Between Us: Growing Relational Possibilities in Clinical Supervision

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About the Author
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Abstract
The practice of clinical supervision holds the potential to shape both practitioners and practice, yet most supervisors have limited training in supervision and find few opportunities to discuss their supervisory practice with colleagues. By default, most clinical supervisors conceive of the supervision they provide as merely adjunct to other work. Common supervisory practices further constrain the possibilities by focusing only on the client or on client-therapist interactions, as though these can be extracted from the contexts in which they exist. By widening the landscape of relationships to consider, we acknowledge that the supervisor, supervisee/therapist, and client are all embedded within larger relational, organizational, and cultural contexts. Attending to this complexity brings essential information into the supervisory dialogue, as relational themes are understood to reverberate between and beyond the supervisory and therapeutic encounters.

Relational-Cultural Theory (RCT) offers a rich foundation of ideas through which to consider a broader vision of supervision. An RCT perspective supports the importance of a supervisory relationship that is grounded in mutual respect, a sense of shared purpose, openness to influence, and a basic belief in the value of relational connection. The most memorable learning occurs not by a one-directional mode of teaching, but through a true dialogue that fosters a collaborative search for continuing understanding. Supervision can be a creative process—a relationship in which both participants experience movement toward clarity, growth, and possibility—and which serves as a model for the client-therapist relationships it aims to support.

Introduction
My first encounter with the potency of clinical supervision took place more than 20 years ago, starting with a box of Kleenex and a conversation with my first clinical practicum supervisor. I was discussing my work with “Alicia,” who had been edging closer to her deep well of loneliness and isolation. At one particular moment in a session, Alicia had closed her eyes as she spoke, her quiet tears giving way to sobs. It was then that I noticed the box of Kleenex on the table next to us, just outside her reach.

At the time, I had begun my coursework but I remained unaware of many accepted notions about how therapy works—for example, the presumed importance of therapeutic neutrality, or for that matter, that a simple gesture of mine could possibly be understood as anything other than how I’d intended it. So I quietly placed the box of tissues closer to Alicia, who thanked me, blew her nose, and continued.

Like most clinicians in training, I was both eager and anxious when I met with my supervisor, Sarah, and came prepared with many questions about my work with Alicia. But I had not anticipated one of Sarah’s questions, in which she challenged my action of moving the box of Kleenex. “I’m not sure I understand,” I said. She hesitated for a moment, and then offered a first response. “This is what I’ve always been taught,” she said, somewhat tentatively. Sarah was pretty new at practicing therapy and supervision, too, and I sensed she was less than sure about how to fill her role as my teacher. When I pressed a bit further, she offered what she had on the subject. “Because,” she said, “it brings too much of yourself into the room, and violates the boundaries between therapist and client. The goal is to be neutral. Pushing the box of tissues closer isn’t neutral; it seems to be
taking a position that could be understood by the client as a message to ‘stop crying.’”

Now, this was not one of those really tough moments in supervision when I felt like hiding, or leaving the room, or perhaps leaving the profession—some of those came later. But a number of things about this exchange with Sarah made a lasting impression on me.

There was, of course, the content she was trying to teach me. This conversation was a first glimpse at the powerful, complex practice of therapy and showed me the importance of looking at the multiple meanings that can attend any words or actions. Even though the way I make meaning and the way I practice now are substantially different, I continue to value looking closely at my own clinical work as fundamental to my growth as a practitioner.

Secondly, the way Sarah talked with me was as important as what she said. Although her comments raised questions about my actions in that therapy session, her approach quietly fostered a relationship conducive to my growth as a therapist. She was warm, direct, and gentle. Although I was a complete novice, she treated me, my work, and my learning process with respect.

Sarah appeared to recognize, perhaps instinctively, that I would feel the difference in power between us as significant, and that even her small comments could have a large impact. When she raised the question about moving the Kleenex box, she seemed to understand that her comment might surprise me and open up a new area of learning. Her manner demonstrated that she recognized the impact her words and her opinions might have on me.

Sarah also honored my questioning of her comments. “Why shouldn’t I give a client a tissue if she is crying?” I had asked. And though she probably did this unintentionally, her answers conveyed, just a bit, her uncertainty about the perspective she was sharing with me. She said, “My supervisor taught me this, so I’m passing it on to you.” When I asked, “Is it possible that the client could see my offer of a Kleenex as a sign of empathy?”—she was open to this being a reasonable question. She did not close down the exchange, as supervisors can do, with a defense of her viewpoint couched in dense language of psychological theories aimed at bolstering her convictions and reinforcing her power as the supervisor.

Sarah’s openness to my questions and even the small doubt she conveyed as she answered, neither troubled me nor prompted me to assess her as someone who “doesn’t know what she’s talking about.” Her willingness to hear my ideas, and further, to show that my ideas had an impact on her, helped to validate my own questions and experience.

I was too green and too full of doubts to raise many questions that year, and Sarah was probably too new as a supervisor to help elicit or explore those doubts. Yet, the openness created between us helped nurture a small space in which I could find room for my own process—trying out ways of being, knowing, relating, and giving voice to my observations as I began to develop my clinical practice.

I’ve probably never seen the matrix of a client, myself, and a box of tissues without somehow recalling that exchange with Sarah. For one thing, this first, small decision about an action in therapy—the offering of a tissue—can be seen as a sort of marker for my own evolving understanding and practice. Despite the gentility of Sarah’s comments, for a while I adopted various approaches to the whole question of Kleenex. I tried placing the box near the client’s chair before she came into the room, or not touching the box at all, no matter how many tears came. Sometimes, I would just tell a client that the tissues were there if she wanted them. Later I began offering tissues to clients, but not revealing this to anyone, fearing reprisal for violating a sacred rule of therapist neutrality.

I felt, somehow, that it was okay to offer a tissue, at least most of the time, but I didn’t know how to back up my feeling with the weight of theory or research. So I just did it, but didn’t talk about it. I hid this small gesture, despite Sarah’s warm and open approach. This speaks not only to my particular self-doubts at the time, but also to some of the larger challenges that exist in all supervisory relationships. Eventually, I have come to offer clients tissues when they seem to be needed—and I can even talk about it—because I have developed my own, clear belief in the value of being present with my client’s experience, including her grief and tears, and of being ready to offer her the concrete solace of a tissue. Such a gesture is not meant as a symbolic communication that she should or should not cry, but as a visible sign of my empathy for her experience, the authenticity of our real relationship, and as a way to have her know that we are here together.

Deciding whether or not to give a client a tissue is not, in itself, very significant in comparison to some of the other choices we must make about our therapy practice. We have all encountered much thornier clinical and supervisory dilemmas. The larger question is about how we find our way to our own clinical understanding, meanings, and actions.

I would venture that this search is often conducted outside the formal structures available for case review