Boundaries in Psychotherapy Supervision

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Objective: This study examines the perceptions of trainees and supervisors on the boundaries of the supervisory relationship. Method: A 19-item questionnaire about the appropriateness of the actions of a psychotherapy supervisor was completed by 43 supervisors and 52 trainees. It was distributed at Grand Rounds and mailed out to psychotherapy supervisors in the community. Results: Generally, trainees and supervisors agreed about the boundaries of supervision. Only one item indicated a significant difference between trainees and supervisors. Trainees considered the discussion of sexual fantasies as less appropriate than did supervisors. Using factor analysis, two scales accounted for 66% of the common variance. Supervisors scored higher than trainees on scale 1 ($F = 5.14$, $df = 1,92$, $p = .03$) and women scored lower than men on scale 2 ($F = 9.88$, $df = 1,92$, $p = .002$). Conclusion: Scale 1, a set of items related to sexual topics, revealed a significant difference in supervisor/trainee response with supervisors considering discussion of sexual items as appropriate compared to trainees. Scale 2, a set of items related to self-disclosure, revealed a significant difference with male respondents favoring looser boundaries and more self-disclosure than female respondents.

The boundaries of the supervisory relationship are important concerns for our profession. This is the first study to provide an empirical evaluation of perceptions of trainees and supervisors on aspects of boundaries in the supervisory relationship. If the findings are replicated, they could contribute to future analysis of trainee/supervisor relationships. The maintenance of good boundaries between trainees and supervisors is crucial to the integrity of the supervisory relationship.

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INTRODUCTION

This article will review the current literature on the boundaries of the supervisory relationship and will present the results of a study of the perceptions of the boundaries of the supervisory relationship.

Supervision has been identified as an essential ingredient for the professional development of the psychiatrist (1) but very little is known about the optimal supervisory relationship. Views about the supervisory relationship have evolved over time. In the last century, beginning with Freud, supervision was an encounter with a master or mentor, who not only indoctrinated the trainee into the profession, but also may have played a part in the personal development of the trainee, enjoying personal relationships outside of supervision. From that time up until the 1980s, trainees in psychotherapy were expected to undergo their own analysis or psychotherapy and in many programs this was considered an essential component of training. Today personal therapy, which has been considered an important resource for understanding the psychotherapy process, is less common among residents (20% in 1994–1995 compared with 70% in 1970–1994) and is seen as optional and irrelevant by many programs and trainees (2).

In this new century psychotherapeutic skills continue to be recognized as a vital part of a psychiatrists' armamentarium, whether or not the psychiatrist will practice psychotherapy and the current trend is to ensure adequate psychotherapy training in all psychiatry residency programs. However, several changes in the past decades have made psychotherapy training more difficult. There is reduced exposure to long-term psychotherapy patients in the inpatient setting, as hospital stays are shorter and focused on crisis management. Trainees, therefore, have less opportunity to develop a psychotherapeutic understanding of patients that grows from spending time "getting to know" patients. Trainees often voice the opinion that their future practice will consist of "medication management" cases and see little relevance in psychotherapy training. When Luhrmann, an anthropologist (3), spent time with psychiatry residents, she found that the resistance to learning psychotherapy came from the slow progress in mastering the material, understanding the patient's doubt, and about being able to become an accomplished psychotherapist. The psychopharmacologists experienced more mastery and certainty of the material and this model of the mind was more easily and quickly embraced by the trainees.

In a search for new ways to teach psychotherapy, several programs have embraced the use of training manuals with group-based instructional

seminars structured with goals and objectives (4). All trainees are evaluated using the same criteria but there is no in-depth work with the trainee and little attention is given to the vicissitudes of the relationship with the supervisor. In this setting, trainees have difficulty bringing up personal issues because of fear of self-exposure. In a literature review, Holloway (5) concluded that trainees could learn the technical aspects of treatment from a manual but that without a supervisor, they had difficulty understanding the therapeutic relationship, the selection of the problem and the timing and nature of their interventions.

The trainee/supervisory relationship remains the central component of psychotherapy teaching and the quality of supervision depends upon the establishment of safe boundaries between the trainee and supervisor. Gutheil and Gabbard (6) have conceptualized the therapeutic boundary as a therapeutic frame, an envelope or membrane around the therapeutic role that defines the characteristics of the therapeutic relationship. The supervisor, like the therapist, needs to construct the elements of the frame such as scheduling the time and place of supervision. In addition, maintaining role boundaries is essential to fostering effective and trusting supervisory/trainee relationships.

The supervisor's role as a mentor, role model, and evaluator can have an impact on the conduct of supervision. However good a supervisor may be, trainees will choose what information to present to their supervisors and almost all trainees will withhold information from them, such as negative feelings towards the supervisors, personal issues not related directly to supervision, clinical mistakes, evaluation concerns, general client observations as well as counter transference feelings (7). Residents often lie to their supervisors, either to present themselves in a good light in the hope of a good evaluation, to shield themselves from narcissistic injury in the face of criticism or to protect themselves in an environment they perceive as unsafe (8). In one interesting experiment of open supervision, a trainee was able to demonstrate to his supervisor how acknowledging feelings of being defeated by the patient, was very productive. The trainee also related that he had to face a fear of losing the supervisor's respect before disclosing uncomfortable feelings (9). Gabbard (10) stated that "the thoughts, feelings and behaviors that a therapist would be most likely to keep secret from a supervisor or consultant are the most important issues to discuss with that supervisor or consultant." The supervisory setting may function as a regressive parental relationship with the potential for the resurgence of adolescent developmental issues, thus becoming an unsafe threatening environment.

Trainees can experience supervision as an intrusion and may have strong opinions about the appropriateness of supervisory behavior. As in the psychotherapeutic relationship, there are boundaries to be maintained in order to allow learning to occur. The boundaries prevent the relationship from moving from a professional to a personal level. The most extreme example is when a sexual relationship has developed between the supervisor and the supervisee. Gattrell (11) commented; "How easily erotic wishes develop out of emotions of a friendly character, based on appreciation and admiration between master and pupil." In a national survey of PGY4 residents, 4.9% of residents indicated that they had been sexually involved with psychiatric educators. Many of these residents commented that they wished their supervisors were more open to talking about sexual attraction, both with the patient and with the supervisor, and recommended talking through as a way to deal with sexual feelings instead of acting out those feelings (12). However, it has been argued that the right to autonomy and thus to having a consensual sexual relationship with a supervisor overrides the facts that such a relationship may be exploitive and not educationally beneficial (13). Sexual exploitation rates for doctoral psychology students are reported to be 8% for women and 2% for men (14) and in a recent sample of members of the American Psychological Association, 19% mentioned unwanted sexual advances in a supervisory relationship, 51% reported knowing of peers who have been involved in a sexual relationship with a supervisor and 9% reported having been involved sexually with a supervisor (15). In 1986 the American Psychiatric Association (16) stated that a relationship between a supervisor and a senior trainee is not necessarily unethical, reflecting the transition from trainee to colleague. In 2001, however, the American Psychiatric Association (17) in its Principles of Medical Ethics, did maintain that in situations when an abuse of power can occur, that sexual involvement between a faculty member or supervisor and a student or trainee takes advantage of the inequalities in the working relationship and may be unethical. The reasons given are that the treatment of the patient being supervised may be affected, that the trust relationship between the student and supervisor may be damaged, that physicians are role models and affect their trainee's future professional behavior. For a trainee to fully benefit from the learning experience, a degree of vulnerability and exposure is required (18). This demands that their supervisors will be caring and respectful in their responses. If trainees do not have a general trust of psychiatrists, they will avoid teaching and supervision, contribute little and learn little and also be less likely to develop the depth of relationship that is necessary to

be an effective psychiatrist. The role of the faculty and departmental leadership in the area of ethics is imperative (19).

Boundaries can also be violated by abusive supervisor behavior, which has been shown to cause greater job and life dissatisfaction as well as an increased likelihood of psychological symptoms (20). Studies show that medical students who report that they have been subjected to abuse have diminished ability to work and participate in the learning environment even avoiding training altogether. For some students, abuse may have lifelong effects (21), (22), (23) and when these students become faculty they may go on to abuse their students, as this is seen as part of the "normal cultural experience" (24).

There is little information on how trainees and supervisors perceive the general boundaries of the supervisory relationship. We considered items connected to relational qualities as well as structural elements of supervision, from appropriate setting for supervision, to a willingness to discuss taboo subjects, delve into the trainee's psyche, discuss supervisor issues, such as serious illness or prior treatment, or to discuss the supervisory relationship in depth. This questionnaire was designed to evaluate the general perceptions of the supervisory relationship of trainees and supervisors in one Department of Psychiatry.

Method

A 19-item questionnaire that asks about the appropriateness of the actions of a psychotherapy supervisor was completed by 43 supervisors and 52 trainees in the Brown University Department of Psychiatry and Human Behavior. It was distributed at Psychiatric Grand Rounds and mailed out to psychotherapy supervisors in the community. The supervisors ranged from psychoanalysts to cognitive behavioral therapy supervisors, from novice to experienced supervisors.

We first examined the set of 19-item response frequencies to ensure adequate variability across item-responses. We then constructed scales using the set of 19 items. We conducted a principal factor analysis with squared multiple correlations as initial estimates of communalities. We used several criteria for selecting a final number of factors (25) including the screen test (26), eigenvalues > 1 and parallel analysis (27). Scales were created from retained factors using items that loaded on respective factors $> .30$. Before comparing trainees and supervisors on scales we first screened for potential covariates by examining univariate relationships of demographic variables of gender and discipline (psychiatrist v. psychologist) with retained scales. The main effect of group (trainee v. supervisor)

on scales was treated in multivariate analysis of variance including covariates as needed. All two-way interactions were entered as a block after all other terms.

Results

The group of supervisors consisted of 39 psychiatrists, 3 psychologists, and one who did not indicate a discipline. There were 23 males and 20 females with an average age of 48.6 (sd 9.9) and an average number of years supervising of 13.4 (sd 8.5). The trainee group consisted of 39 resident physicians, 12 psychologists, 28 males and 23 females with an average age of 34.5 (sd 8.0) years and one trainee who indicated "other" for discipline. There was general agreement about perceived boundaries on most items (see Table I). Of the respondents 90% answered never or occasionally to questions related to disclosure of supervisor's sexual orientation, prior struggles with alcohol, publication of the content of supervision discussions with the resident's consent, and supervision in a public place (e.g., a cafeteria). This group also answered in a similar way to questions related to the supervisor asking the resident about his/her sexual orientation and details of the resident's psychotherapy. Among respondents 55–80% thought that it was occasionally appropriate to discuss the supervisor's recent diagnosis of serious illness, listen to concerns, and give advice about the residents' personal life, disclose details of the supervisor's own prior psychotherapy treatment, talk about movies or books unrelated to supervision, conduct supervision in the supervisor's home, not a home-based office, and interact with the resident alone outside of supervision (e.g., play tennis). They also considered it occasionally appropriate to discuss resident/supervisor relationship such as sexual attraction, racial, ethnic or religious differences and to ask the resident about his/her fantasies about the patient and suggest psychotherapy unless the resident is not already in psychotherapy. Of these respondents, 50–70% considered the following actions by a supervisor as usually or always appropriate; pointing out defense mechanisms the resident uses with a patient, taking an interest in the resident's personal development, outside of medicine, finding out what makes the resident tick and being available for emergency consultation with psychotherapy patients.

Constructing Scales

As a result of the factor analysis, eigenvalue > 1 and parallel analysis, two factors were retained that accounted for 66% of the common variance. Two scales were created using the items loading $> .30$ on either the first or second factor. Seven items (5, 6, 8, 11, 15, 16, 17) loaded primarily on

Table I. PERCEPTIONS OF SUPERVISOR TRAINEE BOUNDARIES (n = 93)

Asking the resident about details of his/her own psychotherapy treatment (if any).			
66% never	33% occasionally	1% usually	0% always
Asking questions about resident's sexual orientation.			
56% never	41% occasionally	3% usually	0% always
Disclosing the supervisor's personal prior struggles with substance abuse.			
56% never	44% occasionally	0% usually	0% always
Publishing identifiable content of supervision discussions, with resident's consent.			
50% never	35% occasionally	12% usually	3% always
Answering questions about the supervisor's sexual orientation.			
50% never	45% occasionally	4% usually	1% always
Conducting supervision in a public place (e.g. cafeteria).			
48% never	*45% occasionally*	7% usually	0% always
Discussing the supervisor's recent diagnosis of serious illness in the supervision.			
9% never	*79% occasionally*	11% usually	1% always
Listening to concerns and giving advice about the resident's personal life.			
12% never	*73% occasionally*	13% usually	2% always
Suggesting psychotherapy if resident is not currently in psychotherapy.			
12% never	*70% occasionally*	11% usually	7% always
Disclosing details of own prior psychotherapy treatment.			
24% never	*69% occasionally*	7% usually	0% always
Talking about movies and books or other things unrelated to supervision.			
8% never	*59% occasionally*	28% usually	5% always
Discussing racial, ethnic or religious differences between supervisor and trainee.			
8% never	*63% occasionally*	23% usually	6% never
Conducting supervision in the supervisor's home (not a home based office).			
32% never	*58% occasionally*	9% usually	1% always
Discussing resident/supervisor relationship, for example, sexual attraction.			
38% never	*58% occasionally*	4% usually	0% always
Interacting with the resident alone outside of supervision (e.g. playing tennis).			
30% never	*57% occasionally*	12% usually	1% always
Asking about the resident's sexual fantasies about the patient.			
19% never	*55% occasionally*	23% usually	3% always
Taking an interest in the resident's personal development, outside of medicine, finding out what makes the resident tick.			
3% never	38% occasionally	*46% usually*	13% always
Pointing out defense mechanisms that resident uses with patients.			
1% never	16% occasionally	42% usually	41% always
Being available for emergency consultation.			
0% never	4% occasionally	25% usually	*71% always*

the first factor formed a scale with an alpha of .74. Item contents of scale 1 were interpreted as inquiring about the appropriateness of discussion of sensitive content areas in supervision. This scale consists of items inquiring about sexual orientation, sexual fantasies, defense mechanisms, and cultural differences between supervisors and trainees. Scale 2 consisted of six items that loaded on the second factor (3, 9, 10, 14, 18, 19) forming a scale with an alpha of .61. This scale contains somewhat heterogeneous contents related to boundaries in the supervision relationship. The items include inquiries regarding discussion of topics unrelated to supervision, disclosing supervisors' struggles with substance abuse, and conducting supervision outside of the office setting. The remaining six items did not load on either factor and were treated individually in analyses.

Univariate Analyses

We evaluated univariate relationships of the two scales and the six individual items using a Bonferronl alpha correction (.05/8 = .006) to protect against Type I error. There were no significant relationships between discipline and the scales or the individual items. Women scored significantly lower on scale 2 ($t = 3.14$, $df = 92$, $p = .002$), item 7 ($t = 2.96$, $df = 92$, $p = .004$) regarding disclosing details of psychotherapy treatment, and item 12 ($t = 2.85$, $df = 89.7$, $p = .005$), publishing content of supervision discussions. Therefore, only gender was included as a covariate in analyses.

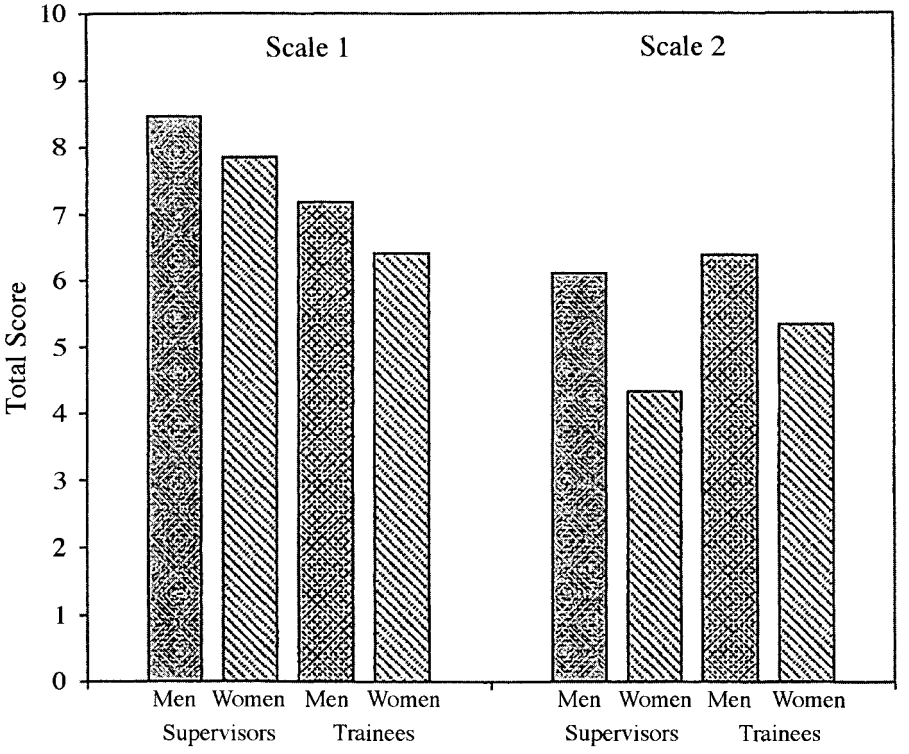
Trainees V. Supervisors

We next conducted a multivariate analysis of variance with alpha set at .05 to evaluate the main effect of trainee status on the two constructed scales. There was a significant main effect (Wilks $L = 0.92$, $df = 2,90$, $p = 0.018$) across the two scales. Follow-up univariate tests showed that supervisors scored higher than trainees on scale 1 ($F = 5.14$, $df = 1,92$, $p = .03$) and women scored lower than men on scale 2 ($F = 9.88$, $df = 1,92$, $p = .002$). Supervisors with more experience scored highest on this scale ($p = .03$).

There was no significant interaction between gender and trainee status ($p > .05$). However, follow-up univariate analysis suggests that female supervisors ($M = 4.30$, $SD = 1.62$) scored lower than male supervisors ($M = 6.11$, $SD = 2.03$) on scale 2 ($t(41) = 3.19$, $p < .003$). Figure 1 shows the group means on scale 1 and scale 2 for trainee status and gender groups.

In a series of six regression analyses with alpha adjusted to .006 to protect against type 1 error, we tested the difference between trainees and

Figure 1.
GROUP MEANS ON SCALE 1 AND SCALE 2 FOR TRAINEES STATUS AND GENDER.



supervisors using the individual items not included on scales while controlling for gender. No individual items were significantly different ($P > .006$).

DISCUSSION AND CONCLUSION

There is general agreement on the boundaries that are or are not appropriate between trainee and supervisor across a number of domains, indicating a sensitivity to the importance and integrity of the relationship. There was little variability on most items, further highlighting this uniformity of responses. Differences did emerge when the boundary issues were more subtle.

There are several limitations to this study: The sample is predominately white Caucasian from a small New England college town. The survey gathers qualitative data and draws on the general impressions rather than actual facts and practices of the subjects. It is not known if these questions

are reliable or valid and actual practice may differ. The Department at Brown University may be idiosyncratic in the differences between the responses of its trainees and supervisors. The creation of the scales by natural aggregation of similar items provides future direction regarding the replication of findings on trainee/supervisor difference and gender difference.

Despite the finding of a narrow range of responses on most items, a few items elicited a broad range of responses. One such item is "asking about the resident's sexual fantasies about the patient" (19% never, 55% occasionally, 23% usually, 3% always), that showed the largest difference between trainees and supervisors (see Table II). In contrast 80% of respondents endorsed pointing out defense mechanisms that residents use with patients, an item, though related appears less threatening than "asking about sexual fantasies about the patient." This is in keeping with the finding that items that included the word "sexual," such as "discussing the resident/supervisory relationship, e.g., "sexual attraction," were perceived as never or occasionally appropriate for supervisors to discuss, both by supervisors and trainees.

Scale 1 consisted of items asking about the sexuality of the trainee, supervisor, sexual fantasies, sexual attraction, racial and ethnic differences, and defense mechanisms. Supervisors scored higher on this scale than trainees, thus more strongly endorsing the discussion of these items. It was also noted that the more experienced supervisors scored highest on this item. An explanation for these findings is that experience increases the understanding of the importance of discussing sexual fantasies and the ability to tolerate discussing sexual issues in supervision. More experienced supervisors endorse the discussion of these items most readily, thus increased experience either of treating patients or of being a supervisor also leads to increased acceptance of the discussion of sexuality in supervision. The use of the adjective sexual, may trigger a high degree of concern in trainees regarding boundaries and therefore elicit a negative reaction. This finding raises concern that rather than being considered a focus for therapeutic examination, discussion of sexuality has become

Table II. SIGNIFICANT DIFFERENCES IN PERCEPTION

Asking about the resident's sexual fantasies.		
Trainee	0.84 (sd 0.64)	
Supervisor	1.40 (sd 0.73)	p=.0002

Scale: never = 0 occasionally = 1 usually = 2

linked to concerns about a potential for abuse. However, as noted above, in Gatrell's study, (11) talking about sexual attraction between supervisors and trainees was recommended by trainees as a way to avoid acting out behavior. Talking about feelings rather than acting them out, is a fundamental rule of a psychodynamically based treatment and should also be a fundamental rule for the supervisory relationship. Caution must be raised in interpreting these results, as items included in the scale may not have allowed for sufficient textural context. Less experienced faculty and residents may have responded in a different manner if anecdotes had been used.

Scale 2 consisted of items related to self-disclosure, such as supervising in a public place or in the home, interacting with the resident alone outside of supervision, disclosing prior substance abuse, talking about things unrelated to supervision and taking an interest in the resident's personal development. Female respondents were stricter in the endorsement of these items, favoring more rigid boundaries and less self-revelation compared to the male respondents who favored looser boundaries and more self-revelation. For example, female respondents tended to consider it less appropriate to discuss the supervisor's prior struggles with alcohol and disclose details of their own psychotherapy treatment, thus being more private compared to the male respondents. Disclosing the supervisor's personal prior struggles with substance use is answered by women more restrictively than by men, although both tend to endorse not disclosing this information. This may reflect society's attitudes about women drinkers, who are less likely to get treatment than male drinkers, and may suffer from more social stigmatization (28).

Suggesting psychotherapy if the resident is not currently in treatment, tended to be endorsed more favorably by psychiatrists than psychologists. This may reflect the higher number of psychoanalytically based psychiatrists compared with the cognitive behavioral psychologists in this community. It has in the past been almost a prerequisite for psychiatric training that the resident be undergoing his or her own psychotherapy during residency.

In conclusion, there is much agreement about the boundaries of supervision. Scale 1, a set of items related to sexual topics, revealed a significant difference in supervisor/trainee response with supervisors considering discussion of sexual items as appropriate, whereas trainees did not. Scale 2, a set of items related to self-disclosure, revealed a significant difference, with male respondents favoring looser and more self-disclosure when compared to female respondents. In particular, female supervisors

compared with male supervisors may have different perceptions of self-disclosure.

This is the first study to provide a baseline of trainees and supervisors perceptions on the boundaries of the supervisory relationship. If the findings are replicated they could form the basis for future analysis of trainee/supervisor relationships. The maintenance of good boundaries between trainees and supervisors is crucial to the integrity of the supervisory relationship and further research is indicated to delineate areas of potential boundary crossing. Further research should explore the differences in perception of boundaries according to gender, clinical experience, type of psychotherapy orientation and prior personal experience in personal therapy.

It is particularly interesting that female supervisors perception of supervision differs from that of male supervisors. An in-depth analysis of how gender influences the supervision process would be worthwhile undertaking, examining for instance, boundary issues in same-gender and cross-gender trainee/supervisor pairings. One recent study, which unfortunately did not control for academic rank, did find that psychiatric resident trainees evaluated female supervisors less favorably than male supervisors (29). Future research could explore whether there are differences in female and male supervisory styles, particularly in the actual delineation of supervisory boundaries and examples of self-disclosure.

In terms of methodology, many respondents to this survey indicated their preference to respond to supervisory vignettes and it is recommended that future questionnaires be structured in this way. It is also important to gather more specific information about the supervisors, such as their level of training in psychotherapy, whether they pursued psychotherapy training after residency and whether or not they have personal experience in psychotherapy. These data would substantially enhance the research into this area.

In many residency programs, the supervisory process is becoming more standardized to ensure that psychotherapy is being taught in a uniform away and the best way to evaluate the quality of the supervisory relationship is an important new area of research. It may be useful to provide guidelines for supervision and pre and posttests could assess attitudes about the boundaries of the supervisory process. It is imperative that we determine the optimal way of teaching psychotherapy and recognize the supervisory relationship as the crucible within which our professional values and ideals are passed on to the next generation.

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