Informal Sources of Supervision in Clinical Training

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Although formal, assigned supervision is a potent source of learning and guidance for psychotherapy trainees, many beginning psychotherapists use other, informal sources of supervision or consultation for advice and support. Results of an online survey of beginning trainees ($N = 146$) indicate that other than their formally assigned supervisor, trainees most often consult with colleagues in their program, their own psychotherapist, and their significant other; that they're most likely to seek these other sources of help when they're feeling stuck or feel they've made a clinical mistake; that they do so because they need extra reassurance and suggestions; that they feel the advice given from these sources is helpful; and that they don't especially regret sharing this information. Several case examples are used to illustrate these points. Discussing clinical material with informal sources is, apparently, a great deal more common than typically acknowledged, and as such, has implications for training programs (including discussions of ethics) and formal supervision. © 2014 Wiley Periodicals, Inc. J. Clin. Psychol.: In Session 70:1062–1072, 2014.

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> When you're standing at the crossroads, and don't know which path to choose
>
> Let me come along, 'cause even if you're wrong,
>
> I'll stand by you, I'll stand by you
>
> *I'll Stand by You* (The Pretenders)

A second-year, 28-year-old doctoral student in clinical psychology—a talented, smart, thoughtful, and conscientious student according to multiple supervisory and faculty sources—was recently assigned a new client at her university-based mental health clinic. The client, 50 years of age, is a twice-married, twice divorced mother of three, currently employed as a real-estate broker, with a history of depressive episodes and suicidal ideation, alcohol abuse, vague paranoid ideation, and family discord (e.g., her two eldest children no longer speak with her); her treatment record at this clinic alone dates back over 20 years, reveals courses of treatment with eight previous therapists, and documents an early childhood history of physical and sexual abuse at the hands of her father and possibly her older brother. Previous psychotherapists have found her charming and insightful but also difficult, "acting out" (in regard to missed appointments and payments), and resistant to change. The student—let's call her AB—had met with her new client three times and despite some initial apprehension, expressed to her supervisor that she found the client likable if "somewhat elusive" and the therapeutic alliance surprisingly strong.

The fourth meeting, however, was difficult and troubling. The client came 15 minutes late, requested almost immediately that the session be allowed to run its full course, was told by AB that

this was "unfortunately impossible," and began belittling clinic policy and the entire therapeutic profession, suggesting that she was just a "guinea pig" for generations of psychotherapists who were "practicing" on her before they went out into the world and made their fortunes. Despite AB's attempts to find out why her client was so angry—including inquiring whether the client was feeling abandoned by her previous psychotherapist or whether she (AB) had done something wrong or insensitive the previous session—the session did not go well and the client intimated upon leaving that she wasn't sure about returning.

AB looked forward greatly to meeting with her supervisor 2 days after this last psychotherapy session. She admired this supervisor—someone with a stellar reputation in the program—and felt quite good about their four previous supervisory sessions (one had occurred before AB began her work with this particular client). AB liked this supervisor's warm, engaging style, appreciated the supervisor's interest in learning about her life and interests and pathway to the profession, and thought the supervisor's comments and suggestions during their first few sessions were helpful, tactfully offered, and very respectful of AB's therapeutic efforts with this often lonely and needy client.

In fact, this next supervisory hour went well: AB spoke of her frustration, her sense of "clumsiness" in trying to enforce the time boundaries of the session, her surprise at being the object of this seemingly "disproportionate" degree of anger, and her fear and shame that she might have jeopardized this client's treatment. The supervisor gently reminded AB of the client's treatment history, including her long-standing diagnosis (borderline personality disorder) and the clinical and therapeutic consequences that typically accompany this, and systematically reviewed the clinical events that led to this apparent therapeutic rupture. AB felt understood and somewhat relieved, and left with several "helpful" suggestions about how to proceed in the next session.

Nevertheless, over the next few days she spoke with several classmates about what had happened—in fact, each of four classmates for upwards of an hour each—with fairly specific details about her client (and her diagnosis) and this particularly difficult session. In retrospect, she says she wasn't seeking advice per se but rather support and encouragement—in essence, wanting to be reassured by several other psychotherapists in training that what she did and felt were normative and that she was still a talented and, if still raw, young professional.

Much the same happened with her boyfriend. In fact, almost immediately after the session in question, she texted him, telling him that she had had a hard day and that she was looking forward to talking with him about it over dinner a few hours later. At her apartment, over dinner, she recounted many of the same details she subsequently told her classmates over the next few days. As she remembers this, there were somewhat fewer clinical details—less about her client's history and diagnosis—and more about her own sense of inadequacy: "I thought I was better at this work than I am"; "I thought I knew more than I obviously do"; "I'm rattled more easily than I thought I'd be"; "Maybe I should see my own therapist more often." She pulled for, and received from her boyfriend, the reassurance she needed that she was an intuitive, sensitive, extremely caring person who just ran into one of those inevitably difficult clinical situations from which she would learn and grow.

The client did, in fact, return the following week and, per her supervisor's suggestions, AB and her client processed what had happened. The client apologized, the rupture (for the moment) was repaired, the psychotherapy continued (with ups and downs) for the rest of the year, and the supervisor never knew that her supervisee (AB) had consulted multiple others in her quest for extra advice and support.

The point, of course, of this reconstructed narrative—an actual case with some details changed in the service of confidentiality—is that although formal, assigned supervision is a potent source of learning and guidance for psychotherapy trainees, it is not uncommon for beginning psychotherapists to use other, informal sources of consultation for advice and support.

Much has been studied about supervision, including its components, stages, models, and ethics (e.g., Barnett & Molzon, 2014; Goodyear, Lichtenberg, Bang, & Gragg, 2014); its inevitable ruptures and dilemmas (e.g., Safran, Muran, Stevens, & Rothman, 2007); its effective

qualities (e.g., Falender & Shafrankse, 2014); the nature and correlates of the supervisory al-liance (e.g., Ladany, Ellis, & Friedlander, 1999); disclosures and nondisclosures of supervisors and supervisees (e.g., Ladany, Hill, Corbett, & Nutt, 1996; Yourman & Farber, 1996); the inter-nalization of supervisor qualities (e.g., Geller, Farber, & Schaffer, 2010); its overall effectiveness in improving clinical work (e.g., Holloway & Neufeldt, 1995); and most recently, its expansion through new technologies, including video-conferencing (e.g., Rousmaniere & Abbass, 2014).

Virtually all these empirical and clinical investigations assume that supervision is a process that occurs between a psychotherapist (often but not necessarily a trainee) and a formally assigned (or hired) supervisor, i.e., one who has been designated to fill this role on an ongoing basis by a training program, or hired, with prescribed obligations and remuneration, by a psychotherapist in practice.

But what is essentially absent from this otherwise extensive and helpful literature on the process and dimensions of psychotherapy supervision is consideration of the possibility, indeed strong likelihood, that beginning psychotherapists avail themselves of multiple sources of help in their quest to understand and help their clients, not only their formally assigned professional contacts (i.e., their supervisors and practica instructors) but also less formal contacts. These informal sources of supervision may include, among others, colleagues in a training program, faculty other than those persons assigned to the supervisory role (e.g., one's mentor), friends, family members, one's own psychotherapist, clergy, and significant others. Most of the students we spoke to about this issue referred to this practice as "informal supervision"—and this is the term we've primarily used throughout this article.

Nevertheless, many who have written about supervision prefer the term "consultation" for what we are describing, averring that consultants, in contrast to supervisors, offer opinions that the professional (or professional in training) may or may not accept and that, moreover, consultants do not have the same legal liability as do formally assigned supervisors (e.g., Bogo & McKnight, 2006; Knapp & VandeCreek, 2012; Thomas, 2010).

One of the very few studies that have even indirectly acknowledged the practice of informal supervision or consultation—a study that primarily investigated disclosure and nondisclosure to formal supervisors—found that when trainees withhold disclosures from their supervisors (e.g., their clinical mistakes or negative reactions to clients), they frequently turn to their peers to discuss this issue (Ladany, Hill, Corbett, & Nutt, 1996).

Furthermore, this study indicated that fully 66% of nondisclosures were discussed with some-one other than the supervisor. There is also a modest literature on peer supervision, a process that may occur on a regular or ad hoc basis, either among groups of like-minded individuals (e.g., within a group practice) or between any two professionals, but which typically does not occur on a contractual or hierarchical basis. Still, as Golia and McGovern (2013) have recently noted, "there is very little written about ad hoc peer supervision in the clinical social work and psychology literature" (p. 5).

To further understand the general phenomenon, we constructed a multipart survey instrument that assesses beginning psychotherapists' use of and attitudes toward informal clinical supervi-sion. We were particularly interested in learning more about with whom (other than supervisors) trainees are most likely to share clinical information; what kind of information is shared with these individuals; what prompts this information to be shared; how helpful the advice or support of informal supervisors seems; and whether these instances of informal supervision/consultation are shared with assigned supervisors.

The Study

We designed and posted online (via Survey Monkey) a self-report questionnaire on the experi-ences of beginning psychotherapists. Participants were recruited through networking, primarily through the senior author sending announcements of this link to directors of training and other faculty colleagues throughout the country, and graduate students in our clinical psychology program sending links to students they knew in clinical and counseling psychology doctoral program and license-eligible master's (MA) programs.

Table 1

Sharing Clinical Information With Informal Supervisors: Extent and Helpfulness of Use (N = 146)

Source	Extent of Use		Helpfulness	
	M	SD	M	SD
Colleague in program	4.9	(1.6)	5.4	(1.6)
Colleague outside program	3.3	(2.0)	4.6	(2.0)
Friend (not in field)	2.7	(1.5)	2.6	(1.6)
Parent	2.6	(1.7)	2.6	(1.8)
Sibling	1.7	(1.5)	2.2	(1.6)
Significant other	4.1	(1.9)	3.4	(1.8)
Faculty member	3.0	(1.9)	4.5	(2.0)
Director of Training	2.5	(2.0)	4.0	(2.2)
Own therapist	3.8	(2.0)	3.9	(2.7)
Religious leader	1.1	(0.7)	1.7	(1.7)

Note. M = mean; SD = standard deviation. Based on a 7-point scale ranging from 1 (*not at all*) to 7 (*to a great extent*).

The final sample comprised 146 students, mostly female (84.2%), Caucasian (74%), and between the ages of 25 and 34 years (70.5%). These students were divided among PhD (39.7%), PsyD (30.8%), and license-eligible MA programs (28.8%). They were well distributed in terms of the theoretical orientation that "informs their work." On a 7-point Likert-type scale ranging from 1 (*not at all*) to 7 (*to a great extent*), these students' responses indicated that their work is at least moderately informed by each of these orientations: psychodynamic (mean *[M]* = 5.02), humanistic/existential ($M = 4.52$), and cognitive-behavioral therapy (CBT; $M = 4.29$). On average, this group was currently seeing 5.4 clients; to date, they had seen, on average, slightly more than 12 clients (12.18). Their mean number of current clinical supervisors was 2.3. Among this sample, 90 (61.6%) were currently in their own psychotherapy.

We asked participants to rate the extent to which they "share clinical information" with each of the 10 potential informal supervisors. Table 1 indicates the three most highly endorsed such individuals: a colleague in one's program ($M = 4.9$), a significant other ($M = 4.1$), and one's own therapist ($M = 3.8$). Individuals who are rarely called upon for consultation by this group of beginning psychotherapists included a parent ($M = 2.6$), one's training director ($M = 2.5$), a sibling ($M = 1.7$), and a religious/spiritual leader ($M = 1.7$).

Our follow-up question asked respondents to rate the extent to which each of these 10 potential sources of informal supervision proved helpful to them. Table 1 also indicates the most highly endorsed responses to this question: a colleague in one's program ($M = 5.4$), a colleague in the mental health field outside one's program ($M = 4.6$), and a faculty member in one's program ($M = 4.5$). Among the lowest-rated sources of helpful advice or consultation include a friend ($M = 2.6$), a sibling ($M = 2.2$), and a religious/spiritual leader ($M = 1.7$).

We then asked participants to rate the extent to which they share certain types of clinical material with their "preferred" informal supervisor. Among the 13 items (types of information) listed, the most often shared were treatment dilemmas/conflicts ($M = 5.3$), the primary problems of the client ($M = 5.2$), the gender of the client ($M = 4.6$), and feelings about the client ($M = 4.1$). Types of information least often shared include the client's marital status ($M = 2.3$), his or her first name ($M = 1.8$), physical description ($M = 1.6$), and, least often, his or her first and last name ($M = 1.0$).

Two similar questions were then posed to these respondents, the first inquiring about the reasons they shared this information, and the second asking about clinical situations that increased the likelihood of their sharing. As to the first question, respondents' most highly endorsed motivations among a list of 10 possibilities included: their preferred informal supervisor was smart and insightful ($M = 5.6$); they needed reassurance ($M = 4.6$); their preferred informal supervisor

possessed knowledge about a specific aspect of a specific clinical case ($M = 4.2$); and they needed more than one opinion on this case ($M = 4.1$). Lowest rated items on this question—all of which point to a vote of confidence for trainees' formally assigned supervisors—include disagreement with supervisor ($M = 2.4$), feeling intimidated by one's supervisor ($M = 2.0$), and feeling that one's supervisor is too judgmental ($M = 1.9$).

The results of the second question—for which there were 15 possibilities listed–point to several overlapping clinical situations that increase the likelihood of trainees seeking added (informal) sources of supervision: feeling stuck ($M = 5.1$), feeling one has made a clinical mistake ($M = 4.5$), and feeling challenged by the work ($M = 4.4$). Somewhat surprisingly, the following seemingly difficult situations were ranked low in terms of catalyzing the decision to seek informal supervision: client threats to terminate treatment ($M = 3.1$), a terminated treatment ($M = 3.0$), and feelings of attraction to a client ($M = 2.7$).

Informal supervision was evaluated quite highly by this group of trainees. On the 7-point Likert-type scale, the mean score for this item was 5.4. Still, when the question was asked about the usefulness of formal supervision, respondents were even more favorable: The mean score here was 6.4. Similarly, when these respondents were asked the question, "When performing therapy is particularly stressful, do you evoke or call forth the presence of your preferred informal supervisor more or less than you call forth the presence of your formal supervisor?" their responses showed that they again favored their formal supervisors: The mean score here was 5.1, in the strong direction of formal supervisors. As to whether trainees regret sharing information with informal supervisors—responses here point primarily to "no": The mean score for this question was 2.1. Last, we queried respondents if they shared with their formal supervisors the fact of having used informal supervision. The answer was essentially "not really," more specifically, the mean score here was 2.9.

Few demographic or clinically related variables were found to significantly affect these results. Trainee gender, for example, had no bearing on any of these findings. But the extent to which trainees acknowledged a psychodynamic perspective was significantly ($p < .05$) related to the likelihood of using either a colleague in their program or their own psychotherapist as a source of supervision/consultation; and the extent to which they acknowledged a CBT perspective was significantly ($p < .05$) related to the likelihood that their decision to consult with an informal supervisor is because of their belief that this person is particularly knowledgeable about a certain aspect of a client's experience. It is also noteworthy that trainees who were in the upper median of clinical clients seen to date (total of 11–22) were significantly more likely than those trainees who had seen fewer clients (1–10) to feel that the advice or help they receive from informal supervision is useful.

There are several conclusions that can be drawn from these findings, most notably that sharing information with informal supervisors—especially colleagues in one's program–happens a great deal more often that is commonly (or at least openly) acknowledged in the literature, in training programs, or even in formal supervisory settings.

These results also suggest that this sharing of information occurs because trainees feel that their informal supervisors are smart and insightful and that these individuals can provide extra reassurance and/or extra knowledge when they (trainees) feel especially stuck or challenged, or when they feel they've made a clinical error. The "extra" piece here seems relevant. That is, 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.

We will have more to say later about the implications of these findings—especially in regard to ethics and training—but first we turn to three first-person accounts of informal supervision. These cases, based on interviews conducted by the second author (VH), provide further details about trainees' reasons for and processes by which they seek support and advice beyond that offered by their formally assigned supervisors.

Informal Supervision: Some Observations and Cases

Our sense, based on several interviews conducted with students in training, is that informal supervision can be roughly divided into two categories: an ad hoc, unplanned type and an intentional type. Ad hoc supervision seems to happen often among students in training, most frequently with classmates. It occurs in casual conversations almost anywhere, though most often in student offices and student lounges in training clinics. In these situations, when the conversation touches upon clinical issues, students share their experiences and seek advice from their peers. By contrast, intentional, informal supervision occurs when students plan to tell a specific person (or group of people) about a particular clinical moment or a dilemma they have faced or are about to be facing.

Although neither of these types has real rules or structure (e.g., a specific timeframe), ad hoc informal supervision seems somewhat more "organic." As working with clients is a large part of students' lives, sharing clinical experiences and seeking advice or support from peers seem both natural and inevitable. Intentional, informal supervision is typically a more complex and fraught event because it tends to be sought when a student is–even more than usual–confused, distraught, and/or demoralized. The following three cases—with identifying information about the student, client, and supervisor disguised or significantly modified—illustrate some of the process and motivations behind informal clinical supervision.

Case 1

At the beginning of my internship, I was assigned my first inpatient case—the first psychotic client I had ever worked with. She was a client with multiple psychiatric hospitalizations in her past and severe symptoms in her present. Despite that, and despite the fact that she criticized the efforts of so many who had tried to help her over the years, our first few sessions gave me hope that I could reach her. She was a brilliant woman and I felt that we had forged a very strong connection from the beginning. Not thinking deeply about it, I offered to meet her every day while she was on the unit. It seemed to me that our best moments together were when her psychosis and hostility were forgotten or treated as "background" by the both of us. At these moments she became very alive and presented not as a psychotic client with bizarre olfactory hallucinations and enormous rage, but rather as a unique woman with clearly articulated likes and dislikes, and disappointments and hopes. In those moments I felt creative and connected, asking her about books she loved, her college years, and her fascination with logic, numbers, and political philosophy. I felt that our work was special and successful.

I became comfortable working with her–too comfortable, as I understood later. One of my (mistaken, in retrospect) interventions was challenging her perceptions of people around her, particularly her perception that people on the unit were unprofessional amateurs who were never helpful. "Do you think it might be a creation of your mind?" I kept asking her. Her rigidity and the uniform, hostile way in which she talked about everyone around her got to me and I became frustrated and even angry. In a particularly heated session, while challenging her statement that the social worker (a woman I respected a great deal) was an "idiot," I got into an argument with her, and at some point, without a great deal of thought, I told her that she was wrong and that if she thought that her approach was the correct one, then "good luck with that." It was a blatant mistake, and a quite regrettable moment. I got carried away and for the first time in my short psychotherapy career, a client stormed out of the room from me. She was hurt and angry. After some persuasion she agreed to come back to the room, but our relationship was never the same afterwards. She never forgave me.

I felt guilty and confused. I blamed myself for ruining the treatment, for being unprofessional, for being too confident and careless. I brought this into group supervision, feeling vulnerable and needing support. My supervisor supported and encouraged me, essentially telling me that failed treatments happen and that I could learn from it for the future. The group members concurred. I did not feel judged or mistreated. I just felt misunderstood. I felt that for someone to *really* understand the significance of what happened–to comprehend how in one session my fragile (if sincere) perception of myself as a person who could finally reach this woman, who

could see and appreciate the healthier human sides of her and give her hope, was shattered–that person would need to understand me, try to know who I am. In retrospect, I probably should have told the supervisor and/or the group that I felt misunderstood, but at the moment my hurt and aloneness translated simply to something like "to hell with it, she/they are not going to get it anyway."

Thus, a few hours after this supervisory session ended, I related this story—the events of the clinical session as well as the supervisory experience–to a close friend (also in the mental health field), someone who I thought could understand me in the context of what occurred. She listened carefully and attentively when I told her about what happened. She understood, I thought, the personal significance of the moment. She suggested ways that I might process and accept this incident, but in a more encouraging and personal way than my supervisor. She recognized that it was not just a "clinical dilemma" and that I did not primarily or exclusively need technical advice (e.g., to avoid aggressively challenging clients with a history of psychosis). Rather, she seemed to know that what I needed at this time, at this point in my career, in the aftermath of this clinical situation, was a fundamental validation that my struggle here was worthwhile, that the hopes I had–in regard to this particular woman and in the general ability of psychotherapy to reach very disturbed people–were not fantasies, and that I should continue believing in my quest, and in myself, despite the crash. I thought about this evening repeatedly in the months following and replaying it was a constant source of support.

Because it was group supervision and focused on several students and many clients, I avoided bringing this case up again in that setting until the client's discharge.

Case 2

I did share an important clinical moment with an informal supervisor: The client was a very heavy, severely traumatized woman whom I saw for several months in an outpatient clinic. From the beginning of our treatment, her physical appearance and her history–she was very poor, had been abused, and was homeless in her past–stood in stark contrast to the content of the things she said. Even in intake I remember noticing that she spoke beautifully and at times poetically. To preserve her confidentiality, I won't reproduce her exact words, but I was struck by how smart and elegant they were.

We made an instant connection and I mentioned to her early in treatment how much I appreciated her perceptiveness and her poetic abilities. She told me that she never thought of herself that way and that she had never been told that before. As the treatment progressed, we had many moments in which I was repeatedly surprised and moved by the things she told me. I shared some of them with my assigned supervisor, but I did not feel that we understood these stories in the same manner—more specifically, I did not sense that my supervisor appreciated the uniqueness of my client. "You have to think why she is so special to you," she told me repeatedly. She was special to me because I thought that she was a real poet. In one of the sessions, and after a discussion about her former therapists, I asked her what she thought about me. Her response–one sentence, a poetic metaphor actually–was the most affirming and touching thing a client has ever told me. It was a very special moment between us. To share it, I felt I needed to feel complete trust and understanding from another. I could not share it with just anyone.

I related this experience to a close friend in my class, looking for a like-minded appreciation of the moment, and he reacted as I hoped he would: He became tearful, just as I did when my client spoke to me. I did not think that my formal supervisor would understand and appreciate this moment as much as I did (or my friend did). I told her about it, but only in passing and without emphasizing how deeply I felt about it. It felt to me too sacred, too personal almost, to share it with her fully.

Case 3

I was the ninth therapist for an unemployed elementary school teacher in his late 30's whom I saw at an outpatient clinic. He complained of severe mood and anxiety symptoms, and was also diagnosed with narcissistic personality disorder. The therapist that handed me the case seemed

defeated and disconsolate, suggesting that this client was a "malignant narcissist" who would "stab you in the neck if you hurt him." She indicated that most of her interventions—save for a few CBT techniques–were futile. So, I began CBT treatment and my supervision focused on CBT techniques.

I saw glimpses of this client's rage, especially (as predicted) when he felt attacked by me. However, because the treatment was mainly CBT-oriented, I focused on skills and techniques within this model, rather than our slowly boiling relationship. He did not especially like the CBT techniques and many of my suggestions were deemed unhelpful, simplistic, and "amateur." I tried to be creative, and with the help of my supervisor, who was thoughtful and theoretically flexible, I attempted more personalized interventions, many of which diverted from the manual. Despite these attempts, and despite his partial acceptance of what I was offering, I continuously felt that I was "missing" him and his experience.

Talking about his homework and the skills that he needed made him angry and frustrated. My age and my perceived lack of professionalism ("You have no idea where this thing is going–am I your first client?") made him angry and frustrated. I felt that we reached a point of crisis and that I had to address the state of our relationship and his constant belittling of me. My supervisor supported me and agreed that it was the right time in the treatment to do so. With his support, I confronted my client. I told him that I thought he hadn't accepted what I offered because he felt ashamed at taking anything from someone he felt was inferior and that until we resolved this issue, we could not work productively. My client reacted with extreme rage, telling me that I was the worst therapist he ever had and that he was going to report me to my superiors and bring my career to an end.

My supervisor was quite supportive throughout this treatment, especially after this failed intervention. However, I was deeply hurt by the client. I felt abused by him and felt that I needed not only more support but also a deeper understanding of my role in this process and my reactions to it. My client's attack made me question myself and my abilities as a therapist. I thought that perhaps he was right and that I was not professional, not good enough. In addition, his attack touched upon a very personal area of my way of dealing with conflict and anger that despite the helpfulness of my supervisor, I felt was "extra-supervisory." Hence, I brought it up in my own treatment. I explored with my therapist my feelings of futility, shame, and my difficulty responding to his abuse. My therapist was helpful and encouraging, and told me that "sometimes experience is earned in moments like these, in which we feel incapable and even stupid." I carried his words forward with me and, together with the support of my formal supervisor, it gave me faith in my abilities to withstand his attacks, overcome the conflict between us, and eventually help him.

Summary and Clinical Implications

Although the literature in the field has expanded in recent years to include discussions of, among other growing trends, competency-based and multicultural supervision, there remains a surprising paucity of clinical or empirical articles focused on what seems to be a rather normative source of clinical supervision and consultation for beginning clinicians—that provided by informal supervisors. This whole other world of supervision that exists outside the domain and purview of "formal," assigned supervision is not only virtually unrecognized in the professional literature but also unacknowledged by training programs—essentially, a "don't ask, don't tell" policy.

Our first attempt here to map out the nature of informal supervision suggests that trainees' peers, psychotherapists, and significant others are often recruited for this purpose. But our data—albeit based on a relatively small sample size—also indicate that this phenomenon occurs not because formal supervision is perceived as poor or unhelpful—in fact, our respondents were more impressed with the usefulness of formal than that of informal supervision—but rather because formal supervision, as typically constituted (i.e., one weekly, 45–50 minute session with each supervisor), does not, or perhaps cannot, serve well the multiple and frequent needs of many beginning clinicians.

This is a group who, unsurprisingly, tends to feel anxious, stressed, inadequate, unknowledge-able, and vulnerable in the beginning stages of their careers (e.g., Farber, 1983; Hill, Sullivan, Knox, & Schlosser, 2007), and whose needs are not entirely commensurate with the existing structure of formal supervision in training programs. Simply put, most trainees need more—more advice, support, affirmation, strategies, opportunities for discussion, and PRN (as-needed) consultations—than training programs provide. Many psychotherapy clients process their psy-chotherapy sessions with significant others and friends (Khurgin-Botts & Farber, 2011)—a phenomenon also essentially overlooked and underemphasized in the professional literature—many, if not most, psychology trainees discuss the clinical sessions they've conducted with their clients outside the bounds of formally structured sessions.

The great advantage of informal supervisors, especially significant others and classmates, is that they tend to be available when needed. Supervisors—except for true emergencies–tend not to be. There are times in the clinical life of a beginning psychotherapist that the wait for the next supervisory appointment a few days or a week later seems interminable, and conversely the availability and proximity of a smart peer or significant other feels like an opportunity too tempting (and potentially helpful) to pass on. What these results also suggest is that these consultations are not random or rare events.

These consultations or informal supervisory sessions are clearly not gossip (Behnke, 2007)—they are in the service of receiving extra help from a person or persons perceived as smart, knowledgeable, and/or supportive. In this regard, seeking as much help as possible in the service of helping a client is consistent with General Principle A, Beneficence and Nonmaleficence, of the APA Ethics Code (2010), which states, "Psychologists strive to benefit those with whom they work" (p. 3). Nevertheless, this practice is ethically dubious, as multiple other aspects of the ethics code make abundantly clear.

In the general principles of the code, **Principle E, Respect for People's Rights and Dignity, states unambiguously, "**Psychologists respect the dignity and worth of all people, and the rights of individuals to *privacy*, *confidentiality*, and self-determination" (emphasis added, p. 3). In Ethics Standard 4.01, Maintaining Confidentiality, the Ethics Code reminds us that "psychologists have a primary obligation and take reasonable precautions to protect confidential information" (p. 7), and in the following Ethics Standard (4.02), Discussing the Limits of Confidentiality, psychologists are mandated to discuss the "relevant limits of confidentiality" (p. 7).

Another relevant aspect of the Ethics Code here is that of Standard 4.06, which pertains to "consultations." This standard requires that when psychologists consult with colleagues, they do not disclose confidential information that might reasonably lead to the identification of the person(s) with whom they've had a professional relationship without the prior consent of that person.

Moreover, in Ethical Standard 10.01, Informed Consent to Therapy, psychologists are en-joined to

> inform clients/clients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties and limits of confidentiality and provide sufficient opportunity for the client/client to ask questions and receive answers. (p. 13)

Supervisees seem to be somewhat aware of the need for confidentiality in sharing information with informal supervisors. Although they typically provide details about the clinical situation or dilemma they're encountering, they rarely provide their clients' names (even first name) or a physical description. Nevertheless, if our data are essentially accurate (i.e., generalizable) and replicated in other studies, then many supervisees are routinely acting in an unethical fashion by sharing clinical information outside the boundaries of formal supervision or practica classes without the knowledge or permission of their client (see Standard 4.06). We imagine, though, that few supervisees would see their actions (especially their consultations with their psychotherapists and peers) through this lens. Indeed, our data indicate that there is not much regret among trainees in regard to their consultations outside the bounds of formal supervision.

We suspect that too few supervisees have considered their actions in light of the Ethics Code, and we also suspect that few, if any, programs have focused explicitly on this issue. We believe too that the Ethics Code, as currently constituted, provides inadequate guidance in regard to some difficult questions: Can trainees discuss their reactions to specific clinical situations and clients within the bounds of their own psychotherapy? Can they consult with peers outside the bounds of the classroom about specific clinical situations with specific clients if they are circumspect about identifying information? Can they consult with peers within the bounds of a training clinic's student lounge? Are they ethically obliged to let clients know that their work is being not only supervised by formally assigned supervisors but also discussed in practica classes and perhaps case conferences with faculty and other students present?

Barnett and Molzon (2014) have noted wisely that "clinical supervisors should actively seek out, and be open to receiving, feedback from supervisees about the supervisory relationship and process, and should actively demonstrate this openness during informed consent and within the supervision sessions." We concur and yet we also hypothesize that beginning trainees, especially in the beginning phases of their first supervisory experiences are unlikely to ask their supervisors to provide them with what they may need most: immediate (or nearly so) accessibility for questions and concerns that arise immediately after a difficult clinical session, and/or the kind of unconditional support or positive regard that friends, lovers, and perhaps long-time psychotherapists have so often and so well provided.

Our belief is that directors of training programs, directors of clinics, practicum instructors, and ethics instructors need to be far more cognizant of this phenomenon, and provide far more guidance around ethics standards regarding these issues—in particular, the unfortunate temptation to share clinical material with friends or significant others–than currently seems to be the case. Training programs and clinics might also consider being more proactive in making available the clinic training director or director of training for PRN supervision.

Last, we believe that formal supervisors should discuss, in the very beginning stages of supervision, the boundaries regarding confidentiality of clinical material, the normative temptations to share clinical material with others, the dangers, including potential legal ramifications, of doing so, and potential avenues and means of receiving additional support and supervision when the supervisee deems it necessary or important to do so.

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