to present case material, have all the answers, have things figured out, or know what I'm going to say ahead of time." Another participant spoke to the humanizing aspect of speaking with complete honesty about her patients in informal supervision: "Sometimes I need a place that does not judge, where I don't have to speak in psychology terms, use constructions or theory, where I can let all of that go and just talk about my patients and myself as people." A second typical domain for why participants sought informal supervision was that their informal supervisor provided *Support; a holding environment*. Many participants sought informal supervision for "support, validation, comfort, and reassurance." Others wanted to know that they were not alone in feeling lost as a beginning therapist. One participant noted: "I seek informal supervision to balance myself out, to remind myself that I know what I'm doing. I seek informal supervision when I'm exhausted, angry, crying about my work because I need someone to listen and take me in."

Another typical domain was *Process personal reactions (e.g., countertransference) in a constructive way*. Participants sought informal supervision to discuss personal reactions to patients that continued to impact upon them well after their therapy session. One participant shared: "It is important to share the affective experience that comes with the work in order to metabolize it and loosen it up, to let it go in a way that wouldn't be appropriate in more of a

formal context ... and to identify my feelings and notice their impact on the work, and how to manage my feelings in the moment.” Many participants emphasized the importance of processing countertransference reactions with an informal supervisor who conveys a sense of understanding for the participant outside of a clinical/therapeutic context. One responded, “The biggest reason (I seek informal supervision) is because something has come up in session that is very difficult for me to contain emotionally and I really want to talk it through with somebody who understands me and understands why it's affecting me.”

Participants’ responses were also typical for *Needs help with clinical work*, as reflected broadly by a participant, who shared: “I seek informal supervision because I want to know how I can do this work better, what am I missing, what did I do well, what can I do better, and what should I stop doing?” Many respondents sought informal supervision because they wanted “advice”, while one wanted to “strategize about appropriate next steps when a client had a family issue involving some violence.” A final typical domain was *Availability*, which captures a basic and essential nature of informal supervision: it is on demand. Many participants sought informal supervision because the time allotment for formal supervision was insufficient. One participant noted: “I had a heavy case load (10 patients) and I couldn’t cover all my patients in an hour of formal supervision, and sometimes I couldn’t wait five or six days to see my formal supervisor when something really upsetting happened, so I’d seek informal supervision. Participants also sought informal supervision when their formal supervisors were busy or unavailable, and at night when their cases were “still on their mind.”

Three invariant domains also emerged in this category. The first, *Issues with formal supervision*, included two types of participants – some sought informal supervision to specifically discuss dilemmas with their formal supervisors and others sought informal

supervision because they either felt unsatisfied with or disconnected from their formal supervisor. The former was typified by the following participants' responses: "I talk about supervisory dilemmas with my informal supervisor", and "I reach out for informal supervision when something has gone wrong with my assigned supervisor. . .[for example] my informal supervisor helped me talk through a rupture with a supervisor I had an icy relationship with". The latter was well-represented by the following participant's response: "Sometimes I seek informal supervision when I don't click ideologically or personality wise with my formal supervisor. As a human being and an adult, informal supervision gives me the freedom to talk about the work with someone who I have great personal chemistry with." Another shared: "I seek informal supervision to get support when my formal supervision isn't going so well or when I need to hear something different." In the second invariant domain, *Shared experience/bonding* participants spoke of sharing clinical work "as a basic human need." Associations were both general – "I feel driven to share my work because it is so exciting and it seems strange to hold it in" – and specific, "I seek informal supervision because it's a bonding opportunity to connect with a friend who knows what I'm going through and can share it with me."

What trainees get out of informal supervision. The third domain captures how informal supervision impacted trainees' personal and professional development. One General category emerged from this domain, *Emotional support and validation*, in which participants valued the extent to which they received "support, reassurance, comfort, validation, and reinforcement" from their informal supervisors. This category highlighted the importance of positive regard. One participant explained, "I get validation that my clinical intuition is right", and another noted, "I get reassurance and reinforcement that clinical work is not easy and I'm doing my best." When trainees received validation and reassurance from their informal

supervisors, they felt a positive impact on their clinical performance. After feeling validated by an informal supervisor, one participant felt “courage”, one “got unstuck when paralyzed by doubts”, and another felt “grounded. Without it, I would feel lost and unsure of what I’m doing and fighting that feeling as opposed to accepting it.” Emotional support was captured by the vital role that informal supervisors played in containing the considerable emotional distress that trainees inevitably experience in learning to do clinical work. One participant spoke of the “catharsis of being able to talk about a really intense session and get things off my chest the day that it happens”, and another noted that “sharing my feelings, venting, makes me feel not crazy.” Some participants noted that informal supervisors help them to reframe and release the sometimes destabilizing emotions that arise from clinical encounters so that they can think more clearly and re-engage their patients more effectively.

Three typical categories emerged for this domain, and the first, *Openness and freedom to discuss fears/mistakes/challenges*, was typified by one participant’s response: “I get to brainstorm with my informal supervisor and authentically express confusion and fear, like I don’t know what the hell I’m doing, this person scares the crap out of me.” Multiple participants noted that by loosening their professional boundaries, they were able to process the most challenging aspects of their clinical work without having to worry about seeming incompetent. One noted: “I get to process the really difficult, emotional stuff that comes up in the process of doing therapy. And that is very helpful, especially when it comes to issues that have come up from my clients that I haven’t totally worked out for myself yet in life.” For these participants, sharing a full range of clinical experiences facilitated new ways of thinking about and working with their patients.

The second variant category, *Different perspective*, reflected how greatly trainees value

the multiplicity of perspectives they gain from informal supervisory conversations. Some participants mentioned the value of consulting with informal supervisors who approached clinical work from a different theoretical orientation, while others appreciated when their informal supervisors presented them with alternatives to action that hadn't been previously considered. One participant noted that her informal supervisor's different perspective allowed her to deepen her understanding of her work: "It gives you a chance, in a less stressful situation, to talk about it, explain it, hear feedback, and maybe add or change the way that you're thinking about particular aspects of the case to arrive at a deeper and different understanding of the problem." A final typical category, *Insight*, highlighted the extent to which trainees learned from their informal supervisors. Examples included excellent feedback, suggestions, specific ideas for interventions, clinical wisdom, context-dependent advice, and culturally-sensitive insights. Many participants noted that they received clinical insights that took into account the impact of the trainee's personality on treatment. For example, one participant shared: "What he offered to me is that it was an aspect of my personality that he was aware of that could be a little stronger, not harsher, but a little bit more direct and honest and frank with my patient. I got a unique perspective on how that was impacting the treatment and relationship I have with my patient."

Two variant categories also characterized this category. *Connection*, a sense of closeness born from sharing the experience of becoming a clinician, was a common and important outcome of seeking informal supervision. Participants spoke of feelings of intimacy and closeness as a result of informal supervision offsetting the sometimes isolating nature of clinical work. One participant's response best captured this sentiment: "There's the camaraderie, the element of going through with other students, going through this, the same learning curve as somebody, and knowing you are sort of on pace with everybody else, when you have these conversations with

other students, you're building these bonds that ultimately help you stay in your profession, helps you appreciate your profession and feel connected to other people.” The last variant category, *Increased capacity to access feelings*, described how informal supervision discussions facilitate a deeper exploration of participants’ feelings about their patients and themselves. One participant spoke about how informal supervision helps her to overcome her tendency to intellectualize patients, instead allowing her to experience powerful feelings that permit her to remain present and centered in her clinical work. Another participant “was able to let off steam about how much I disliked her patient’s mother. My informal supervisor said to me some of the more extreme things I thought about my patient’s mother but didn’t feel comfortable saying, like how terrible the mom was and that the mother was emotionally negligent.”

Tone of Informal Supervision. The fourth domain reflected the tone – the distinctive quality or character, i.e., subjective ‘feel’ – of informal supervision conversations. Two typical categories emerged, and the first, *Humorous and playful*, highlighted the uniquely playful, light, funny, and humorous aspects of informal supervisory exchanges. One participant noted: “With some students [informal supervisors], I think it's lighthearted, it's really fun. It takes this very serious work and adds an element of levity and humor to it that's not always apparent when you're just working alone with clients.” The second typical category was *Natural and causal*, and captured the informal nature of these conversations. One participant shared: “The tone is informal. My thoughts are less formulated. I probably sound less certain of myself that I would otherwise. It feels much more like a conversation between friends as opposed to a presentation or summary,” and another noted, “The tone is easy and natural. It often starts in the lounge after a session. My informal supervisor may ask, ‘How was it?’ And then once we start talking the tone and vibe is warm. There’s a relaxedness to it and it feels very comfortable.”

Four variant categories, including *Supportive and mutual*, *Honest and direct*, *Emotive*, and *Energizing and engaging*, also emerged. The first, *Supportive and mutual*, highlights the multidirectional and reciprocal tone of informal supervisory conversations. Participants noted that “we lean on each other”, “there’s a shared excitement about the work, the experience of being in the room, a drive to share, a trust in the process, and a sense of mutuality.” For many trainees, a supportive and mutual tone allowed them to communicate more easily about their cases. The second variant category, *Honest and direct*, captured the open and to-the-point nature of these exchanges. One participant shared that the honest, open, and trusting tone allowed her to not make excuses, and another extrapolated: “The tone of informal supervision is usually as brief and direct as she can manage, and less theoretical. I am like, ‘This is the situation, this is my impression, and I just need a moment to acknowledge that this is weird or wonderful or whatever’”. The third variant category, *Emotive*, reflected the emotion-laden tone of some informal supervision conversations. One participant spoke about how depending on her mood, the conversation can be all over the place, and another noted that “the tone can range from real serious, sad, or angry. I go through my emotions with my patients and my informal supervisor listens and reacts.” Many participants noted that the tone is close to their real feeling state in the room with patients. The fourth variant category, *Energizing and engaging*, captures the excitement of discussing clinical work. Participants described the tone of these conversations as “energizing, enthusiastic, intellectually curious, and excited.”

Topics and themes discussed in informal supervision. The fifth domain captured the major clinical topics and themes, i.e., the ‘what’ that trainees discussed in informal supervision. One General category emerged. *Personal reactions to patients/countertransference* were the topic of conversation for almost all participants. Trainees discussed romantic

countertransference, defensiveness, doubts, insecurities, anger, sadness, anxiety, guilt, and therapeutic ruptures. One participant “remembered being in session and physically shaking inside although I appeared composed on the outside. I was able to talk about some of that in formal supervision, but it was in informal supervision where I was able to talk about how much he got under my skin.” Another participant explored his personal reactions to a patient and arrived at a deeper understanding of his dynamics with his informal supervisor: “I shared my experience, how terrified, upset, and angry I had been (with his patient). Then we explored this parallel process between me blaming my patient for my own problems and my informal supervisor blaming me for her problems.”

Three typical categories emerged, and the first *Self-doubts*, included both participants’ general fears of incompetence (e.g., “I felt like I failed my patient”; “I was freaking out about my patient wondering if I did something terrible and wrong, and wondering, ‘what should I do’”) and worries that specific clinical decisions (e.g., not following a CBT protocol but instead interpreting dreams) negatively impacted upon treatment. One participant’s response epitomized the general feeling of self-doubt that many participants discussed in informal supervision: “I discuss my doubts and the places where I feel really insecure - my confusion about cases and progress for each case.” Another participant discussed feeling self-doubt in the context of a very specific clinical situation: “I worried that a high-risk patient with PTSD, bipolar disorder, and substance use who did not endorse SI/HI ideation during session but was observed exhibiting erratic behavior post-session would hurt himself or someone else over the weekend. I was afraid I made a mistake by not hospitalizing patient. I went home and felt guilty and worried: ‘What have I done’?”

Stresses of working with challenging patients captured participants' experiences working with patients who evoked trainees' felt distress. These stresses ranged from fear of making a critical mistake, experiencing a parallel process to a patient's primary problem in one's personal life, feeling devalued, and having difficulty relating to patients' traumatic life experiences. One participant shared: "I talked about a really difficult, resistant, and defensive patient, and how hard it is to gain access to her emotionally, as well as how tough it is to deal with the patient's defensiveness. Another said: My first case was sort of my personal fear realized: a very aggressive male who didn't see me as a person, and was explicitly in my face, asking me to prove herself and the value of therapy. I remembered talking about being in session and physically shaking on the inside. The last typical category, *Patient's diagnoses (especially severe pathology)*, included patients diagnosed with bipolar disorder, schizophrenia, PTSD, OCD, narcissistic personality disorder, borderline personality disorder, anxiety, and OCD. One participant talked with her informal supervisor about working with "a particularly challenging, 16-year-old, Caucasian patient with multiple inpatient stays presenting with borderline features and difficulty attaching to adult figures." Relatedly, the fourth typical category, *Stresses of working with difficult patients*, reflected trainees' need to share the significant personal stress of clinical work with an informal supervisor. One participant shared: "Being able to sit in the room with my patient while going through a similar process (in my personal life) and having these previously unconscious fears now in the room scared me greatly", while another noted, "My first case was sort of my personal fear realized, a very aggressive male who didn't see me as a person and was explicitly in my face, asking me to prove myself and the value of therapy. I remember being in session and physically shaking on the inside."

Three variant categories were also formed based on participants' responses.

Unsurprisingly, some participants talked to their informal supervisors about *Disagreements with formal supervisors*. These participants' followed their formal supervisors' directions even though they disagreed with them, and thus sought informal supervision as a space to process their feelings about these disagreements: "The staff of a city hospital did not show respect toward a transgender patient. I wanted to tell my experience to my informal supervisor and just say 'Can you believe this nonsense is happening', and also to see whether I did the right thing and ask what my informal supervisor would have done." Another variant category was *Difficulties working with a multidisciplinary team*, which captured moments when participants' spoke to their informal supervisors about difficulties working with others to achieve a common goal in regard to patient care. One participant shared: "I had a case transferred to me on an inpatient unit and it was a patient that everyone hated, was very challenging to manage on a team level, wet the bed every night, whined, and (basically) acted like a three-year-old. The team was so horribly annoyed with the patient that they were beyond being able to help me with the case." The last variant category for this domain, *Challenges of conceptualizing cases from different perspectives*, included a participant who talked with her informal supervisor about how to best treat PTSD from multiple therapeutic approaches and a trainee who wondered how to best conceptualize a patient who initially wanted structured CBT treatment for anxiety but later shared a deep, underlying traumatic experience that led the trainee to re-conceptualize her patient's problems in the context of his trauma.

Comparisons between formal and informal supervision. The sixth domain highlighted significant differences (and in some cases, similarities) between the nature, uses, and impact of formal versus informal supervision conversations on trainees' clinical work and professional

development. One General category emerged for this domain. In this General category, *Differences resulting from power dynamic*, participants' emphasized that in formal supervision, they experience a strong power imbalance that often inhibits "free, safe, flexible, spontaneous, and playful interactions" because they feel "evaluated and judged, did not choose my formal supervisor, (and) want a good letter of recommendation, want to maintain a professional presentation, need to be organized, (and) am intimidated by how much more experience they have." As a result, one participant noted: "From the start, formal supervision has felt more high stakes, where I have to be accurate about sessions, give evidence or a transcript of everything that has transpired." Another noted how the absence of power dynamics in the informal supervisory relationship leads to more enlightening supervisory conversations: "Because she's not evaluating me and because there's a real confidentiality there, I feel much more open about what I can share with her." Another said, simply: "The lack of boundary deepens the informal supervisory experience."

Three typical categories emerged, and most participants noted the stark *Differences in language, structure, and tone, i.e., informal supervision is more informal* between formal and informal supervision. Participants described differences in language, e.g., "In formal supervision, I try to use academic language and sound smart, whereas in informal supervision, I talk about patients as if I were describing a new person" and "In formal supervision, I feel trapped using jargon and there's more use of constructions and theory, whereas in informal supervision, I am more descriptive," structure, e.g., "In formal supervision, I try to present my clinical work more cohesively in terms of narrative and what I have concerns about or want advice about, whereas informal supervision is much less structured", and tone, e.g., "Informal supervision is more conversational ... it has a very different tone." One participant best captured these differences in

a single response:

In formal supervision, I use an academic, clinical language where I have to be zipped up in terms of how I talk. And the conversations are structured differently.

In formal supervision, I'm more attentive to the structure and presentation of the conversation, which is organized around content, whereas in informal supervision, the structure is organized around emotion and stems from a certain feeling.

The third typical category, *Informal supervision is organized around emotions and countertransference reactions*, highlighted the extent to which participants used informal supervision, in contrast to formal supervision, to let their guard down and openly explore their emotions and personal reactions to patients without fear of negative consequences. One participant shared: "With my formal supervisor, I hold back more of my own values and emotional reactions (but) in informal supervision, I can share what I want because it's more about sharing how it feels as opposed to some exact on the record transcript of what happened". Another noted: "In informal supervision, I am able to be much less guarded about my personal reactions and feelings, which come out in a way that it does not or cannot in formal supervision." One participant shared how the personal nature of her relationship with her informal supervisor facilitated a deeper emotional exploration of her clinical work: "My informal supervisor knows me intimately and can access deeper aspects of my work that a formal supervisor just can't. [With my informal supervisor], I can be emotionally vulnerable and just let go and say whatever I feel by using a casual language that's closer to my feeling state."

While participants noted significant differences between formal and informal supervision, many noted important commonalities, as captured by the typical category *Informal and formal*

supervision are more similar than different. Participants shared that they often discussed “the things from session that feel most salient, valuable, and relevant” – typically challenging clinical moments and mistakes – in both types of supervision, and some participants noted they are similarly “honest, open, and genuine” in both contexts. One participant shared a relatively uncommon experience: “I haven’t said anything to my informal supervisor that I wouldn’t say to a formal supervisor.”

The one variant category for differences between formal and informal supervision was *Differences in content*, which referred to the different topics of conversation in formal versus informal supervision. One participant shared that he had more philosophical conversations about the nature of psychotherapy in informal supervision and another said that she talked about how her personal relationships impacted treatment in informal supervision. Both participants noted that they did not have these types of conversations with their formal supervisors because of the evaluative nature of that relationship. One participant’s response best encapsulated this category: “Other things come up in supervision, things about relationships and things about lifestyle but they’re evaluating me and they’re going to be writing recommendation letters, and I know that they’re things that I want to share with somebody that are simply too private to be sharing with my supervisors, who’ll be writing these evaluations.”

Changes in use of informal supervision over time. This domain spoke to the ways that participants’ use of informal supervision changed over the course of their clinical training. One typical category, *Informal conversations more intentional and focused over time*, emerged. One participant’s response captured this phenomenon:

Over time, I stopped casually falling into conversations [in informal supervision] about clinical work. I then began to seek informal supervision with purpose,

in a thoughtful way in a private place, whereas early in training I shot the shit about clients in the lounge just to make conversation about her client's personal life or about what's going on with me and my work with her client. I still speak casually but appropriately in the lounge about what I'm experiencing as a therapist in training, but I am circumspect about anything I might say about a client.

Many participants shared that early in training, they sought informal supervision because they felt anxious, overwhelmed, and uncertain about their ability to help their clients. These trainees reported that with time they realized that they could contain their experiences on their own and that they were developing into competent therapists, and thus began to use informal supervision in more intentional and targeted ways. One participant shared: "As the years went on, I realized I was a decent therapist and informal supervision became based more on my relationships and less on feelings of confusion about the work. It focused more on specific issues with patients, feelings that came up about the patient or my issues like countertransference, and issues with supervisors". Another said: "As my clinical abilities have increased and I have become a more sophisticated clinician, my informal supervision sessions have become more sophisticated or nuanced and my ability to just say more about what was going on between me and a patient in session has come through more in [(informal)] supervision. Now it would be more about reflecting on my experience, the process, and the interaction between me and my patient."

There were two variant categories for changes in use of informal supervision over time. The first variant category, *Greater reliance on informal supervision to discuss specific clinical issues versus basic parameters*, showed that early in training, participants used informal supervision to ask questions about how to establish a therapeutic frame (e.g., what to do when a

patient doesn't call back) and to discuss general feelings of confusion about clinical work. Over time, these participants used informal supervision to discuss specific clinical issues, "like shameful thoughts and feelings and challenging clinical encounters." One participant noted: "As the years went on, I realized I was a decent therapist and informal supervision became based more on her relationships and less on feelings of confusion about the work, and focused more on specific issues with patients." *Less need for informal supervision to provide emotional support over time*, the second variant category for this domain, showed that some participants relied less on their informal supervisors for emotional support as they became better able to contain their emotional responses to patients. One participant noted: "When I just started, I was really leaning on the people, who were in the years above me. But now that I've been seeing clients for 2 years, you know, like I'm a big girl. I can put my big girl pants on."

Reasons for informal supervision with significant other. This domain reflected trainees' experiences seeking informal supervision from their significant other. One typical and two variant category emerged for this domain.

The one typical category for this domain, *Emotional support*, reflected participants' experience receiving "emotional support, holding, a warm hug, [and] real empathy" when seeking informal supervision from their significant other. Most participants spoke about their emotional reactions to patients with their significant others and felt grateful for the support they received, often at the end of a long day. One participant spoke about how informal supervision with her significant other allowed her to release tension left over from clinical work so she could enjoy her evening at home: "I'm grateful I can use my boyfriend as an outlet at the end of a challenging day to talk about the emotional impact of certain cases or scenarios that I'm not able to let go of so that they don't fester, and this also helps me transition to not being at work."

Another participant spoke more generally about her experience receiving emotional support from her significant other: “I get emotional support, support to explore my ideas with someone who thinks I’m a good person and knows what I’m doing. I go through my emotions with my patients, talk about specific issues with patients, feelings that came up about the patient, the work in general, and countertransference feelings.” Another participant shared that she specifically seeks emotional support without clinical guidance from her husband: “When I’m talking to my spouse, I want support and a warm hug, not his thoughts on what she should do or what something means going forward.”

Two variant category emerged for this domain. *Helpfulness of significant other*, the first variant category for this domain, captured the extent to which participants’ experienced their significant other as “helpful, thoughtful, insightful, and respectful.” One participant’s response best captured the essence of this category: “She knows me intimately and I trust her opinion a lot so I can explore countertransference with patients with her. I seek informal supervision from her for a different perspective, help, insight, and resolution around not knowing how to handle challenging situations. I talk about aspects of [clinical] work that I don’t share with formal supervisors because it isn’t comfortable sharing.” Another trainee echoed this participant, adding: “I have found informal supervision with my husband to be very helpful and similar to the experience with my informal supervisor.” The second variant category for this domain, *Beneficial aspects of limiting clinical details with significant other*, captured the ways that participants felt that they benefitted from sharing some but not many clinical details with their significant other. One participant’s response best encapsulated this category: “When I first started doing therapy, I shared things that happened during the day in very informal conversation and not necessarily to seek guidance. I express general satisfactions like when I had a great

experience with a patient or felt really helpful, but will not go into too many details. I will share broadly when I am having a rough day. I see his role as being protective of me, not necessarily understanding my (clinical) experience.” One participant noted that she shares minimal details with her husband because she does not want him to feel like her field is alien to him and wants to cultivate an attitude of openness towards what she’s experiencing as a developing clinician, while another participant shared: “He gets highlights, like if something really wild happens or a patient says something really outlandish but there’s not the [same] discussion I would have with a colleague. He’s not in the field so that limits what I want to or can discuss with him about my work. I don’t really talk to him about many day-to-day details with cases.”

Reasons for informal supervision with one’s therapist. Similar to the above domain, this domain reflected trainees’ experiences seeking informal supervision from their personal therapist. One typical and three variant category emerged for this domain.

The only typical category to emerge for this domain, *Discuss countertransference reactions*, reflected the extent to which participants sought informal supervision from their therapist to explore emotional reactions to their patients. One participant’s response broadly captured this phenomenon: “I go to her when material from session is very difficult for me to contain emotionally and I really want to talk it through with somebody who understands me and understands why it’s affecting me. The biggest thing that I’m getting [from informal supervision with my therapist] is processing the really difficult, emotional stuff that comes up in the process of doing therapy.” Another participant noted that in processing her emotional reactions with her therapist, she can then bring those insights to her formal supervisor: “I see it as similar to informal supervisor [with peers] in the sense that I process feelings or thoughts and like realize I identify with a patient and try to think through how it influences my work, and can then bring

that to formal supervision. I have occasionally talked about cases with my therapist to try to process something that has come up for me, like when I was anxious about telling a patient I was pregnant for the first time.”

The three variant categories to emerge for this domain were *Issues with formal supervisors*, *Emotional support/validation (holding environment)*, *Advantages re: occasional short consult*, and *Helpful but complicated*. *Issues with formal supervisors* captured trainees’ experiences speaking to their therapists about “issues or problems with (formal) supervisors.” One participant shared that she sought informal supervision from her therapist when she experienced a crisis in her clinical work and “needed something different” from what her formal supervisor offered, while another noted that speaking to her therapist about an issue she was having with her formal supervisor led her to “talk about [the issue with my supervisor] a lot because it related to my past and my own dynamics.” Not surprisingly, trainees received *Emotional support/validation (holding environment)* when seeking informal supervision from their therapists. Participant responses included “I feel nurtured and taken care of by my therapist”, “I used my therapist for informal supervision a lot, especially toward the beginning of my clinical work to figure out if I was doing an okay job and was on the right track,” and “(she) basically helps me feel more comfortable in the room with (my patients) and lets me know that I feel taken care of.” The third and final variant category for this domain, *Helpful but complicated*, captured the ways that trainees felt their therapists to be helpful in providing informal supervision while also feeling conflicted about whether seeking informal supervision from their therapists was the best use of their time. One participant shared: “I felt my therapist was really good in terms of providing me with a sense that I would be okay, but I felt like talking about the specific issues of the case might be time better spent with someone else. In therapy, I wondered

whether I was talking about her work to avoid talking about myself.” Another participant best summed up the dilemma as captured by this category: “I have used informal supervision with my therapist, but I find that it is a hard decision to make because it feels like my time and I want to be talking about myself, but I also feel like my (clinical) work is part of me and I am invested in what my therapist has to say because of my respect for him as a clinician. I have always found informal supervision with my therapist valuable, and I think he is cautious of not being directive and is aware of how talking about clinical work may influence therapy or our relationship.”

Concerns about using informal supervision. This domain captured participants’ concerns about using informal supervision, ranging from worries about breaking privacy and confidentiality to wanting a more open dialogue about the appropriate uses of informal supervision to regrets about using informal supervision.

Four typical categories emerged for this domain. *Privacy/confidentiality* captured participants’ concerns that they had violated APA’s ethics codes regarding privacy and confidentiality. Many participants felt conflicted about whether or not it was acceptable to share identifying details about their patients with informal supervisors and some felt anxious that they had violated ethical boundaries. One participant shared, “This informal supervisor and I have run into boundary issues about what is appropriate for us to be sharing with each other about our respective cases... I wonder if I’m overstepping those.” Another noted: “I feel a little bit conflicted sometimes even when I share with my husband, like how much is okay to share (e.g., identifying information), if it is okay to share at all, and I try to withhold some things.” Many participants shared that even though they were concerned about breaking privacy and confidentiality, they were careful to only discuss clinical material with informal supervisors whom they trusted to maintain their patients’ privacy. For example, one participant reported: At

first I was a little more nervous about it and wondered whether it was an ethical problem. I'm still cautious with it and careful about who I use for informal supervision, only people I know and trust. I think people have to be careful, like not talking on the train after class, which is the toughest piece of it." This participant was one of many who noted feeling concerned that some peers talk about their patients in inappropriate places (e.g., the student lounge; the subway). Interestingly, the second typical category, *No concerns about privacy/confidentiality*, suggested that many participants are not worried that using informal supervision breaks APA's ethics codes. Some noted that they go to great lengths to protect their patients' privacy, as reflected by one participant's statement: "I'm not concerned about violating HIPAA because in general I protect identifying information and confidentiality, and I don't go into details, especially when in public." Others felt that it did not feel unethical to discuss patient material with fellow trainees, since they too are careful to respect patient confidentiality: "I feel like it should be generally be okay to discuss things psychologist to psychologist, as I have been taught that confidentiality is always within the system of care." Another reported that he "does not see any ethical concerns with discussing a case with another trained clinician." Lastly, one participant noted that she does not worry about confidentiality because "We kind of practice doing this already. We practice informal supervision in our classes."

The third typical category, *Informal supervision is inevitable*, captured participants' belief that it is unrealistic to expect trainees to not discuss their clinical work outside of formal supervision. One participant's response best encapsulated this sentiment: "People are going to do informal supervision because they benefit from it due to the field being a container for people's experiences, emotions, fears, and to hold all of those things is difficult. These feelings can be overwhelming, and so there's a draw to informal supervision, to help cope with the stress of

doing psychotherapy.” Some participants noted that clinical work is so central to trainees’ lives that it is nearly impossible not to seek informal sources of supervision: “I think it would make sense to develop some realistic norms, ethical codes, and expectations around what happens while people are actively in a training environment (because) it’s going to happen, it’s human that we would be talking about our cases to each other.” Another remarked: “Everyone does it. I think it would be nice if we were open with each other about the fact that everyone uses informal supervision and that it is helpful.” One participant suggested that it is unethical to not use informal supervision during and after training “because it helps with the work, keeps therapists accountable to more than themselves, and makes sure they are not doing it entirely on their own.”

The last typical category, *Wants open dialogue and guidelines regarding the use of informal supervision*, reflected participants’ belief that since informal supervision is an important and inevitable way that trainees develop as clinicians, it would be helpful for doctoral programs to openly discuss the uses of informal supervision and the ways to engage in informal supervision without breaking HIPAA’s ethics codes. Participants noted that “guidelines for ethical practice around informal supervision would be helpful”, and one participant noted: “I think informal supervision should be talked about more, and it needs to be clear and realistic about what’s acceptable and not acceptable. When I took an ethics class (in program), there was an unspoken feeling of how unrealistic some of the stipulations are, and that they are the product of a vague culture and profession.” Another trainee added: “Which would allow for some useful guidelines to be formed instead of just saying that no one can talk to anyone about anything. I think it would be nice if they were open with each other about the fact that everyone uses informal supervision and that it is helpful ... instead of just saying that no one can talk to anyone

about anything.” Multiple participants noted that the APA ethics code don’t cover everything and that there are many grey areas in which there may be a place for informal supervision. One participant reported: “I wish informal supervision was spoken about openly and I wish there were a component of a supervision class or a whole class (instead of it being) a hush-hush thing.”

There were three variant categories for this domain. The first variant category was *Confusion about whether or not informal supervision is ethical*. One participant’s response best encapsulated this category: “I’m just not sure what the bounds are ... there’s a lot of confusion here, policy-wise, around this issue of informal supervision. There’s a real ambiguity here. I’m confused about psychology’s rules and would like real clarifications from a practical standpoint of what people in the world are doing.” In general, participants noted that they felt confused about how much clinical material was appropriate to share with informal supervisors – that they did not know how far the lines of confidentiality extend. One participant shared: I think there are mixed messages in the field. Patient details are discussed throughout training and in group supervision with peers and with supervisors, but at the same time, chatting with a peer or co-therapist might be problematic for some therapists.”

The second variant category, *Negative experiences with informal supervision, e.g., regrets*, captured experiences in which participants’ used informal supervision and later felt regret, either because they worried that they had disrespected a patient by speaking negatively about him/her or had missed out on a learning experience by consulting with an informal supervisor instead of their formal supervisor. One participant shared: “I regret over-sharing some of my anxieties about a particular patient who made me feel uncomfortable. I felt as though I painted him in a negative light by speaking about him poorly when I should be looking for the good.” Another noted: “I’ve had regrets that I did a disservice to a patient by talking about her

outside of formal supervision, and I learned from this experience that I need to learn to tolerate and sit with challenging clinical situations more as opposed to just going out and asking for help.” One participant questioned whether he used informal supervision “to serve his own interests or as gossip or amusement”, and also noted that he was concerned “about appearing incompetent to other people by needing their help.” The third and final variant category, *Concern regarding lack of authorization*, reflected participants discomfort with providing informal supervision since they are not experienced therapists. These participants hoped that their clinical guidance would be off the record and not used as the deciding factor for how a fellow trainee proceeded with a patient. One noted: I have to make a sense of judgment about when or where it is useful or helpful because somebody who you're getting informal supervision from, at least in my experience, has been on a similar playing field and has a similar level of experience, so there's a little bit of uncertainty attached to it just based on that dual relationship.”

Experience providing informal supervision. The eleventh domain captured participants’ experience providing informal supervision to their peers. One typical category, *Positive/powerful experience*, emerged for this domain. One participant’s description best encapsulated this category:

Providing informal supervision creates a shared feeling and experience, a very positive one, and helps me realize how much I know. In offering input, feedback, and opinions, I feel surprised at how much I know. This experience also gives me more confidence. It’s also nice and feels reciprocal to hear a peer express some of the same thoughts and concerns that I’ve expressed to my peer.”

Many participants noted that giving informal supervision provided was a tremendous learning experience because it provided them with the opportunity to think through challenging cases in creative ways. Other participants noted that they gained experience as clinicians by working together with their peers to help conceptualize and approach tough cases in novel ways.

Participants also noted that providing informal supervision helped them to build intimacy and a sense of mutuality with their peers. One reported: “I think it is important to feel close to others, and talking about one’s therapy is a great way to get close to another person. There’s almost nothing else more intimate than that relationship with one’s patient, so it’s very intimate to share that with another person.” Another noted: “I really enjoy it and see it as a really nice way to build community and connection with peers, share minds, and a way to help one another, prevent isolation.” Relatedly, one participant shared that “it can be validating that somebody seeks your thoughts or a different perspective from you”, and multiple participants noted that they gained confidence in their own clinical capacities from offering clinical guidance to their peers.

Four variant categories emerged for the domain “Experience providing informal supervision”, and the first, *Frequent topics: Countertransference and clinical challenges*, captured the content that participants’ most frequently discussed when providing informal supervision. Participants provided informal supervision on “topics including exploring interpersonal dynamics with difficult patients with personality issues”, “how to deal with a difficult patient and making decisions about patient safety”, and providing support “when there’s been a highly acute suicidal scare and they can’t reach their formal supervisor.” The next variant category, *Provided common factors, e.g., support, empathy, and encouragement*, described participants’ experiences providing “support” and “empathy.” One participant noted that “it feels good to be able to help somebody and offer support.”

Another variant category, *Reciprocal nature*, captured participants' felt experience of mutuality and connection when providing informal supervision to their peers. One participant noted: "Informal supervision is reciprocal and there's no sense of burdening and that's why it's so powerful, there's a sense of mutuality and playfulness when you can bring your knowledge of your friend and their life to providing informal supervision." Another shared: "When I'm the informal supervisor, it just makes me feel closer to them. It makes me feel like we're sharing knowledge, and we're part of the same field and, that we have the same values, and there's a feeling of camaraderie and being a part of, entering into the right profession I guess is the right idea, and that I'm being surrounded by people who have the same values as I do and the same interests." The last variant category, *Concern re: feeling sufficiently competent to provide informal supervision*, reflected participants' recognition that although they generally enjoy and benefit from providing informal supervision in a multitude of ways, some worry that they are not experienced enough clinicians to provide clinical supervision to their peers. For example, one trainee said:

I guess, there's also a part of it that feels a little strange because, like I said earlier, I'm not a full licensed, practicing psychologist. So, I guess it can be a little bit of a double-edged sword, like it feels good to be able to help somebody and offer support or feedback, but there's some consideration about the fact that I might not have the same credentials as a formal supervisor, and what does that actually mean for the way that somebody takes what

I say and applies it or chooses not to apply it to their own case.

One participant shared that "there are definitely times where I give informal supervision and I need to hedge my bet or I feel like my supervisee should really talk to her supervisor about it"

and another noted “sometimes it’s anxiety provoking and burdensome to provide informal supervision, especially when I hear about clinical mistakes because then I wonder about my involvement and ethical duty as an informal supervisee.” The latter comment is especially noteworthy, as it suggests ethical considerations for those who provide, in addition to those who seek, informal supervision.

Chapter IV: Discussion

The primary aim of this study was to investigate the ways that beginning therapists utilize ‘informal supervision’, the process wherein therapists in training engage individuals who are not their formally assigned supervisors in significant conversations about their clinical work. The most important findings were as follows: in seeking informal supervision, trainees received emotional support, validation, freedom and safety to discuss personal anxieties, personal reactions to patients, clinical mistakes and challenges, insight, diverse approaches to clinical interventions, and an increased capacity to access their feelings in their clinical work. Additionally, trainees sought informal supervision in conjunction with – rather than in lieu of – formal supervision. Lastly, trainees noted that they felt concerned about the extent to which informal supervision is an ethical practice. As a result, they wanted clear guidelines, in line with APA’s ethics codes, for the ethical practice of informal supervision.

In this discussion section, I begin by presenting findings in the context of the nine research questions in this study. The discussion will then explore this study’s findings as related to the existing literature on formal supervision, informal supervision, and clinical training/education. Next, I will present the limitations of the study. Finally, the implications for clinical practice, clinical training, ethical considerations of informal supervision, and suggestions for future research will be examined.

Research Questions

Study findings are examined in relation to each of the nine research questions developed at the beginning of the investigation.

Research question 1: With whom, how frequently, and why does informal

supervision usually take place, and what tone typically characterizes these discussions?

Participants' experiences can be understood with regard to this question through an integrative summary of material from the demographics questionnaire and from the following two domains:

a) *Reasons for seeking informal supervision* and b) *Tone of informal supervision*.

A cardinal reason why trainees sought informal supervision was also a defining feature of the phenomenon of informal supervision, namely that it is – in contrast to formal supervision – available on demand. Participants also sought informal supervision to process personal (i.e., countertransference) reactions to their patients, and because they felt a unique sense of freedom to discuss these reactions honestly and without fear of evaluation. Participants' ability to engage freely and genuinely with their informal supervisors was likely influenced by their desire for (and receipt of, as discussed later in “what trainees get out of informal supervision,”) support and validation from their informal supervisors. The tone or ‘feel’ of these conversations was, not surprisingly, consonant with the reasons why trainees sought informal supervision. Participants described the tone of informal supervision as ‘honest and direct’, and ‘emotive’. Lastly, participants described the tone of informal supervision as “playful and humorous” and “natural and casual”: both may be uniquely common to informal supervision, perhaps in relative contrast to the typical tone of formal supervision.

Participants were asked to select their primary informal supervisor, i.e., the supervisor from whom they seek informal supervision most frequently. The great majority of participants named as their primary informal supervisor either a peer/colleague in their training program or outside of their training program; a minority sought informal supervision primarily from their significant other. That the majority of trainees sought peers/colleagues as their primary informal supervisor was heartening, as the legitimacy of the practice depends on the extent to which it is

used ethically. Informal supervision with a significant other, while tempting, is incongruous with the APA's ethics codes (see further discussion below). Regarding how frequently trainees sought informal supervision each month from different individuals, nearly all trainees sought informal supervision from a peer/colleague in their program at an average rate of 3.67 times per month, a great majority from colleagues outside of their program at a rate of 2.81 times per month, many from their significant other at a rate of 5 times per month, many more from a faculty member (not a supervisor) at a rate of 2.20 times per month, and most from their personal therapist at a rate of 1.5 times per month. The average length of a typical informal supervision session was almost 19 minutes. This seminal finding – that participants sought informal supervision frequently and from a diverse group of people – supports Farber and Hazanov's (2014) finding that trainees use informal supervision far more often than is acknowledged in the current research literature.

As expected, many participants sought informal supervision because their informal supervisors were available on demand. Many participants felt that they needed “more supervision” than was allotted by their formal supervisors; for example, one participant shared: “Supervision happens once a week for an hour and everything can't be covered. If something happens, I don't want to just put it away but I want to talk about it.” Very simply, beginning therapists sought informal supervision as a proactive augmentation to their once weekly formal supervisory hour. Participants also sought informal supervision specifically when they “needed someone” but their formal supervisors were busy or inaccessible. Participants appeared to resourcefully take matters into their own hands and seek informal supervision when they felt their formal supervisors to be unavailable. It is important to note that participants who sought informal supervision due to their informal supervisors' (un)availability did not appear to do so in

lieu of formal supervision; rather, it either served as a reinforcement or in addition to the weekly formal supervision hour.

Trainees sought informal supervision to process personal reactions to patients and because they wanted to do so freely and honestly. These important reasons for seeking informal supervision may be a direct response to inherent limitations of formal supervision. Considering the near universality of supervisee nondisclosures in formal supervision (Ladany, Hill, Corbett, & Nutt, 1996), and Yourman and Farber's (1996) finding that 47% of clinical supervisees acknowledged telling their supervisor—at moderate to high levels of frequency—what he or she wanted to hear, it makes sense that half of participants mentioned, in some form, that by removing the evaluative nature that permeates the formal supervisory relationship, they felt able speak with greater comfort and honesty about their clinical work. One participant noted, “I don't have all the answers, have things figured out, or know what I'm going to say ahead of time the way I would with a formal supervisor.” The latter response suggests that trainees seek informal supervision, at least in part, to express uncertainty, the extent to which they ‘do not know’, and to access ‘unformulated experience(s)’ (Stern, 1983). Furthermore, the expression of raw, unfiltered experience appeared to be a hallmark of why trainees sought informal supervision.

A major finding was that trainees commonly sought informal supervision to discuss clinical interactions that led them to feel emotionally dysregulated, overwhelmed, confused, concerned, upset, and drained – i.e., those aspects of experience that are often not disclosed or are carefully curated in their presentation to formal supervisors – so that they could better understand and use their countertransference reactions to influence their clinical work. One participant shared: “The biggest reason is because something has come up in therapy that is very difficult for me to contain emotionally and I really want to talk it through with somebody who

understands me and understands why it's affecting me.” More specifically, participants sought informal supervision to process reactions to draining sessions, terminations, difficult patient disclosures, and feeling overwhelmed, paralyzed, foreign, and un-relatable.

Trainees’ wish to process personal reactions to patients with openness and honesty, as discussed above, paralleled the tone or style of these conversations. Notably, an “authentic, honest, open, and trusting” tone characterized many conversations, as did an “emotive tone”, best encapsulated by the following participant’s experience: “(the tone is an) expression of my real feeling in the room, the doubts about my own abilities, and my true experience of my patients.” Both of these tones are likely to be characteristic of formal supervision as well.

In contrast to the aforementioned tones, many trainees described the characteristic tone of informal supervision as some combination of playful, humorous, or fun. Although no research literature to date references the typical tone of formal supervision, it seems likely, given the considerable pressure, self-doubt, and anxiety that trainees report due to evaluative pressures and desires for strong letters of recommendation from their formal supervisors, that trainees’ description of the feel of informal supervision as “humorous and playful” is a unique and important aspect of the phenomenon of informal supervision. Perhaps the characteristically playful tone that characterized many trainees’ informal supervisory discussions helps to facilitate – as suggested by Winnicott (1971) – the development of creativity and self-discovery. Similarly, that beginning therapists’ experienced a “natural and casual” tone also suggests a unique characteristic, and perhaps even corrective, to the presumably more formal and restrictive tone of formal supervision. Just as trainees may seek informal supervision to express themselves with a ruthless honesty that permits the emergence of unformulated experience, the informal and

natural tone of these conversations may further contribute to their ability to discover ‘unknown knowns’ (Stern, 2010).

A major finding was that a substantial number of trainees sought informal supervision for “validation, support, or comfort.” One participant’s response – “I am seeking immediate support. I want my informal supervisor to acknowledge that I’m not going crazy due to the day to day frustrations and interactions of a challenging environment” – suggested that beginning therapists sought “unconditional positive regard” (Rogers, 1957), a felt experience that can help trainees to safely explore their clinical work without fear of scrutiny so that painful aspects of experience can be normalized and worked through. That many participants sought unconditional positive regard suggests that informal supervision helps soothe the considerable distress that trainees inevitably experience early in their clinical work. Lastly, and not surprisingly, trainees sought informal supervision because they needed help with their clinical work. Some trainees sought advice on a specific clinical case, while multiple other participants wanted to brainstorm how to navigate a difficult clinical situation, try to understand what’s happening in therapy, ask questions, and consider alternative choices to approaching clinical work: presumably, these mirror what trainees seek in formal supervision too.

Research question 1: Summary of findings. In summary, participants sought informal supervision for compelling reasons: to process personal reactions to patients, discuss their clinical work authentically without fear of negative judgment or professional evaluation, receive emotional validation and support, particularly when feeling inadequate and self-doubting, and perhaps most importantly, to discuss their clinical work when they wanted to, i.e., on demand. The tone or characteristic feel of informal supervisory discussions included several elements: playful and humorous, causal and natural, and honest and emotive. The former – playful and

humorous – was particularly noteworthy, as it suggested that at times participants created a light and fun informal supervisory tone that provided a contrast with a more serious, formal tone that is more likely to characterize formal supervisory discussions. Additionally, the “natural and casual tone” described by many participants may also be uniquely common to informal supervision, and provide a relative contrast to the typical tone of formal supervision.

Research question 2: What qualities/characteristics do beginning therapists value most highly in their informal supervisors? The narrative content of the domain *Preferred qualities of informal supervisor* encapsulates this central question.

Findings indicated the following conclusions. In contrast to formal supervision, where trainees are assigned a supervisor with whom they may have little in common, trainees sought informal supervision from individuals who shared a similar perspective and experience, i.e., they too were beginning therapists, approached clinical work in similar ways, and sought informal supervisors with whom they had established close relationships. Not surprisingly, trainees also sought informal supervisors who were thoughtful, gave helpful feedback, and possessed Rogerian attributes (i.e., open-minded, nonjudgmental, and validating). It is likely that participants also value these attributes in their formal supervisory relationships.

A major finding, and perhaps a defining feature of informal supervision, was that many participants chose a primary informal supervisor who was also a psychologist in training and with whom the participant shared a close personal relationship. Participants said: “My informal supervisor knows me better than anyone else in my life”; “He knows all of my ins and outs”; and “The main thing is that she’s a good friend.” These participants valued both feeling close with and known by their informal supervisors, and having had similar clinical experiences to their informal supervisors (also trainees). This result suggests that relatability and comfort, qualities

that are less likely to be present – at least initially – in the formal supervisory relationship due to differences in age, experience, and power dynamics, were highly valued by participants in their informal supervisory relationships.

Trainees also preferred qualities in their primary informal supervisors, such as being thoughtful, curious, open-minded, nonjudgmental, validating, and knowledgeable, that most would presumably value in any (e.g., formal) supervisory relationship. A majority of participants referred to their primary informal supervisor using some synonym of “thoughtful.” Generally, participants sought a primary informal supervisor who listened thoughtfully and provided genuine and helpful feedback, as captured by one participant’s response: “My informal supervisor is really thoughtful about working out what actually happened with the client. She is genuinely and authentically interested in this work.”

Research question 2: Summary of findings. In summary, trainees sought informal supervision from individuals whom they felt a kinship with, both regarding a close personal connection and a perceived similarity in how they approach clinical work. Both qualities seemed to permit trainees to feel trusting, which facilitated their ability to speak honestly about their clinical work. That many trainees sought informal supervisors who shared similar perspectives about clinical work suggests a potential pitfall of informal supervision: some trainees may seek informal supervision from individuals whom they know a priori will support their preferred way of working with patients, and therefore preclude opportunities for challenge and disagreement. However, that trainees also valued informal supervisors who were challenging and direct in their feedback suggests that many also seek individuals whose viewpoints do not align with their own. As expected, trainees also sought informal supervision from individuals who were curious, attentive, provided insightful feedback, possessed Rogerian attributes (i.e., caring,

nonjudgmental, and supportive). It is likely that participants value these attributes similarly in the context of formal supervisory relationships.

Research question 3: What do therapists in training get out of informal supervision?

Results from the third domain, '*What trainees get out of informal supervision*', provide insight into this central research question. Trainees received from their informal supervisors the very same things that they sought: emotional support and validation, freedom to discuss fears/mistakes/challenges, insight, and an increased capacity to access their feelings in their clinical work. Importantly, all of these parallel what many trainees get out of formal supervision. This finding provides support for the claim that informal supervision is an important addendum to – rather than replacement for – formal supervision.

A central finding of this study was that all but one participant (one of three General categories in this study) received emotional support and validation from their informal supervisors. This finding captured both the vital role of unconditional positive regard in bolstering trainees' clinical development, and the extent to which trainees received a 'holding environment' to help tolerate the considerable emotional distress that they inevitably experienced in their clinical work. In general, participants looked to their informal supervisors to support and encourage them to trust their clinical decisions. Trainees who received emotional support from their informal supervisors received active reassurance that their sometimes emotionally dysregulated reactions to patients were normal. One trainee said, "I get reassurance that I am not crazy", and another shared, "My informal supervisor contains my emotions. I get a sense that just because I have my own issues does not make me an incompetent therapist and doesn't make me unable to treat other patients." These trainees received positive feedback from their informal

supervisors that allowed them to feel capable of providing provide effective psychotherapy when they felt destabilized.

Participant responses also captured the immediacy with which informal supervision provided them with a form of self-care and self-regulation. The immediate impact of receiving informal supervision on demand suggested an additional benefit to receiving informal supervision in addition to formal supervision. Considering that trainees likely also receive validation and emotional support from their formal supervisors, it is important to consider the potential drawbacks of receiving informal supervision immediately following a session as opposed to waiting for formal supervision. It is possible that these trainees missed out on important opportunities to hold their immediate discomfort and distress so that they could learn to process it on their own or later with a formal supervisor. This could lead trainees to become dependent on informal supervisors for immediate gratification of their needs when they may be better served by coping independently. This topic will be further explored in the ‘limitations’ section of the discussion.

A majority of trainees got an “openness and freedom to discuss fears/mistakes/challenges” from informal supervision in perhaps the only category from this domain that offered a unique and potentially additional component to formal supervision. One participant said: “I get a sort of freedom, like batting practice, so it allows me to think a little bit more freely about aspects of each case that I might not have considered or talked about (in formal supervision), where I sometimes feel judged and evaluated.” This trainee’s analogy to batting practice implies that he used informal supervision as a space to play with aspects of his clinical work that he felt less comfortable talking about in formal supervision. As noted in the section above on “similarities and differences between formal and informal supervision”,

trainees appeared to use the nonjudgmental space of informal supervision to explore their clinical work, especially the “shakier” parts. Importantly, it would be optimal if a trainee who was hesitant discussing insecurities could say to her formal supervisor, “I worry that if I share my real feelings about my patient, you will think less highly of me”, and then share the depths of her fears and self-doubt. With that caveat in mind, informal supervision may provide a unique space for trainees to explore these fears productively. Presumably, over time, trainees could utilize the validation and emotional support they received through informal supervision to boldly discuss these very same fears and mistakes in formal supervision.

That trainees received insight and different perspectives on their work highlighted the extent to which trainees learned from their informal supervisors. Both suggest that informal supervision is a valid and valuable source of clinical training in its own right. Regarding insight, trainees received excellent feedback, specific ideas for interventions, direct feedback, and theoretical knowledge that contributed to more nuanced and impactful clinical work. As trainees move through their programs and seek to establish a personal approach to treatment, trainees appeared to gain important insights through informal supervision that fostered their capacity to make clinical choices that facilitated their patients’ therapeutic growth. Similarly, trainees received different perspectives than their own as a result of informal supervision. One participant’s response best captured the essence of this category: “With peers, I get many different ways of thinking about cases and interpreting things that happened. I get breadth and depth of perspective from people whose opinions and experience I really respect and value.” While it is a given that trainees receive alternate ways of conceptualizing their patients and approaching clinical dilemmas in formal supervision, trainees clearly received similar benefits from informal supervision too.

Research question 3: Summary of findings. In sum, results showed that trainees received substantial emotional support and validation, insight, different perspectives to approaching clinical work, and a sense of freedom to openly discuss clinical mistakes and challenges, as well as personal fears and anxieties. Taken together, these findings substantiate the positive impact of informal supervision on trainees' ability to provide effective psychotherapy.

Research question 4: What are the similarities and differences between informal and formal supervision? Is there something inherent in the formal supervisory relationship that contributes to trainees' wish/need to seek informal supervision? Material from domain 6, *Comparisons between formal and informal supervision*, addresses this primary question, specifically the differences (and in some cases, similarities) between the nature, uses, and impact of formal versus informal supervision conversations on trainees' clinical work and professional development. The results indicate that trainees are acutely aware of the power differential that exists in the formal supervisory relationship, which in turn impacts upon structure (e.g., use of language), emotiveness (e.g., informal supervision is organized around countertransference reactions), and self-presentation (e.g., there is a greater performative aspect to formal supervision). Importantly, many trainees noted important similarities in how they approach and experience formal and informal supervision.

A major, and unsurprising finding, was that trainees were acutely aware of the power imbalance that inherently exists in the formal supervisory relationship and that the dynamic that resulted from this imbalance impacted trainees' experiences in both formal and informal supervision. A majority of participants noted that they felt a lack of control and a need to perform in formal supervision, both of which are absent from informal supervision. One response best captured this notion:

I'm required to do formal supervision and am assigned to my formal supervisor so I have less control over who I talk to and there's only one person to talk to. It's an inherent situation of being judged and having to perform due to evaluations from my formal supervisor and wanting a good letter of recommendation.

Clearly, and presumably despite most formal supervisors' efforts to downplay evaluative pressures, trainees are acutely aware of the power dynamic that exists in informal supervision.

A second major finding was that many participants described their informal supervisory discussions, in contrast to their formal supervision, as organized around emotions and countertransference reactions to patients. Sharing feelings about one's patient with a supervisor is a profoundly human and vulnerable experience that can open trainees to criticism, self-doubt, and shame. In Ladany et al.'s (1996) study, the second most cited reason for formal supervision nondisclosures was the personal nature of the nondisclosure. Relatedly, Yourman (2003) noted that shame inhibits authenticity and often leads an individual to hide or withdraw from others. One participant clearly expressed a commonly shared sentiment: that the power imbalance resulting from the inherent dynamic of formal supervision is strongly related to trainees' tendency to orient their informal supervisory discussions around personal reactions to patients: "Emotionally, they [my formal supervisors] are not there for me in the way that my therapist is. Because I am being evaluated, I feel like there's an element of reporting that's going on, which makes me feel a little more formal, a little stiffer, a little less likely to let my guard down."

Relatedly, and in line with Farber's (2006) research and Goffman's (1959) observation that individuals present themselves –revealing and concealing important aspects of their experience – so that others approve of them, participants described a performative aspect to formal supervision that was absent from informal supervision. This relates to the finding that participants sought informal supervision to share their experiences freely and openly, and that

they valued an honest and authentic tone, described in greater detail above in the discussion section for research question #1. That trainees appeared to have a pervasive fear of doing things wrong as well as a desire to do them right, and as a result shaped their presentation of case material in formal supervision to try to best please their supervisors, suggests that trainees likely miss out on opportunities to cope with ambiguity and uncertainty, important experiences in the development of any clinician.

Results also showed that another way that participants' experienced feeling constrained by the power, boundaries, and nature of the relationship was that they were less authentic in the ways that they structured and used language in formal versus informal supervisory discussions. While there is value to trainees learning the language (and jargon) of psychotherapy, and being asked by formal supervisors to use theory to form case conceptualizations and construct a cohesive narrative, it appears that trainees also valued a balance, as indicated by their willingness to seek out informal supervisors to discuss their clinical work in more informal and descriptive ways.

A final, important finding was that half of participants experienced at least one important aspect of formal and informal supervision similarly. This finding suggests that many trainees are consistent in their approaches to formal and informal supervision, and supports Farber and Hazanov's (2014) finding that informal supervision is often sought not in lieu of but in addition to formal supervision.

Research question 4: Summary of findings. In summary, beginning therapists described many differences and some similarities between formal and informal supervision. Differences included heightened awareness of power and discrepancies in locus of control in formal supervision stemming from evaluative pressures, desires for good letters of recommendation, and

not being able to choose formal supervisors. These differences impacted participants in the following ways: they generally felt more free, comfortable, open, and honest in informal supervision, discussed countertransference feelings more frequently in informal supervision, presented themselves more authentically and less guardedly in informal supervision, and described their clinical work in more unconstrained ways, using less jargon, theory, and constructions that otherwise felt obligatory in formal supervision. Importantly, findings also showed that half of participants experienced at least one important aspect of their experience in both formal and informal supervision similarly, suggesting that informal supervision is more advantageously used as a corollary for, not replacement of, formal supervision.

Research question 5: When beginning therapists describe a specific case with an informal supervisor, what common themes, topics, and challenging issues emerge? Results from this research question explain ‘the what’ – that is, the themes, topics, and issues – that trainees discuss in informal supervision. The first presented here – insecurity regarding clinical competence – is likely unique to informal supervision, whereas the second three – personal reactions to patients, stresses of working with challenging patients, and patients’ diagnoses (especially severe pathology), are probably common to both informal and formal supervision.

A major finding was that half of participants discussed their personal doubts, fears, and insecurities with their informal supervisors. Some spoke generally, whereas others reported more specific experiences. Farber and Coren (2015) found that trainees significantly underreport to their formal supervisors the extent to which they feel insecure during psychotherapy sessions, and results from this study suggest that trainees do indeed share their “worry, guilt, fear of failing (a) patient, self-doubt, anxiety, (and) incompetence” with informal supervisors, as also suggested by Golia and McGovern (2013).

A major finding was that a majority of participants discussed countertransference reactions, such as defensiveness, doubts, insecurities, anger, sadness, anxiety, guilt, therapeutic ruptures, and romantic countertransference, with their informal supervisors. One participant discussed her “self-doubt, anger, sadness, and anxiety” after a difficult termination session. That participants discussed the messy, emotionally-dysregulating aspects of their personal, clinical experiences in informal supervision further supports the notion that trainees need additional and different supervisory contexts to discuss some of the most personally challenging aspects of their clinical work.

Another major finding was that many participants discussed their patients’ diagnoses, particularly those with severe pathology, and relatedly shared how stressful it felt to work with challenging patients. Multiple participants shared how difficult it was to work with patients presenting with co-morbid psychological disorders. This result supports the notion that trainees seek informal supervision as an additional space to process the strains and challenges of working with difficult patients.

Research question #5: Summary of findings. In summary, participants discussed the aspects of their experience with informal supervisors that may otherwise induce feelings of vulnerability and shame in more formal settings, namely self-doubt regarding their competence. Moreover, they talked about troubling countertransference reactions to patients, stresses of working with challenging patients, and specific patients’ diagnoses in informal supervision. Surprisingly, participants did not discuss other important aspects of clinical work with informal supervisors, such as therapeutic technique, multiple theoretical approaches to clinical work, or multicultural issues in treatment. This finding suggests that trainees receive sufficient support from their formal supervisors in these critical areas of clinical work.

Research Question 6: Does trainees' use of informal supervision change over time?

Results from this question showed that over time, the quality of participants' conversations with informal supervisors deepened, participants relied less frequently on their informal supervisors to provide emotional support, and participants focused informal supervision discussions more on specific clinical issues versus the basic parameters of therapy. Each of these results is discussed in turn below.

A major finding was that a majority of participants experienced more “advanced, specific, targeted, (and) deep” conversations about their clinical work with informal supervisors as they progressed in their training. This important finding suggests trainees experience a similar developmental trajectory in informal supervision as in formal supervision; as trainees become more experienced, they discuss more advanced issues with their informal supervisors. Over time, participants noticed that they stopped falling casually into conversations about clinical work, as is typical of beginning therapists, and instead began to seek informal supervision with greater purpose. As in formal supervision, it is likely that as participants became more confident in their clinical work, the quality of their informal supervision conversations deepened.

Some participants noted that they relied less on their informal supervisors to provide emotional support over time. This finding suggests that as participants became better able to contain their emotional distress, the quality of their informal supervision conversations sharpened. These participants noted that early in their training, clinical work was so anxiety provoking that they leaned heavily on their informal supervisors for emotional support. One participant shared: “In the beginning I needed to just get my thoughts, feelings, and interactions about patients out there to cope. I wanted to talk to every cohort member at any opportunity, [I] overshared [because I] was not able to contain it better.” This finding supports the notion that

there is a developmental trajectory to informal supervision: as trainees gain clinical experience, they rely less on their informal supervisors for emotional support and more for intentional discussions about clinical work.

The last important finding for this research question, that informal supervision discussions were more focused on specific clinical issues compared to the basic parameters of therapy, also supports the general impression that participants' use of informal supervision followed a developmental trajectory that evidenced their overall growth and confidence as clinicians.

Research question 6: Summary of findings. In summary, results from this study suggest that participants used informal supervision in more targeted and advanced ways over time. They relied less on informal supervision to contain emotional distress, discussed more specific clinical issues, and experienced a deepening in their clinical discussions. As in formal supervision, participants used informal supervision in ways that reflected their growing confidence and competence as clinicians.

Research question 7: Do beginning therapists have concerns about using informal supervision to further their development and clinical work, and do they think the psychology field needs new rules, ethical codes, or simply more openness about the practice of informal supervision? The narrative content of domain 10, *Concerns about using informal supervision*, encapsulates this central research question. Results showed that participants' concerns about using informal supervision are considerable, and include anxiety about breaking APA's *Ethical Principles of Psychologists and Code and Conduct, Privacy and Confidentiality* (Ethics Code; APA, 2010), worry about not knowing the appropriate parameters for using informal supervision, i.e., what is and is not considered a breach of ethics, and regrets about

negative experiences with informal supervision. These concerns were balanced by participants' recognition that: 1) trainees use of informal supervision is inevitable; therefore, 2) participants wanted open dialogue and clearer guides regarding the use of informal supervision; and 3) the very same participants who reported feeling worried about breaking APA's ethics codes also expressed feeling confident that they used informal supervision responsibly and that it significantly enhanced their clinical work and professional development.

A major finding was that a majority of participants expressed concern that by using informal supervision, they broke APA's ethics codes regarding privacy and confidentiality. Most participants' expressed varying levels of concern in rather general terms, suggesting that participants are both aware of this issue and also seriously consider ethical issues related to the use of informal supervision. Participants elaborated upon their ethical concerns, most notably by expressing confusion about the appropriate parameters for using informal supervision. One resolution to this conflict would be for the APA to be, as one participant put it, "clear and realistic about what's acceptable and not acceptable." After all, one participant shared: "I don't know the ethical codes and what the APA handbook has to say about informal supervision." The need for greater clarity is apparent, given the high percentage of participants' who worry that they break ethical codes by using informal supervision, but the need for 'realistic' codes seems equally necessary. This will be discussed further in the discussion of participants' belief that the use of informal supervision is an inevitable and critical aspect of their clinical training below.

While most participants reported feeling concerned that they violated privacy or confidentiality by using informal supervision, these participants *also* described not feeling worried about breaking privacy or confidentiality. Participants' supported this belief by noting that they protected identifying information and confidentiality by leaving out identifying details,

rarely if ever sought informal supervision in public, only sought informal supervision from trusted individuals or colleagues with whom they already practiced sharing information about cases and protecting privacy/confidentiality in practicum classes, and believed that it should be acceptable to discuss clinical work with fellow psychologists. Although participants reported that they rarely if ever sought informal supervision in public, it is likely that, given the context of a research study undertaken by a fellow student and trainee, participants may have minimized the extent to which they did, at least at times, provide identifying details. Lastly, one trainee's response appeared to best summarize participants' relative lack of concern re:

privacy/confidentiality: "I guess I don't really have concerns because I feel like I'm good at choosing people who are intelligent when it comes to confidentiality and appropriateness. So that's part of the reason I don't worry about it. We kind of practice doing this already. We practice informal supervision in our classes." In other words, it is likely that some participants underreported the extent to which they shared information they should not have, but felt protected nonetheless by the confidentiality afforded by their informal supervisor.

A major research finding was that the vast majority of participants believed that trainees' use of informal supervision is inevitable. Many of the reasons that support this claim were discussed above (see 'why trainees seek informal supervision'), and will be explored below in the section on ('what trainees get out of informal supervision'): most importantly, participants reported that informal supervision is an 'important and overlooked' aspect of their clinical training. Many participants' reported that the benefits of informal supervision were well worth the costs. For example, one responded, "There are some things therapists try to abide by that aren't always possible, and informal supervision is invaluable so I don't know if going to the extremes for confidentiality is worth the sacrifice."

Research question 7: Summary of findings. Results showed that trainees are acutely aware of, and carefully consider, the many benefits and potential harms of using informal supervision. Some participants felt worried that they broke APA's ethical rules and were concerned about the ambiguity and relative lack of clarity of APA's ethical expectations regarding the use of informal supervision. These same participants shared that they have used and plan to continue using informal supervision regardless of whether or not they break APA's ethical codes because they consider informal supervision to be an important, necessary, and overlooked aspect of their training. Therefore, participants expressed a desire for safeguards, such as more open dialogue regarding the use of informal supervision and clearer ethical guidelines from both doctoral programs and the APA that might help assuage trainees' anxiety regarding the use of informal supervision and help prevent trainees from making unnecessary errors, as many plan to use informal supervision throughout their clinical careers.

Research question #8: Why do beginning therapists seek informal supervision from their significant others and personal therapists? Material from domain 8, *Reasons for informal supervision with one's significant other*, and domain 9, *Reasons for informal supervision with one's therapist*, addressed this research question. Results showed that the primary reason that trainees sought informal supervision from their significant other was to receive emotional support related to the stresses of clinical work, whereas the most significant reason trainees looked to their personal therapists for informal supervision was to discuss countertransference reactions to patients. Many participants who sought informal supervision from their significant other said that it was helpful to limit the specific details about patients, as this helped trainees to feel that they did not violate ethical boundaries regarding privacy and confidentiality. Somewhat surprisingly, only two participants voiced concerns about using their

significant other for informal supervision. The clinical and ethical implications of this finding will be examined below, and again – more fully – in the ‘ethics’ section of the discussion. Perhaps less surprisingly, multiple participants sought informal supervision from their therapists to discuss formal supervisory challenges. Some of these trainees brought these issues to their therapists because they felt that complicated supervisory dynamics might inform and/or reflect similarly complex dynamics with important people in their personal lives.

Many participants sought informal supervision from their significant other in order to receive emotional support, which in turn allowed them to work through lasting emotional reactions to patients and restore a sense of balance that enabled them to return to their clinical work with clarity. Research has shown that clinical work can lead to therapist burn-out (Farber & Heifetz, 1982). As a result, therapists are encouraged to engage in self-care activities and behaviors, such as exercising and socializing, to help them to step out of their clinical work so that they can return to it feeling revitalized. Results from this domain suggest that discussing clinical work with significant others may be a unique self-care behavior. For example, one participant noted: “I get at my feelings with my significant other and she helps me reframe or release some of my worries and holds them for me. Sometimes informal supervision with my significant other is complaining or cathartic. I get support, insight, holding, and a sense of release.” Other participants shared that they discuss clinical work with their significant other because they took their work home with them and were afraid that their romantic relationships would be negatively impacted as a result. In general, these participants felt that discussing clinical work with their significant other was an unburdening and emotionally gratifying experience.

Surprisingly, only two participants discussed specific concerns about using their significant other for informal supervision. One shared: “I really cut back on informal supervision with my significant other because I feel that clinical work is really personal, private, and a privilege to be a part of, so I see it as disrespectful to talk about it with anyone outside of the field because then it feels more like gossip or telling a story.” This participant’s response captured how privileged and honored she felt to participate in clinical work, as she noted her duty to protect the sanctity of the therapeutic enterprise. By sharing clinical work with one’s significant other, trainees risk overexposing their patients and put their patients at risk for being reduced from complex, suffering human beings to instruments for gossip.

More than half of respondents sought informal supervision from their personal therapist to discuss personal reactions to patients: half of these participants hoped that their therapists would help them to better understand their reactions in order to use them productively in treatment while half felt that their personal reactions were related to their own personal issues, and were therefore important to explore in order to better understand their personal and interpersonal challenges in living. Participants who sought informal supervision from their therapists wanted to consider strong countertransference responses to patients in the context of the issues she discussed in her personal therapy. Others wanted to better understand how her countertransference reactions might inform her clinical work: “I process my feelings and thoughts, like when I realized I identified with a patient. Then we try to think through how it influences my work.”

A variant number of participants talked to their personal therapists about issues with formal supervisors, ranging from general “issues or problems with supervisors” to “frustration with an interaction with a formal supervisor”. One trainee talked to her therapist about how a

formal supervisor was “mean” and another talked about how her formal supervisor recommended that she seek her own therapy. Considering that formal supervisors are often older, authority figures who are assigned to, not chosen by, supervisees, the formal supervisor-supervisee relationship is a fertile ground for evoking and exploring parental dynamics. Thematically, these dynamics can include issues related to autonomy, dependence, power, control, dominance, and submission. The relative infrequency of these discussions amongst participants may in some way reflect the relative maturity and experience of this sample. Most participants in this study were nearly half-way through their fourth year of clinical training. It is likely that since these participants were closer to finishing than starting their training, they were by and large sufficiently experienced and autonomous enough to experience a working relationship with supervisors that was more balanced in power and thus less likely to evoke more explicitly parental dynamics that may be more characteristic for supervisees early in their clinical training.

Research question 8: Summary of findings. Findings showed that trainees sought informal supervision from their significant others for validation and emotional support. Some trainees sought warmth and comfort from their partners when they felt emotionally drained by their patients, while others felt it was imperative to share their distress in order to feel unburdened and thus freed up to be more present in their free time with their partners. Trainees were more likely to turn to their therapists than significant others to discuss strong personal reactions to their patients. Some of these participants used their countertransference reactions to patients as an entryway to discussing their own problems. Surprisingly, only a couple of trainees expressed concerns about sharing their clinical work with their significant others. Others, much less

surprisingly, used informal supervision with their therapists to talk about challenges in their formal supervisory relationships.

Research question #9: To what extent is informal supervision reciprocal? Material from domain 11, *Experience providing informal supervision*, addresses this primary question. Results showed that participants experienced providing informal supervision as reciprocal and mutual, and that providing informal supervision was a powerful and meaningful experience. Participants provided validation and support for those who sought informal supervision from them, and some gained confidence in their abilities as clinicians. This latter finding suggests that providing informal supervision may be a low-stake but meaningful way for trainees to develop supervisory skills. Lastly, some trainees expressed concern that they were not competent enough to provide supervision. These trainees worried that their guidance may be insufficient or misguided, and they hoped that the individuals whom they provided informal supervision for also consulted with their formal supervisors before implementing their clinical suggestions with patients. This latter, important finding, will be discussed more fully in the ethics section of the discussion.

Many participants described the experience of providing informal supervision as reciprocal and mutual. Multiple participants also expressed that providing informal supervision feels like a bonding experience and builds connectivity to peers. For example, one participant said: “When I’m the informal supervisor, it just makes me feel closer to them. It makes me feel like we’re sharing knowledge, and we have the same values, and there’s a feeling of camaraderie. I feel that I’m being surrounded by people who have the same values as I do.” While it was surprising that more participants did not directly address the reciprocal nature of informal supervision, all of the research participants noted that they provided informal supervision to their

peers, and a majority stated that providing informal supervision was a meaningful component of their clinical training.

A major finding was that most participants felt that providing informal supervision to peers was a positive and powerful experience. These participants shared that providing informal supervision helped them to feel confident in their own clinical skills and ability to provide constructive guidance to peers, that it was a creative way to develop their own capacities as clinicians, and was experienced as a unique opportunity to engage in playful and creative conversations about their peers' clinical work. One participant's response best captured these aspects of providing informal supervision:

Providing informal supervision is a gratifying experience if I can help elucidate a part of another therapist's experience of being with a patient, ask a question they might not have thought of, or find humor and laugh with something with the trainee. I find it really nice to be able to reflect on the clinical experience with a colleague and engage in something that feels more like a conversation where there is less of a power dynamic.

Another participant's response captured the creative and fun aspects of providing informal supervision: "I enjoy providing informal supervision. It's been really fun because I enjoy talking with my peers about their cases and I learn a lot from providing informal supervision, such as creative ways to handle tough clinical situations and new ideas." That multiple participants learned from providing informal supervision to their peers suggests that providing informal supervision is a powerful tool in trainees' development of supervisory skills.

Regarding the content discussed when providing informal supervision, many participants noted that the most frequent topics discussed when providing informal supervision were personal reactions to patients and clinical challenges. These participants provided support, empathy, and encouragement to their peers. Both of these findings are consistent with reasons that trainees sought informal supervision.

Lastly, participants shared reservations about providing informal supervision. These ranged from concerns that they were not experienced enough to provide informal supervision, to worry that trainees would apply their guidance without consulting their formal supervisors, to feeling anxious that individuals with whom they provided informal supervision might make egregious clinical errors that negatively impact their patients. One participant's response addressed the latter: "Sometimes it's anxiety provoking and burdensome to provide informal supervision, especially when I hear about clinical mistakes because then I wonder about my involvement and ethical duty as an informal supervisor." This participant's concern speaks to the importance of using informal supervision as a complement to, not substitute for, formal supervision. In order for informal supervision to be used appropriately and effectively, informal supervisors need to feel authorized to speak honestly and without reservation about their concerns, and in these cases, encourage their peers to seek guidance from their formal supervisors. One participant summed up this quandary concisely:

There's a part of it that feels a little strange because, like I said earlier, I'm not a full licensed, practicing psychologist. It can be a little bit of a double-edged sword. It feels good to be able to help somebody and offer support or offer or feedback, but there's some consideration about the fact that I might not have the same credentials as a formal supervisor. What does that actually mean for the way that somebody takes what I say and applies it or chooses not to apply it to their own case?

Research question 9: Summary of findings. Findings showed that providing informal supervision is in indeed a reciprocal and powerful experience that provides opportunities for trainees to learn from their peers' clinical work and develop confidence in their capacities to provide helpful clinical guidance and support. This result suggests that providing informal supervision helped these trainees to develop supervisory skills. While many participants felt that providing informal supervision was a positive and useful experience, others expressed worry that

their advice might be used in lieu of formal supervision. This finding suggests an important limitation (discussed at length in the ethics section below) that must be taken into consideration when considering guidelines for the ethical use of informal supervision.

Limitations

Questions of validity and reliability are raised due to nature of the data, i.e. self-report, such as the impact of social desirability on participants' responses. In the present study, this methodology raises questions about the extent to which trainees accurately remember and represent their experiences using informal supervision throughout their training, the extent to which they have previously considered the impact of informal supervision on their personal and professional development, and whether the nature of this interview primed participants to over-value the role of informal supervision to further their clinical work. Additionally, due to the open-ended and neutral valence of the interview questions, as per Hill et al.'s (2005) CQR guidelines, it is possible that participants did not reveal the full extent of the darker side, i.e., the drawbacks and pitfalls, of informal supervision.

The sample also had unique characteristics. The majority of participants were of Caucasian ethnicity and enrolled in clinical psychology doctoral programs, i.e., 94%. On average, participants were in the advanced stages of their training, i.e., 4.43 years. While the advanced trainee status of this sample allowed for participants to reflect on their experiences using informal supervision throughout their clinical training, findings may be less representative of how trainees use informal supervision in the early stages of their training. It is also worth noting that only 12% of participants identified their primary theoretical orientation as cognitive-behavioral. While it seems unlikely that trainees who identify as cognitive-behavioral versus psychodynamic or integrative use informal supervision differently or less frequently, this

possibility cannot be ruled out.

Lastly, CQR's methodology for data analysis relies on the subjectivity of the research team. CQR endeavors to control for this subjectivity by employing the stability check, auditor, and the use of consensus throughout the process. Additionally, the expectations and biases of the team were identified when conceptualizing the study and creating the interview protocol, then reviewed and continuously referred back to as the data was coded. Our research team meticulously upheld CQR procedures; however, it may be possible that certain skewed interpretations or perceptions of the team impacted our understanding of the data.

Clinical Implications: Personal and Professional Development

Findings showed that informal supervision is an important and valid process through which trainees in clinical and counseling doctoral programs in psychology develop clinical and professional competencies. This growth is evident in a multiplicity of arenas: in seeking informal supervision, trainees received validation and reassurance, emotional support, freedom and safety to discuss personal anxieties, strong countertransference reactions to patients, clinical mistakes and challenges, insight, diverse approaches to clinical interventions, and an increased capacity to access their feelings in their clinical work. Not surprisingly, these outcomes parallel those of formal supervision. This finding provides empirical support for the following claim: informal supervision is an important companion to – rather than replacement for – formal supervision. This claim is bolstered by the important finding that trainees sought informal supervision to augment to their once weekly formal supervisory hour.

The important differences between formal and informal supervision, however, provide strong evidence for the unique clinical implications of using informal supervision as a primary

tool in training programs. ‘Differences resulting from the power dynamic in informal supervision’, one of three General categories, showed that trainees are acutely aware of how the power differential in formal supervision impacted upon the ways they used, or failed to use, formal supervision to maximize their clinical training. These differences included heightened awareness of power imbalances and discrepancies in locus of control in formal supervision that stemmed from evaluative pressures, desires for good letters of recommendation, and fear of appearing incompetent, as well as accompanying feelings of anxiety and self-doubt. Trainees used informal supervision in targeted ways to address and/or counteract the aspects of formal supervision that lead trainees to lie, conceal, or not disclose important aspects of their clinical work.

These differences impacted participants in important ways. A majority of participants noted that the expectation that they perform and please their formal supervisors inhibited them from exploring the full extent of their clinical experiences in formal supervision. Participants felt more free, comfortable, open, and honest in informal supervision, discussed countertransference feelings more frequently (the second of three General categories), presented themselves more authentically and less guardedly, and described their clinical work in more unconstrained ways, using less jargon and carefully curated language. One participant noted: “In formal supervision, I constantly sense the evaluative component. Formal supervision doesn’t feel free, safe, flexible, spontaneous, and playful unless the formal supervisor goes out of their way to make it feel that way. There’s real confidentiality (in informal supervision). It’s more open, I have less fear, and I don’t have to wonder how being received.” This sentiment – that trainees experienced themselves as more truthful, authentic, and willing to express self-doubt – in informal versus

formal supervision, provides powerful evidence for the value of informal supervision as a primary avenue to discuss formal supervisory nondisclosures and to mitigate shame.

In informal supervision, trainees let down their guard and felt free to speak to the most challenging personal and interpersonal aspects of their clinical experiences. Regarding the latter, trainees sought informal supervision to process personal reactions to patients freely and honestly. A major finding was that trainees commonly sought informal supervision to discuss clinical interactions that led them to feel emotionally dysregulated, overwhelmed, confused, concerned, upset, and drained – i.e., those aspects of experience that are often not disclosed or are carefully curated in their presentation to formal supervisors – so that they could better understand and use their countertransference reactions to influence their clinical work. Regarding the former, i.e., personal challenges of clinical work, trainees revealed their personal anxiety, self-doubt, uncertainty, and shame frequently and non-defensively in informal supervision. This provides empirical evidence that trainees discuss those aspects of their experience that they underreport to their formal supervisors (Farber & Coren, 2015) with their informal supervisors. By accessing these reactions to clinical work through informal supervision, trainees create an opportunity to integrate these hidden, “not me” (Sullivan, 2013) aspects of their experience, allowing them to use more of themselves in their interactions with patients. Additionally, participants valued Rogerian attributes in their informal supervisors, and sought and received validation and emotional support.

Informal supervision also provided participants with a singular space to be playful about their clinical work in ways that facilitated clinical creativity, spontaneity, and curiosity. More than half of trainees described the characteristic tone of informal supervision with a synonym of playful, humorous, and fun. Given the considerable pressure, self-doubt, and anxiety that trainees

report due to evaluative pressures and desires for strong letters of recommendation from their formal supervisors, trainees' capacity to access humorous and playful aspects of their clinical experiences emerged as a unique and important aspect of the phenomenon of informal supervision.

Trainees who relied on their significant other as their primary informal supervisor gained emotional support but also incurred risks and concerns that justify the following conclusion: although it is tempting and understandable for trainees to want talk about their clinical work with their significant other, it simply should not be done. By sharing clinical work with one's significant other, trainees risk overexposing and betraying their patients' confidentiality, a breach that is essential to maintaining the bedrock of trust that permits effective clinical work. Since findings showed that trainees valued and benefitted from the emotional support that they received from their significant other, trainees are encouraged to continue to share their distress, self-doubt, anxiety, etc., but to limit details, i.e., not seek informal supervision and/or clinical guidance from their significant other. For example, a distressed trainee could come home from an intense day of clinical work and say to their significant other: "A patient tried to commit suicide today. I feel so overwhelmed right now." A disclosure of this nature would allow a trainee to communicate the impact of his clinical work and evoke emotional support without discussing the technicalities of this case.

Surprisingly, participants did not regularly discuss important aspects of clinical work with informal supervisors such as therapeutic technique, how to integrate multiple theoretical approaches to clinical work, or multicultural issues in treatment. This finding suggests that trainees may receive sufficient support in these aspects of clinical work from their formal supervisors and teachers.

Ethical Considerations

Results showed that participants' concerns about using informal supervision are considerable, and include anxiety about breaking APA's ethics codes regarding patient privacy and confidentiality, as well as worry about not knowing the appropriate parameters for using informal supervision, i.e., what is and is not considered a breach of ethics. These concerns were balanced by participants' recognition that: 1) trainees use and will continue to use informal supervision because it is a vital and vibrant part of their clinical training and professional development; therefore, 2) participants want open dialogue and clearer guides regarding the use of informal supervision; and 3) the very same participants who reported feeling worried about breaking APA's privacy and confidentiality codes also reported using informal supervision responsibly by leaving out identifying information so as not to break APA's ethics codes regarding privacy and confidentiality.

While findings from Farber and Hazanov's (2014) research and the current study support the notion that trainees do not use informal supervision in lieu of but in addition to/as a complement to formal supervision, there are still important risks to using informal supervision that must be carefully considered. Since trainees practice psychotherapy under their formal supervisors' licenses and informal supervisors are not legally responsible for their feedback, it is of the utmost importance that the dynamic pitfalls of informal supervision, specifically regarding the legal and ethical relationship between formal and informal supervision, are explicated so moving forward, trainees engage in informal supervision in ethical ways. Findings from the current study showed that participants practiced informal supervision in secret. While some participants used informal supervision to inform formal supervisory discussions, many did not share their informal supervisory explorations with formal supervisors. Viewed through this lens,

informal supervision is essentially a form of ‘cheating’ on one’s formal supervisor. Trainees who seek informal supervision without also consulting about the same topics with their formal supervisor risk splitting the guidance of their formal and informal supervisors, thus creating a situation by which they undermine their formal supervisors’ authority and expertise by concealing clinical material that has important implications for their patients and their own development.

Additionally, trainees may be tempted to seek advice from informal supervisors if they suspect that their formal supervisors will disagree with or provide guidance that runs counter to their wishes. This situation is essentially a form of colluding by which trainees seek guidance that confirms their preconceived notions and precludes opportunities for therapeutic growth. It also places their patients at risk for missing out on interventions that may be clinically indicated. Thus, it is of the utmost importance that trainees disclose their informal supervisory conversations with their formal supervisors in one of two ways. Ideally, trainees will openly report these conversations to formal supervisors so that they can be reflected and expanded upon in formal supervision. However, if trainees choose to conceal their informal supervisory conversations, then they should discuss the very same topics/personal reactions/concerns with their formal supervisors. In this way, trainees would both preserve the primacy and sanctity of formal supervision, while ensuring that their formal supervisors are aware of and contribute to their clinical interventions, since formal supervisors are legally responsible for their supervisees’ clinical work.

It is also important to consider how the practice of informal supervision may unintentionally undermine the impact of formal supervision on trainees’ clinical work by diluting the supervisory process. It would be prudent for trainees who seek informal supervision because

they want on demand supervision and/or need more supervision than is provided in a single formal supervisory hour once a week to consider the potential benefits of holding and containing their distress until they can meet with their formal supervisor. It is possible that trainees who seek instant gratification from their informal supervisors miss out on important opportunities to learn how to hold their immediate discomfort and distress and process it independently or later with a formal supervisor. The process of waiting to discuss clinical issues and concerns with formal supervisors can provide trainees with confidence in their capacities to function autonomously and strengthen the impact of their sessions with formal supervisors. Trainees are thus encouraged to be thoughtful about how, when, and why they seek informal supervision, and to consider the wide-ranging implications of discussing their clinical work in an informal context.

Lastly, findings showed that participants were concerned that they were not experienced enough to provide informal supervision, they worried that trainees would apply their guidance without consulting their formal supervisors, and felt anxious that individuals with whom they provided informal supervision might make egregious clinical errors that negatively impact their patients. Thus, in order for informal supervision to be used appropriately and effectively, informal supervisors need to feel authorized to speak honestly and without reservation about their concerns, and in these instances, encourage their peers to seek guidance from their formal supervisors.

With these important caveats and accompanying appropriate actions to counteract the potential pitfalls of informal supervision in mind, the practice of informal supervision is by definition ethical in that it serves to enhance trainees' development, expertise, and emotional capacities, all of which facilitate trainees' capacity to provide more effective psychotherapy. In

other words, *it is ethical* to provide therapists with as many opportunities as they need to discuss their work. Furthermore, if trainees do not share identifying information about their patients and consult with their formal supervisors about the very same issues that they speak about with their informal supervisors, the practice of informal supervision does not violate APA's ethics codes. The guidelines outlined above are in keeping with *APA article 4.06 - Consultations*, which states (Ethics Code; APA, 2010): "When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. The guidelines proposed for the ethical practice of informal supervision, as outlined above, also takes into account *Ethics Code 4.07 – Use of Confidential Information for Didactic and Other Purposes* (Ethics Code; APA, 2010), which states: "Psychologists do not disclose in their writings, lectures or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so."

In conclusion, informal supervision is an ancillary, not primary, form of supervision. Because informal supervisors/peers are not licensed, and trainees practice under their formal supervisors' licenses, conversations about patients in informal supervision must be discussed with formal supervisors too, especially when regarding decisions regarding interventions.

Processing of countertransference reactions may sometimes be better contained to informal supervision, although trainees are encouraged to use their reflections/insights to then open up conversations with formal supervisors.

Proposal for Integrating Peer Supervision into Doctoral Programs

Given the profound impact, utility, and widespread use of informal supervision (Farber & Hazanov, 2015), it is recommended that peer supervision be integrated into doctoral training programs in clinical and counseling psychology. The following proposal provides flexible guidelines and suggestions that can be tailored to fit individual programs. In order to maintain the integrity and usefulness of the ‘informal’ aspect of informal supervision, it is essential that formally assigned teachers and supervisors do not participate and that students are not mandated by programs to engage in informal supervision. Somewhat paradoxically, however, students need authorization from their directors of clinical training, teachers, and formal supervisors to use informal supervision so that it is no longer a secretive practice. The director of training, in conjunction with the faculty, can decide the extent to which they want to legitimize the practice of informal supervision in their programs by openly acknowledging and discussing its use. Once that decision is made, the director of training and/or in conjunction with faculty can hold a colloquium/seminar or two to discuss the phenomenon of informal supervision, including its benefits, potential drawbacks, and ethics.

Results from this study showed a clear developmental trajectory for how trainees used and benefitted from informal supervision. Early in training, trainees relied more exclusively on informal supervision to provide emotional support and validation. As trainees gained clinical experience, they sought more focused and intentional discussions about clinical work. Therefore, it is recommended that a no-credit and no-fee practicum called “Informal Supervision” is created

and built into first or second year (depending on when students start seeing patients) trainees' schedules. Students could be encouraged, but not expected, to participate in informal supervision throughout their first year of clinical training, permitting the holding environment in which the Rogerian attributes that trainees sought and valued in this study to be utilized. As trainees progress through their programs, and their clinical and research work magnifies and intensifies, it is recommended that students then independently choose a once or twice monthly time to use informal supervision in more targeted ways.

It is in these later years of training that trainees may gain an additional, valuable experience from the phenomenon, i.e., providing informal supervision. Findings showed that participants' experiences providing informal supervision to their peers helped them to build confidence in their own clinical skills and ability to provide constructive guidance to peers, was a creative outlet for developing their own capacities as clinicians, and was a unique opportunity to engage in playful and creative conversations about their peers' clinical work. Thus, informal supervision may be a low-stake and meaningful way for trainees to develop supervisory skills, note situations in which they feel uncomfortable providing clinical guidance, learn when to seek additional consultation, and lastly, begin to establish a practice of clinical consultation with trusted colleagues that can extend well beyond training and protect against therapist isolation and burn-out. The latter is particularly noteworthy, as the practice of informal supervision overlaps with and may in fact be preparatory to "peer supervision" among more experienced therapists.

Future directions

This study's findings indicate several recommendations for future research. First, results of the present study raise important questions about the darker side, i.e., the potential drawbacks and pitfalls of informal supervision. As noted above in the limitations section, findings showed

that some participants were concerned that they were not experienced enough to provide informal supervision, felt worried that trainees would apply their guidance without consulting their formal supervisors, and felt anxious that individuals with whom they provided informal supervision might make egregious clinical errors that negatively impact their patients. Additionally, informal supervision as currently construed is a secretive practice that occurs away from formal supervisors, and thus has potentially negative ramifications for trainees' development, such as the potential for informal supervision to represent a form of 'cheating' on formal supervisors, splitting between informal supervisors and formal supervisors, colluding with informal supervisors against formal supervisors, and diluting the power of formal supervision to further trainees' development and clinical skills. Relatedly, it is possible, even likely, that informal and formal supervisors will at times provide different, even contradictory suggestions for clinical work. If a trainee prefers the clinical guidance of her informal supervisor, it is incumbent upon the trainee to discuss her preferred therapeutic intervention with her formal supervisor, thus opening the formal supervisory space for further learning and understanding while maintaining the formal supervisory structure as primary. Lastly, if informal supervision is built into the curriculum and legitimized, it is possible that formal supervisors may feel undervalued or even resentful. As noted above, it is of the utmost importance that trainees are transparent with their formal supervisors regarding their use of informal supervision, so that the informal supervision enhances rather than detracts from the primacy of formal supervision. Future research should directly address these pitfalls in an effort to better understand the darker side of informal supervision, and the specific ways that using informal supervision enhances and detracts from the utility of formal supervision, as applied to trainees' development.

Secondly, while the current study gathered a comprehensive understanding of the

phenomenon of informal supervision, it failed to capture the extent to which – and more specifically how – trainees act on their informal supervisory conversations. For example, how do trainees put into action the guidance and advice that they receive from informal supervisors? How often do they use informal supervisory feedback to directly inform clinical interventions, and to what end? Is informal supervision primarily used as a space to freely vent and share feelings about clinical work? Future research should directly address these questions to gain a clear understanding of this important aspect of the phenomenon.

Thirdly, findings showed that for some participants, informal supervision served as a model for continuing to seek consultation after graduation. Additionally, some participants noted that their experiences providing informal supervision helped them to develop their own practice of providing supervision. Future research detailing these aspects of the phenomenon might show that informal supervision is indeed a valuable and unique space to learn how to provide supervision, as well as provide an entryway towards developing a community of practitioners through which clinicians can seek clinical consultation once they graduate from programs and become independent practitioners.

In sum, while prior research (Golia & McGovern, 2013; Farber & Hazanov, 2014) has shown that informal supervision is a ubiquitous and secretive practice that is a valuable complement to, rather than replacement for formal supervision, and contributes to trainees' development, this is the first study to detail the wide ranging uses and impact of informal supervision, including a proposal for legitimizing and integrating informal supervisory practice into doctoral training programs, and an important discussion of ethics. The results of the present study highlight the diverse range of important ways that trainees use informal supervision throughout their training to enhance their clinical and professional development.

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Table 2

Cross-Analysis: The Phenomenon of ‘Informal Supervision’

Domains and Categories	Frequency Label
Preferred qualities of informal supervisor	
Similar background/perspective	Typical
Thoughtful/ curious/gives good feedback	Typical
Open-minded, nonjudgmental, and validating (Rogerian)	Typical
Experienced and knowledgeable therapist in training	Variant
Close relationship with my informal supervisor	Variant
Challenging/direct	Variant
Provides alternative perspective	Variant
Available on demand/as needed	Variant
Reasons for seeking informal supervision	
Liberty to speak honestly about clinical work	Typical
Support; a holding environment	Typical
Process personal reactions (e.g. countertransference) in constructive way	Typical
Needs help with clinical work	Typical
Availability	Typical
Issues with formal supervision	Variant
Shared experience/ bonding	Variant
What trainees get out of informal supervision	
Emotional support and validation	General
Openness and freedom to discuss fears/mistakes/challenges	Typical
Insight	Typical
Different perspective	Typical
Connection	Typical
Increased capacity to access feelings	Variant
IS prevents burnout/isolation	Rare
Tone of informal supervision	
Humorous and playful	Typical
Natural and casual	Typical
Supportive and mutual	Variant
Honest and direct	Variant
Emotive	Variant
Energizing and engaging	Variant
Creative	Rare
Topics and themes discussed in informal supervision	
Countertransference/personal reactions to patients	General
Self-doubts	Typical
Stresses of working with challenging patients	Typical

Patients' diagnoses (especially severe pathology)	Typical
Disagreements with FS	Variant
Difficulties working with a multidisciplinary team	Variant
Challenges of conceptualizing cases from different perspectives	Variant
Multicultural issues in treatment	Rare
Parameters/frame of psychotherapy	Rare
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Comparisons between formal and informal supervision	
Differences resulting from power dynamic	General
Differences in structure, language, and tone, i.e., IS is more informal	Typical
IS organized around emotions and countertransference reactions	Typical
IS and FS are more similar than different	Typical
Differences in content	Variant
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Changes in use of informal supervision over time	
IS conversations more intentional and focused over time	Typical
Greater reliance on IS to discuss specific clinical issues vs. basic parameters of therapy over time	Variant
Lesser need for IS to provide emotional support over time	Variant
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Reasons for informal supervision with significant other	
Emotional support	Typical
Beneficial aspects of limiting clinical details with SO	Variant
Helpfulness of SO	Variant
Concerns about using SO for IS	Rare
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Reasons for informal supervision with one's therapist	
Discuss countertransference reactions	Typical
Discuss issues with formal supervisors	Variant
Emotional support/validation (holding environment)	Variant
Helpful but complicated	Variant
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Concerns about using informal supervision	
Privacy/confidentiality	Typical
No concerns about privacy/confidentiality	Typical
IS is inevitable	Typical
Wants open dialogue and guidelines re: IS	Typical
Confusion about whether or not IS is ethical	Variant
Concern regarding not feeling authorized to provide IS	Variant
Negative experiences with IS, e.g., regrets	Variant

Experience providing informal supervision

Positive and powerful experience	Typical
Reciprocal nature	Typical
Frequent topics: countertransference, clinical challenges, and advice	Variant
Provide common factors, e.g., support, empathy, encouragement	Variant
Reciprocal nature	Variant
Concern re: feeling insufficiently competent to provide IS	Variant

Note: general = 15 to 16 cases; typical = 9 to 14 cases; variant = 3 to 8 cases; rare = 2 cases.

Appendices

Appendix A

INFORMED CONSENT:

Description of the Research: You are invited to participate in a research study on a clinical phenomenon called “information supervision”. Informal supervision is the extent to which therapists in clinical and counseling doctoral training programs engage individuals who are not their formally assigned supervisors in significant and/or meaningful conversations about their clinical work. This inquiry extends Farber and Hazanov’s (2014) research on the phenomenon of informal supervision, which showed that trainees discuss clinical material with informal sources more frequently than typically assumed by those who write about the supervisory process. This study aims to capture -- through a semi-structured interview that will take approximately 45 minutes to complete (you will be responding to interview questions that are open-ended) -- a broad and detailed phenomenological understanding of how, when, with whom, and under what circumstances do beginning therapists utilize informal supervision? How does the practice of informal supervision affect trainees’ clinical work, their relationships with their formal supervisors, and their burgeoning therapeutic identity? Examples of interview questions include: “How are conversations with your formal and informal supervisors similar to and different from each other” and “What has it been like for you to provide informal supervision”?

Risks and Benefits:

It is possible, albeit unlikely, that subjects may experience distress when talking about the ways they have used informal supervision to inform their clinical work.

To minimize risks, study participants will be informed they can stop participation and withdraw from the study at any time. Participants can also skip any questions that they choose. They can also withdraw from the interview at any time and have their data destroyed. Further, all interview questions are open-ended, which allows the subject to share only the information that they wish.

While this seems highly unlikely, in the event that a participant expresses an interest in seeking psychological services, they will be provided with the contact information of the Principal Investigator’s research mentor, Dr. Barry Farber, a licensed clinical psychologist. Subjects who contact the investigator will be assisted in finding local counseling facilities. Should the participants require referral, a list of sliding scale and free counseling clinics will be offered.

RIGHTS: *Taking part in this study is completely voluntary.* You are free to decline to take part in the project. You may choose to skip any questions you do not want to answer and are free to stop participation at any time. There will be no penalty to you or loss of benefits to which you are otherwise entitled.

COMPENSATION: Subjects will be remunerated for their participation by being entered (if they choose) into a lottery system for a \$150 Amazon gift card. I will state the odds of winning (1 in 16) in our consent form.

DATA STORAGE TO PROTECT CONFIDENTIALITY: Subjects will be interviewed and audiotaped only by the Principal Investigator during the semi-structured interview. If a subject agrees to participate in the study, the Principal Investigator will ensure that the subject understands that audiotaping will only take place with their permission. Subjects are thus fully informed that audiotaping is voluntary. If they agree to audiotaping but feel uncomfortable at any point during the interview, the recording can be stopped. Further, if they choose to stop participation altogether, the interview can be stopped at any point.

The Principal Investigator will keep audiotapes in a locked file in his private office that only he has access to for the duration of time it takes to make a transcript; subsequently the tape will be deleted. The Principal Investigator will remove identifying information from any transcripts and descriptions of information derived from the tapes. Coding and data materials will be stored on password protected, secure data files and on password protected computers that will only be accessible to the Principal Investigator, and once the Principal Investigator has removed all identifying information, his research team will have access to it too (three Masters students in Clinical Psychology at Teachers College, Columbia University). All data collected through the semi-structured interview will be kept entirely confidential.

Once the interview is complete, the Principal Investigator will create a transcription document using only the subject's assigned ID number. At the conclusion of data gathering, all identifying information will be wiped from 1) the file used to create a contact list for the interviews and 2) the interview transcripts. Members of the research team will refer to subjects solely by ID numbers in order to protect identity and private information. Any quotes taken from interviews will be de-identified. While interviews will be audio taped, those tapes will be kept only long enough to create a transcription and will then be destroyed. Data from the semi-structured interview will be viewed by members of the research team only after all identifying information has been removed by the Principal Investigator, who will be conducting the interview.

All members of the research team have received appropriate training about securing and maintaining confidentiality and safeguarding data. Data analysis will take place on password-protected computers belonging to the Principal Investigator.

All subjects will be required to sign this informed consent prior to participating in the interview.

Time Involvement: There will be one phone interview that will take approximately forty-five minutes to complete.

How the results will be used: Data from the interview may be reported in professional publications and conferences. I will de-identify all quotations in order to protect your confidentiality. By participating in this project, you will be helping to advance knowledge in the field of psychology, particularly in regard to professional training.

If you have questions: If at any point you have questions or concerns regarding this research, you can contact the Principal Investigator, Sidney Coren, at sac2176@tc.columbia.edu or by phone at 214-476-7181. You can also contact the Principal Investigator's research mentor, Dr.

Barry Farber, at farber@exchange.tc.columbia.edu or at 212-678-3125. This study has been reviewed and cleared by the Teachers College, Columbia University Institutional Review Board (IRB). If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact the IRB at (212) 678-4105.

We thank you for your time and consideration. You will be given a copy of this form for your records.

Statement of Consent: I have read the above information, and have received answers to any questions I asked. I consent to take part in this study.

Your signature: _____

Your name (printed): _____

In agreeing to participate, I also consent to having the interview audio recorded.

Your signature: _____

Signature of person obtaining consent: _____

Printed name of person obtaining consent: _____

INFORMAL SUPERVISION PARTICIPANT'S RIGHTS

Principal Investigator: Sidney Coren, M.A.

Principal Investigator's Research Mentor: Barry Farber, Ph.D.

Research Title: Informal Supervision

- I have read and discussed the Research Description with the researcher. I have had the opportunity to ask questions about the purposes and procedures regarding this study.
- My participation in research is voluntary. I may refuse to participate or withdraw from participation at any time without jeopardy to future medical care, employment, student status or other entitlements.
- The researcher may withdraw me from the research at his/her professional discretion.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue to participate, the investigator will provide this information to me.
- Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have any questions regarding the research or my participation, I can contact the principal investigator, who will answer my questions. The principal investigator's phone number is 214-476-7181.
- If at any time I have comments, or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact the Teachers College, Columbia University Institutional Review Board /IRB. The phone number for the IRB is (212) 678-4105. Or, I can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY, 10027, Box 151.
- I should receive a copy of the Research Description and this Participant's Rights document.
- Audio taping is part of this research: I () consent to be audio taped. The written and audio taped materials will be accessed only by the Principal Investigator, Research Coordinator, and members of their research team.
- Optional: I give my consent for my written and audio material to be presented in an educational setting outside the research ()
I do not give my consent for my written and audio material to be presented in an educational setting outside the research ()
- My signature means that I agree to participate in this study.

Participant's signature: _____ Date: ____/____/____

Name: _____

Investigator's Verification of Explanation

I certify that I have carefully explained the purpose and nature of this research to _____ (participant's name) in plain language. He/She has had the opportunity to discuss it with me in detail. I have answered all his/her questions and he/she provided the affirmative agreement (i.e. assent) to participate in this research.

Investigator's Signature: _____

Date: _____

Recruitment Letter:

Dear Dr. _____,

My name is Sidney Coren, and I am a doctoral student in clinical psychology, mentored by Dr. Barry Farber, at Teachers College, Columbia University. I am recruiting doctoral students in clinical and counseling psychology Ph.D. and PsyD programs across the country who may be interested in participating in my dissertation on the use of “informal supervision”, i.e., when psychotherapist trainees engage individuals who are not their formally assigned supervisors or teachers in significant or meaningful conversations about their clinical work. I would very much appreciate it if you would please forward this email to students in your program who may be interested in participating.

I have developed a semi-structured interview in the hopes of obtaining a broad and detailed phenomenological understanding of how trainees use informal supervision to further their clinical work. Participation entails a 45-minute phone interview, during which participants will be asked for their personal thoughts and perceptions on their use of informal supervision throughout their graduate training, and how it has influenced their growth as a clinician as well as their burgeoning therapeutic identity.

To participate or for more information, please contact Sidney Coren at sac2176@tc.columbia.edu. A full description of the research, as well as an Informed Consent Agreement will be sent to you at that time.

Best,
Sidney Coren, M.A.
The Psychotherapy Research Lab, Teachers College, Columbia University

Demographics Survey:

1. Age

2. Gender

Female

Male

Other (please specify): _____

3. Ethnic Identity (check all that apply)

Asian/Asian-American

Pacific Islander/Pacific Islander-American

White/Caucasian

Native American

Black/African-American

Hispanic or Latino(a)/Hispanic or Latino(a)-American

Other (please specify): _____

4. Type of graduate program

Clinical psychology program

Counseling psychology program

5. Degree Program

PhD

PsyD

6. Year in program (i.e., 1, 2...)

7. Number of clients in individual therapy currently in your caseload, or most recent caseload

8. Number of clients in individual therapy treated to date (including those seen currently)

9. Number of supervisors you currently work with on an ongoing, regular basis

10. Do you have a significant other?

11. Are you or have you been in your own psychotherapy?

12. If yes, for how long (total)?

13. Please identify your primary theoretical orientation

Cognitive-Behavioral

Psychodynamic

Humanistic/Existential

Integrative

14. On average: How frequently on a monthly basis have you used informal supervision with the following people?

a. Colleague in your program

b. Colleague in the mental health field but outside of your program

c. Friend (not in the mental health field)

d. Family member

- e. Significant other
- f. Faculty member in your program (other than formal supervisor or practicum instructor)
- g. Your own therapist
- h. Religious leader/spiritual guide

15. Please identify your *primary* informal supervisor:

- a. Colleague in your program
- b. Colleague in the mental health field but outside of your program
- c. Friend (not in the mental health field)
- d. Family member
- e. Significant other
- f. Faculty member in your program (other than formal supervisor or practicum instructor)
- g. Your own therapist
- h. Religious leader/spiritual guide

16. For how long does a typical informal supervision session last?

Semi-Structured Interview Protocol:

As you know, we'll be talking about informal supervision, which we are defining as meaningful conversations about your clinical work with individuals who are not your formally assigned teachers or supervisors. You've mentioned that you consider XXX to be your primary informal supervisor, so....

1. Why do you consider ____ to be your primary informal supervisor?
2. Why do you seek informal supervision from [name]?
Possible prompt: What do you get out of informal supervision?
Possible follow-up prompt if all answers are positive: Anything negative?
3. What is the tone like during these informal supervision conversations?
4. How are your conversations with your formal and informal supervisors similar to and different from each other?
Possible follow-up: Please compare and contrast your descriptions of patients/ therapy sessions to your formal and informal supervisors.
5. Please tell me about a salient time in which you sought informal supervision for a specific case.
6. Please tell me about your use of informal supervision over the course of your clinical career.
If no answer, can prompt: For instance, describe how your use of informal supervision changed since you started your clinical work.
7. If it doesn't come up over the course of the interview but participant has marked that he/she is in therapy or a relationship, ask:
What is informal supervision like with your therapist? Significant other?
8. We've talked about some of the things that you get out of informal supervision. Are there any concerns that you have about using informal supervision? (Can prompt if needed; for example, what about ethical considerations?).
9. Have you ever provided informal supervision? (If yes) What has it been like for you to provide informal supervision?
10. What thoughts do you have about the relationship between informal supervision and psychology's practices, "rules" and/or ethical codes?
Possible prompt: Would you propose any new rules or codes?
11. Is there anything that you would like to add about informal supervision that I didn't ask?