Balancing Duty to Client and Therapist in Supervision: Clinical, Ethical and Training Issues

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ABSTRACT. The clinical, ethical and training implications of supervision as a dual contract with supervisee as therapist and client as care recipient are considered. Particularly for the still unlicensed professional, the supervisor has a responsibility to ensure that treatment meets the standard of care which includes recognizing the existence and meaning of a dual contract with client and therapist. Careful selection of therapists does not fully ease the search for the proper balance of tolerance and oversight related to the supervisee’s therapy work. In a field dedicated to accepting people in a very fundamental fashion, both supervisors and supervisees have difficulty with the evaluation and limit-setting sometimes involved in the training process. Two underlying aspects of the supervision process, modeling and relationship, modulate and shape supervisee learning. When the supervisor’s responsibilities to the evolving supervisee/therapist and the client do not lead themselves to reconciliation, the clinical, ethical and training aspects of the supervisory process all fall on the side of client welfare. A number of supervisory vignettes illustrate the complexities of the supervisory process. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-5004. E-mail address: getinfo@haworth.com]

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In psychotherapy supervision, as in psychotherapy, it is necessary to find one's way through a maze of competing alternatives. This is true both at the level of conceptual formulation and at the level of practical behavior. As the training of supervisors and the processes of supervision receive increasing attention in the literature, the depth and breadth of consideration of the issues has increased as well (Alonso, 1985; Hess, 1980; Kadushin, 1985; Stoltenberg & Delworth, 1987; Wallerstein, 1981). The complexities of the multiple roles and responsibilities of supervision, however, have not been sufficiently addressed (Thompson, 1990). Given that the supervisor always has a double contract, one with the client, and one with the supervisee, it is important to consider the tensions and problems that arise in such a multiple role situation (Rubin, 1995). What are the clinical, ethical and training implications of therapist-client difficulties? What are, and indeed what should be, the limits of supervisor tolerance for therapist inexperience, inadequacy and failure to perform adequately in psychotherapy treatment? At the same time, the potential costs for therapist and client when undue attention is directed to therapist difficulty, inexperience, and partial failure are considerable as well. In the present paper, the implications of supervision as a dual contract with supervisee as therapist and client as care recipient will be considered. After reviewing issues and case material, the art of balancing clinical and ethical requirements for therapists and clients will remain a complex task for all of us.

From the very outset, the responsibility and conflict potential in this field are clear. For example, from both the clinical and ethical vantage points, the supervisor and agency have the responsibility to ensure that the treatment meets the standard of care of the profession and complies with the ethical requirements that the profession sets forth (American Psychological Association, 1992; Bersoff & Koeppi, 1993; Furrow, Johnson, Jost, & Schwartz, 1991). This principle, however, sets forth parameters that communicate very little about how to view and manage the failures and fluctuations that are a part of treatment by developing (and developed) clinicians. Every training institution must maintain its commitment to help the client or patient at a level of care that is adequate or better. It is equally true that no training setting can train and prepare practitioners for future independent work without a commitment to tolerate the trial
and error that is part of the learning process. In every case of supervised psychotherapy work of the unlicensed professional, the supervisory relationship occurs in the context of a commitment to the client on the one hand, and to the therapist on the other.

It is common practice to acknowledge the potential conflict of interest involved in working with individuals where a conflict of interest is or may be present. For example, when members of a family are seen either conjointly or individually (Keith-Spiegel & Koocher, 1985), the therapist is advised to anticipate and discuss with clients the potential for conflict and how it is to be handled. How therapists manage this will vary, but the importance of raising sensitivity and giving thought to possible conflicts in treatment is part of the ethical and competence-based practice of psychotherapy. Similar attention to potential for conflict is necessary in the establishment of the supervisory and therapeutic contracts (Berman, 1988). In contrast to the attention paid to possible conflict of interest in psychotherapy, however, the issues raised by therapist-client impasse, non-improvement or deterioration in the training and supervision contexts have been neglected (Lamb, Cochran, & Jackson, 1991). The greater the willingness to contemplate the issues involved, the more likely it is that the issues will become more understandable to clients and supervisees. Understanding the dual nature of the supervisory relationship for supervised therapy is a basic requirement to help client and therapist effectively consider the meaning of their contract. The obligation of the therapist to communicate to the client that the treatment is supervised, and even who the supervisor is, is a standard of practice in some regions. The communication of the fact of a double contract, however, is by itself insufficient to assist the client understand the implications of the circumstances. Adding the reassurance (based on the supervisor’s discussions with the therapist) that the client’s needs are paramount, will go far to addressing the most basic and legitimate of client concerns. It also serves to address the therapist’s fears about potential for harm to the client.

**PRELIMINARIES:**

**BASIC REQUIREMENTS OF THE THERAPIST**

In the context of undertaking a dual contract with supervisee and client, the supervisor and/or supervisory setting has a responsibility
to first determine that the therapist is suited to the task of conducting therapy. The training facility, the educational program, and the individuals involved share responsibility to ensure that the supervisee is or can be up to the task. The literature on what constitutes a good therapist, what his or her qualities should be, and how to predict these has not been heartening (Persons, 1991). At the level of general qualities, and indeed at the level of specific traits, there are a number of useful guidelines (Dryden & Spurling, 1989; Fromm-Reichmann, 1950; Garfield & Bergin, 1986; Greenson, 1967; Guy, 1987; Matarazzo, 1978; Rogers, 1951; Sullivan, 1970). For the serious student of prediction of outcome in psychotherapy training, the multiplicity of training models and the absence of agreed criteria are formidable producers of variance in this field.

Despite the complexity of the issues, it is possible to suggest a number of guidelines that have a measure of face validity in the selection process. Absence of major active psychopathology (which would interfere with patient care), some capacity for empathy and genuine emotional contact, and an ability to learn from training and experience might be acceptable starting points for trainees in the eyes of many involved in the training of psychotherapists. A reasonably developed ethical sense as it extends to the practice of the profession would probably also qualify. After the initial selection, whether to graduate school or to a practicum or internship setting, the dominant aspect of the training mandate is to assist the student to develop into a competent therapist proceeding from the particular mix of assets and liabilities present in each individual.

Once enrolled in training, the capacity to learn and develop are central qualities in the formative years of the psychotherapist in training. Perhaps analogous to the particularly long development period in the primates and human species as compared with other mammals (Fleagle, 1988), the not fully mature therapist is in training and under supervision for a relatively long time. At least one reason for this is the complexity of the therapeutic environment that the mature therapist must continue to adapt to (Casement, 1985). Considerable importance attaches to the developmental process in the learning of psychotherapy, and a developmental perspective adds an important dimension to conceptualizing the training process (Stoltenberg & Delworth, 1987). How to respond most appropriate-
ly to the differing needs of therapists at different levels of training is a serious question, but it is not the focus of the paper.

As long as the therapist is not a fully independent professional credited with her or his license to practice independently, the supervisory relationship will involve the assumption of some responsibility for the proper handling of the therapeutic process by the supervisor and setting. The extent of this responsibility and what it entails, however, occurs at the interface of the responsibility to maintain standards of proper care in the treatment of clients and the responsibility to maintain standards of care in the education of psychotherapists. These responsibilities function orthogonally at times, and raise dilemmas for the supervisor/overseer of treatment (Gottlieb, 1993). In the next section, the importance of supervisors recognizing this dual responsibility is explicated.

THE FACILITATION
OF CLIENT CARE AND THERAPIST GROWTH:
BALANCING SUPPORT WITH OBJECTIVITY

In a field such as psychotherapy, dedicated to accepting people in a very fundamental way (Rogers, 1951), sensitivity to the most fundamental anxieties of the self (Havens, 1986; Kohut, 1971; Sullivan, 1970), acknowledging the positive effects of much of our imperfect capabilities (Winnicott, 1965), and recognizing value in the ability to speak freely without fear (Freud, 1933), it is not surprising that both supervisors and therapists have difficulty with the evaluative and limit-setting aspects of the training process for its impact upon the nature of the supervisory relationship. The need to monitor at least loosely the progress of the client in treatment with the supervised therapist adds another layer of complexity to the supervisory relationship.

It is instructive to consider how changes in the legal and professional sphere have affected the conceptualization of the doctor-patient relationship. For many years there has been a movement to limit the discretion of practitioners in the definition of what duty to the individual patient/client may entail. Instead, there is an awareness that the practitioner is in partnership with the client, and information is to be shared with him or her (Emanuel & Emanuel,
1992). Similarly, the evolution of therapist understanding of the requirements of responsibility to third parties has been particularly apparent since the Tarasoff case. In the landmark set of rulings, psychotherapists had to confront the legal sequelae of decisions made regarding the extent of duty to one’s client and duty to others. The mandatory reporting laws in cases of child and elder abuse have also framed the discussion of what is considered the limits of the client’s rights to confidentiality (Hirsh, 1995). Even in cases where the sharing of information is done in the context of voluntary seeking of treatment, mandatory reporting laws require that the duty to others and society as codified in law be understood as no less significant than the duty to one’s immediate patient. These developments in the practice of treatment are aspects of the evolution of the understanding of what the ethics of patient/client care require. Taken together, they are part of the movement away from doctor-patient relationship as the sole context of clinician responsibility, and towards a more complex doctor-patient-external society relationship with additional expectations and awareness that these external limitation require communication to the client.

These developments—involving partnership, sharing and responsibility to others—are also important for the understanding and the explication of what the supervisory relationship involves. The supervisory contract is a therapist-client-other contract where expectations by the training institution and/or the funding sources impact on the treatment. Respect for autonomy of the client suggests that they be informed of many things. In addition to standard information such as the limits to confidentiality and the impact of funding constraints upon treatment planning, clients should also know that the existence of a training contract implies an involvement in making sure that therapists develop as well as that clients receive a high standard of care. This requirement underscores the value of helping the client understand the existence of a matrix of involvements in the contracting process of therapy.

Once the therapist’s suitability for the task has been considered, it is equally important to ensure that the clients are suitable for the therapist as well. It is reasonable to assume that the clients assigned to the therapist are appropriate for the therapist in supervision within the treatment setting (Harrar, VandeCreek, & Knapp, 1990).
When this assumption is violated, it will be the supervisor's responsibility to redress the imbalance. This may involve additional supervision, a transfer of the case, the use of additional personnel, etc., but what is common to all of these approaches is the supervisor's attention to the problem. The following case vignette illustrates a number of these points.

**CASE VIGNETTE 1: IS THE CLIENT SUITABLE FOR THE THERAPIST?**

T., a third year graduate student in midyear of her second practicum setting at a University Counseling Center, was assigned a young man for evaluation. At the initial meeting, the client displayed much anxiety and unease. He spoke of his attraction to women, his need to dominate, and asked T. if she thought she could "handle a man as powerful as me." A partial intake was completed and the client was told he would be contacted by the clinic with a decision of what the treatment plan would be. When the material of the initial session was presented to the supervisor, T. shared her concerns about the client. She perceived him as a disturbed individual with difficulty in controlling his sexual and aggressive urges. The supervisor, by contrast, felt that the therapist's attractiveness and general manner had contributed to the client's display of "macho" behavior. Both parties felt that further evaluation of the client was necessary, but the supervisor felt that there would be no problem with T. undertaking the evaluation. T. herself had misgivings but, on the basis of her respect for the supervisor, agreed to his plan for an extended evaluation. At the next meeting, both T.'s assessment and her supervisor's counter-assessment remained unchanged. The supervisor attributed the client's swagger to macho behavior, while the therapist thought it more the product of psychological difficulties. By the third session, however, deterioration in the client and his difficulty with impulse control were so striking as to raise the supervisor's concern. The material included descriptions of the client's stalking the therapist, a description of the client's difficulty tolerating the wait between sessions, and his fantasies of violent attacks on individuals. In response to this material, the supervisor became very concerned. He made himself available to the therapist
for additional discussion and supervision, consulted with senior clinic staff, and within a short period came back with a recommendation for immediate transfer of the client to another clinic designed to deal with more psychiatrically disturbed clients.

The case vignette reviewed above was presented by the student in an ethics seminar at the point when her supervisor and she were still divided on their assessment of the client. Within a short time, events resolved themselves and confirmed important aspects of T.'s analysis of the client. The failure of the supervisor to understand sufficiently early that the client in question is unsuitable for the supervised therapist and the clinic setting is an important part of the story. When failures of this kind do occur, the supervisor's prompt response and taking charge of correcting the error and providing the supervisee with the requisite support go far to redress the problem. Such an approach allows for adequate client treatment to continue where possible, and adequate support and facilitation of therapist's work and learning to continue as well. The supervisory response furthermore demonstrates how to utilize new information, consult with colleagues, remain available to others in crisis and act swiftly to respond to a problem. In this case, the supervisee felt reassured that her assessment of the client had been vindicated and appreciation of her clinical skills had grown. In her evaluation of the experience, T. maintained her respect for the skill of the supervisor, valued his support and availability, and felt that their good working relationship had remained intact. What was not addressed in the open forum of an ethics seminar, however, is important to the clinical exploration of the supervisory misperception of the client. That point relates to the issues of sexuality, power, and gender, which operate not only in the therapy dyad but in the supervisory relationship as well. An exploration of this issue would be considered appropriate for most forms of interpersonal and dynamic supervision.

Of the postulates that underlie psychotherapy training in general, and supervision in particular, one in particular stands out: It is not only what you teach, but also what you do, that has impact on those whom you are trying to teach (Rubin, 1986). To the extent that there is a conflict between words and actions, one would assume, at best,
that the conflict itself is transmitted. At worst, one may assume that the least optimal aspects of the conflict make the greater impact.

In supervision, the therapist and supervisor work together to assist the client and the therapist to maximize the efficacy of psychotherapy. When the client is informed of the supervisory relationship and the client’s autonomy is respected, there are still requirements to avoid harm, to have therapy practice proceed beneficently, to maintain fidelity to the client, and so forth (Beauchamp & Childress, 1994; Gillon, 1985). Yet the creation of the therapeutic alliance will be facilitated if the therapist can be helped to feel both supported and neither overpowered nor abandoned by the watchful gaze of the supervisor. Furthermore, the basic tolerance of the other, so necessary in treatment, must not be undercut by too critical and/or too intrusive an approach. So the paradox here is how to support people on the one hand while maintaining openness to the watchful vigilance necessary to prevent harm, error, deterioration, etc. On the one hand, many therapists assume that a basic principle of psychotherapy involves the creation of a non-judgmental setting that facilitates trust and allows people to change. Yet on the other hand, when working with individuals in crisis or with more severe pathologies, and when working with the therapist who has lost the ability to maintain a proper therapeutic stance, it is the vigilance that also offers protection if not relief for all parties.

**CASE VIGNETTE 2:**

**THERAPEUTIC IMBALANCE AND VULNERABILITY**

The following case illustration occurred prior to the emphasis on ethics training which is now standard in graduate education in the U.S. and is becoming increasingly so in Israel (Rubin & Dror, 1996). As such, it presents some of the dilemmas of supervision around ethical issues that may occur in various situations for which consensus has not emerged.

In a supervision group of licensed advanced postdoctoral psychologists, Dr. A., a 32-year-old-male therapist, presented his ongoing psychotherapy treatment with a combination of skill and ineptitude. Following a detailed report of the patient’s presenting history and the general course of the 5-month treatment to date, it emerged that
the therapist often drove the client home after the therapy session. This had begun when Dr. A. had driven the (young, single female) client home at the end of the work day on a rainy afternoon, and it had continued unabated. This was mentioned matter-of-factly in the small supervision group, with no sign of tension, conflict, or awareness that this might reflect a problem of boundaries. In the group discussion of the treatment, the group members began by responding to other points of the presentation, but not to the issue of boundary confusion. The supervisor intervened fairly early in the discussion to emphasize his concerns regarding the potential blurring of boundaries in treatment and the risk that a dual relationship with the client was being encouraged. The supervisor’s perspective was that such behavior threatened the integrity of the treatment contract.

Aware that direct comment by the supervisor early on in the case presentation was unusual, the comment was phrased thus: “In order for me to be able to listen and be open to what is going on, I have to say that I am very troubled by the boundary issue questions raised by the car rides home. This is a behavior that you will need to cease, and which will also be important to explore and understand. It appears very problematic and seductive and can threaten the basic treatment contract.” Dr. A. became defensive, made excuses, and rationalized the behavior somewhat lamely. He did, however, make the required change in behavior without being able to explore the issue with the patient. His ability to explore the issue in the group was circumscribed as well. At several points in the group’s life, the group leader’s criticism of the therapist was discussed. It remained as one of the salient memories of the group and throughout retained some of its power as proof that the group was a mix of safety and threat. The supervisor’s intervention had exacerbated the anxiety of the group members and contributed to heightened defensiveness among group participants. While supportive and beneficial aspects of the group experience for all members were appreciated and acknowledged, they did not sufficiently overcome the impact of the supervisor’s “strict” intervention.

It is not surprising that negative feedback has threatening implications for individuals who are involved in a supervision group. Given that the incident occurred relatively early in the group life, the threatening aspects of the supervisory intervention were magni-
fied. A less critical intervention might have communicated the same information in a different manner—although perhaps it may have been associated with a more ambiguous message regarding boundary blurring. In the consideration of the occurrence and management of therapist sexual fantasies regarding patients, a non-threatening atmosphere for the airing of such features has been advanced by leaders in the field (Pope, Keith-Spiegel, & Tabachnick, 1986; Pope, Sonne, & Holroyd, 1993). While one can hardly suggest a more dampening feature than the threat of sanction for the opening up of confusing and conflictual feelings, there remains the need to educate clinicians as to the importance of client and psychotherapy boundaries. The rigors of therapist training are not intended to interfere with either learning or the flow of material—but the protection of client and therapy are primary.

Some colleagues have advocated an alternative mode of addressing the issue. For example, one approach might have involved the group in a discussion of boundary blurring behaviors and implications. Advocates of this approach feel that this may have provided a less intrusive and less threatening intervention and also contributed a more educational focus rather than limit-setting focus to the boundary issue. Perhaps in this way, the group and the therapist would have been less threatened by attention to the importance of boundary issues. Other colleagues support the approach described in the vignette as underscoring clear and firm boundaries regarding what is acceptable therapeutic behavior. With either approach, however, one would hope that the changes in therapist behavior would have been better integrated into both treatment and supervision. The question of how to approach the issue of blurred boundaries in the supervision of therapy is far from resolved, but the hallmarks of successful supervisory interventions differ less than the means employed to achieve them.

The therapy literature has considered the potential for harm extensively over the last years. How to deal with harmful thoughts and behavior of clients is an important aspect of psychotherapy training and contracting. In therapy, it is accepted that privilege is a necessary part of allowing the therapy process to proceed, yet it is also acknowledged that confidentiality cannot supersede the safety and well-being of others. It is no wonder that confidentiality of the thera-
therapy process is both necessary and legislated as the right of therapist privilege (Keith-Spiegel & Koocher, 1985; Hirsh, 1995). Some of the limits of confidentiality have also been considered and received grounding in law. For example, the duty to warn has been raised in cases where the potential for harm to specific individuals has been determined (Keith-Spiegel & Koocher, 1985). Similarly, the requirement to report suspected child abuse is another situation where curbs on therapist privilege and patient confidentiality have entered into the therapy process. In an analogous manner, it is necessary for the supervisory relationship to consider both the importance of safeguarding supervisee confidentiality and its limits. The ultimate goal is to facilitate learning while protecting both therapist and patient.

Limits of Tolerance and Limits of Criticism

The rights of therapists in training to develop and receive supervised contact with clients is a basis for much of the in vivo training of therapists. The therapist’s progress is monitored and often reports are made to the teaching (training) institution. A fair degree of latitude for error and difficulties in the learning process are probably the norm in this situation. Yet there are occasions when the limits of the training program’s “holding” and tolerance for error may be reached. Continued and serious interpersonal difficulties with clients and supervisors might be one type of difficulty. Similarly, a single ethical violation (e.g., sexual contact with a client) might well be considered so serious as to lead to termination of training. The mechanisms and procedures for handling such complaints may vary according to program and site, but they are generally in place. Protecting the rights of the trainee as well as the client requires that the process be both fair and perceived as such.

The therapist is a developing individual and as such is entitled to support and encouragement to face and grow even in the face of anxiety-arousing difficulties. It is also clear that the supportive and non-judgmental stance in training can serve to further burden troubled young student supervisees. Such a non-judgmental stance can exacerbate an already heavy burden on the individual, who may be encouraged to stay in the field and in the field of conflict and to work out problems without the necessary resources to do so. As in any situation of such importance, a careful monitoring of the situa-
tion and supervisee is required. As stressed above, how we relate to
students and supervisees will shape how they relate to clients in the
matter of form and content. Striking the proper balance between
criticism and limit-setting on the one hand, and support and tolerance
for minimal competence on the other, may not always be possible, but it is certainly a desirable goal. The reasons for thera-
peutic dysfunction are typically of multiple origin and overlapping.
On one level, therapeutic dysfunction may be diagnostic of failures
in the supervision and of the interactional process there (Ekstein &
Wallerstein, 1972). On another level, the meaning of success and
failure reflects the interaction of the therapy dyad itself. It may be
that a degree of failure may also stem from and reflect a client’s
need to experience the therapist’s failure (Casement, 1985). Yet we
cannot ignore that an additional source of therapeutic impasse may
reflect inadequacies and difficulties in the ability of the therapist to
connect and help the client. With the beginning supervisee, and at
nodal points in training, the ability to understand and examine what
is transpiring must wait for some reduction in anxiety and a stabili-
zation of the situation. In the meantime, there is a departure from
an idealized standard of competence. With the more advanced su-
ervisee, a higher standard of basic competence should have been
established. Deviations from the basic level of competence can then
be examined as a function of the client, therapist and supervisor
contributions to the therapy process.

In some combination of client, therapist and supervisor, the ori-
gins of therapeutic misalliance, impasse and failure reside. This is
not to deny that the client, by virtue of psychopathological difficul-
ty, character structure, motivational set, or other variables, may not
cooperate with the tasks of therapy. Often this is the case. One
would argue, however, that therapy requires of the therapist modes
of action, interpretation and intervention that are matched to the
needs of the client. The gap between what a client needs and what
the therapist is able to provide (by virtue of personality, experience
and training) is what is being considered here (Klerman, 1990; Stone, 1990). Without minimizing the dynamic process of therapy
and the remaining potential of most psychotherapy as conducted, it
would be equally difficult to ignore the serious problems that may
result from a therapy gone awry.
When the supervisee as therapist is unable to conduct the therapy in ways that the primary supervisor considers fully adequate, it is important for supervisor and supervisee at some point and in some way to recognize the inadequacy of the therapy and to adopt means to modify the situation. If these prove unsuccessful, it can be useful to consider alternatives to the therapy being conducted as well as who is conducting (and/or supervising) it.

Most of the material arising in a therapy being supervised should be examined and contained within the therapy process (Rubin, 1986). "Failures" in treatment are integral to the progression of therapy and need to be accepted. Indeed, one of the supervisor's tasks is to help the supervisee/therapist to understand and work with the patient even if that work does not lead to "success." Much can be learned from attention to process in therapy and not only to outcome (Rubin & Nassar, 1993). There are times, however, particularly when therapy and/or the therapist seem unable to profit from supervision, that the possibility of case or supervision transfer is a legitimate course to explore. In my estimation, the frequency of this problem is small, but the frequency of this fantasy on the part of client, supervisor and therapist is significantly higher.

**CASE VIGNETTE 3: MINIMAL THERAPEUTIC WORK WITH THE CLIENT**

G., a third-year graduate student, had lost his mother to suicide 4 years before beginning his rotation. In his inpatient practicum he asked to be assigned to work with a schizophrenic woman who had made several suicide attempts. Although the potential meaning of the request to treat the patient was explored with the supervisee, G. was unable to emotionally identify either his own investment in the case or how his own history might affect his ability to work with the client. Over the course of the next 5 months of treatment, G. was unable to maintain a consistent therapeutic stance with his client. The therapy was not considered harmful, but it did not provide assistance beyond a basic relationship to the client characteristic of nursing staff personnel. Because the treatment was in a closed setting, and other mental health professionals were involved, and because no other psychotherapy would be scheduled for the client should G. discon-
tinue, the supervision proceeded to try to help G. respond more attentively and appropriately to his client. Numerous cognitive, didactic, and experiential interventions in supervision were attempted to no avail. For the first 6 months of work, G. was unable to respond more helpfully to his client. While there was no crisis in the psychotherapy that required consideration of transfer, and owing to the circumstances of the case where the relationship was considered of therapeutic benefit, it was not difficult to allow the therapy to proceed.

The case of G. working in a setting where psychotherapy is not necessarily provided meant that his client would not receive treatment by anyone else were he to withdraw. Such a situation may, and probably should, raise questions about the allocation of resources and philosophy of care at the institution. Focusing on the therapy itself, however, may be more instructive at this time. While the therapy provided was not thought to be harmful, neither was it considered to be conducted competently or adequately. Rather it proceeded at the level of relationship to the client (and with full understanding that relationship is a significant aspect of the psychotherapeutic enterprise), characteristic of non-mental health personnel. Had there been a negative effect upon the client, or had there been other treatment options available, the balance of therapist (training needs/emotional state) versus client needs (potential beneficial effects of psychotherapy) would have required that case transfer or some other change in treatment plan be considered. Yet consideration of all the options includes recognition that it may be most beneficial to the client that the treatment with this therapist continue. The lack of improvement in the quality of treatment does not deny the value or importance of considering the therapist’s developmental as well as personal needs. The balance of these differing needs, however, requires that the clients’ needs be weighted differentially and more strongly.

CASE VIGNETTE 4:
THERAPEUTIC FAILING IN THE CONTEXT OF RISK TO THE CLIENT

In the case of S. working with a suicidal daughter and overwhelmed mother, the choices were typical of the conflicts of re-
sponsibility that supervisors face. In that therapy, S., a fourth-year graduate student, failed to adequately understand and respond to her clients. As therapist, she identified with the overwhelmed mother who was unresponsive to her daughter's needs. In her therapeutic role, however, she was unable to sense a burgeoning crisis in the treatment or the escalating threat of an incipient suicide attempt that the daughter was contemplating. A number of modes and modalities of communicating with the therapist and attempting to help her more fully understand the dynamics of the case and ways to intervene were tried to no avail. The supervisor consulted with the supervisee, colleagues and ultimately the head of the training program to contemplate the necessity of transfer of the case to a clinician better able to handle the material. Paradoxically, it was the possibility/threat of transfer rather than any of the other interventions that finally enabled the therapist to understand her case and respond with the necessary understanding and firm limits.

Proponents of the parallel process model of supervision may see the therapist's difficulty as reflecting, in part, the mother's own stance towards her daughter (Ekstein & Wallerstein, 1972). The supervisor's intervention could be interpreted as the means by which the therapist experienced the need to understand the seriousness of the situation. As a result, she was able to undertake confrontative measures in her work with both mother and child which were appropriate to the seriousness of the situation. Thus, the supervisory intervention served a shared clinical and ethical purpose, designed to assist the therapist to provide the appropriate therapy to the clients.

There are times when a prolonged stage of inefficacy in therapy and/or supervision results in dysfunctional psychotherapy. Attempts to use traditional educational, supportive and explorative supervision interventions should be tried if time and the situation permit. If these interventions do not yield change, the supervisor will most likely become increasingly concerned. When lack of supervisee/therapist improvement occurs in conjunction with risk to the client, both consultation and the need to set a time limit for assessing the suitability of the therapy as currently practiced are appropriate. The primary clinical, ethical and training task of the supervisor is to help the supervisee/therapist work with the client—and this is ultimately for client benefit (Sullivan, 1970).
It is difficult to gauge the state and the impact of events and processes upon the therapeutic process, but it is the responsibility of the supervisor to attempt to do so (Harrar, VandeCreek, & Knapp, 1990). In therapy where serious difficulties present themselves, the examination of the therapeutic process should extend as far as deliberating the transfer of cases to appropriate treatment when there is a clear and compelling rationale to do so. The negative impact of therapist transfer upon the client as well as upon the developmental progress of therapists in training cannot be minimized. These negative factors, however, must be weighed against the negative aspects of inadequate therapy where risk to the client is present as well.

**Balancing Acceptance and Limits**

As highlighted above, there is a basic tension between the supportive and accepting aspects of training on the one hand, and the reality-oriented more objective aspects of the therapy experience on the other. To the extent that assisting clients via psychotherapy requires a tolerance and acceptance of the other at a very basic level, there is no contradiction between the clinical and training aspects of the supervision model that interprets the supervisor's basic tolerance of the therapist as a sine qua non for supervision and as a model for therapy. From the ethical point of view, the thread that joins psychotherapy and supervision winds through the need to accept the other as a valuable person even as the change and growth desired are the focus of intervention and the change process. These may well be assisted by a clear and forthright process of contracting with client, therapist and supervisor. Thus, in supervision with an educational component, the mandate to be sought and obtained from the client and therapist is one that will address how the therapist is to be assisted to provide the help that the client needs. Both acceptance of what is present, and the lack of acceptance reflected in the search for something not yet achieved, are part of the assistance that client and therapist can benefit from. The acceptance and lack of acceptance are two sides of a stance that are best understood in relation to each other. They are not opposite experiences as much as axes of the training as well as therapy matrix. That is, they are both present and are both operant in varying degrees.

The mutually reinforcing nature of acceptance and nonaccep-
tance can be illustrated by taking two different examples which share a similar structure. The first example is based on the Talmudic tale regarding a pagan who approached the two great Jewish sages of his day with a request (Neusner, 1992). He asked each of them to teach him the Torah while standing on one foot. The response of the sage Shamai was adamant. He threw the man out for the disrespect he showed the great body of law and practice by this frivolous request. Hillel on the other hand told the man "That which is hateful to you do not do unto your neighbor. All the rest is commentary which may be studied later." (p. 31a). The story concludes with the man so taken by Hillel’s warmth and wisdom (by his joining with the questioner/client) that he immersed himself in the study of the subject and later converted to the faith.

The second example comes from a clinical vignette involving a troubled Chicago businessperson who came for psychotherapy assessment. After listening to the man’s troubled life story, and considering this man’s exceedingly busy schedule, the therapist recommended a treatment regimen of one session per week. The client replied that he was too busy to come that frequently. Upon hearing this refusal, the therapist reflected back to himself and realized that he had failed to hear the client’s pain adequately. His initial offer had been too timid and had communicated a lack of hope. The therapist thereupon offered a much more intensive treatment regimen of 5 times weekly psychoanalysis, which was accepted. The rejection had been to the dilute treatment plan which did not adequately promise to involve the client. The more intensive treatment plan was accepted and adhered to with a favorable outcome (Giovacchini, 1979-80).

These stories delimit the parameters of intervention. They range from the more strict (classical approach) limit-setting on the one hand to the relatively supportive and flexible response on the other. There is little doubt that each has a place. Shamai and Hillel (Neusner, 1992) both had great respect for their belief system, as did the analytic therapist recommending weekly and then a 5-times weekly treatment to his prospective client. In the story of the Talmudic sages, it is the less strict or accepting approach that is credited with success; in the other the reverse is true. Yet each of these tales gains its fuller impact by the presence of the counterpoint—and by the
subtle hint that the experience of both sides of each story has a value as well. For each of the stories can be easily reversed, with the alternative approach portrayed as successful. For example, the pagan might have been impressed with Shamai’s uncompromising devotion to his truth, while the prospective client might have respected and been moved by a less dogmatic approach to therapy than classical psychoanalysis.

In a manner consistent with these Talmudic and psychoanalytic vignettes, the accepting and non-accepting poles of the approaches to supervision contain an ambiguity and a complementarity that balance and enhance each other. The existence of objective criteria for assessing therapists in training varies according to setting and supervisor yet the subjective criteria for assessing and responding to therapists in training are universal. While strong positive or negative perceptions of the supervisee’s work are not easily acknowledged aspects of the supervisory relationship, they need to be addressed. The cost of the unexamined exclusion or inclusion of these features in the training context is far too serious to encourage.

On Maintaining Fidelity to Clients and Supervisees

Psychologists and psychotherapists who function as supervisors have a dual responsibility to facilitate both client benefit and therapist development. The obligation to inform clients of the existence and nature of the supervisory relationship derives from many sources. These include the requirements to respect client autonomy, obtain informed consent, avoid deception, as well as to maintain fidelity to the client and the therapeutic role inherent in the supervisory responsibility (Beauchamp & Childress, 1994). Making sure that clients know that they are being offered supervised treatment is only part of the story. They may require assistance to understand what it may mean to receive therapy from a person in training where the setting has some investment in therapist welfare. Respect for their autonomy is insufficient if it is not accompanied by concern for their welfare. Clients in the therapy field need to know that their rights are protected and that the beneficent goal of helping them remains primary (Klerman, 1990; Stone, 1990).

The role responsibility of the supervisor, however, requires that the duties to the therapist be discharged optimally as well. On this
side of the equation, the therapist must be assisted to achieve the optimal level of treatment for the clients under his or her care. The supervisory role can be many things, but it is never primarily a therapeutic relationship nor is it a role that can lose sight of the primary responsibility to client welfare (Carifio & Hess, 1987). In supervision, client welfare and therapist development can be facilitated in numerous ways. They are probably least effectively assisted by too active or too intrusive a supervisory stance. Too little “acceptance” of the supervisee and his or her work can be detrimental as well. In most cases, the optimum level of supervisor activity, acceptance and nonacceptance, balance between didactic and experiential work, and client- or therapist-focused work, will be determined by the needs of the client-therapist dyad. Too great a readiness by the supervisor to diagnose failure in the therapy is as maladaptive as too little awareness of difficulty (Lane, 1990; Rubin, 1989a, 1989b). The role of supervising clinician demands much of those who undertake it. In exchange for the dual responsibility of the role, however, the opportunity for a “double-return” on the investment provides a measure of compensation for those who undertake the work.

AUTHOR NOTE

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