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A qualitative study of supervisees' internal representations of supervisors

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Abstract

Eleven US-based doctoral student supervisees were interviewed regarding their internal representations (IRs) of their clinical supervisors. Data were analyzed using consensual qualitative research. In speaking about their

overall IR experiences, supervisees reported that their exposure to IRs occurred at off-site practicum placements. The IRs, which were both spontaneous and intention-ally invoked, usually were auditory in form, were stimulated by supervisees' clinical work, were used to guide their clinical performance, and were considered a normal part of their development. When describing one specific IR, supervisees characterized the relationship with the supervisor as positive, and noted that supervision focused on clinical interventions. These brief and vivid IRs were auditory/verbal in form, occurred spontaneously, and consisted of the supervisor instructing or supporting the supervisee when s/he felt challenged or doubted her/himself clinically. The IRs yielded positive effects, but were usually not discussed with supervisors. Implications are addressed.

Keywords

supervision; supervisors; supervisees; internal representations

Introduction

Clinical supervision is fundamental in helping novice therapists develop their conceptualization and intervention skills. As trainees begin taking on the role of therapist, anxiety and uncertainty are common companions, which supervisors can help ease both through didactic, intervention-oriented instruction as well as by helping trainees process their ongoing emotional reactions to clients. Supervision is thus integral in the development of counselors, and lies at the heart of training mental health professionals (Bernard & Goodyear, [2]; Campbell, [4]; Clark, [5]; Stoltenberg & Delworth, [22]). In fact, for novice therapists, supervision is a more salient influence on development than direct client experience (Ronnestad & Skovholt, [20]), and the provision of holding and containment in the face of supervisee demoralization is one mechanism through which supervision may exert its effects (Bruss & Kopala, [3]; Ecklar-Hart, [6]; Friedman & Kaslow, [7]; Lampropoulos, [15]; Mollon, [17]; Watkins, [23]).

While one important element of supervision is didactic training in specific interventions (Ronnestad & Skovholt, [20]; Worthen & McNeill, [24]), as noted above, trainees also likely absorb implicit messages about how to be a therapist via contact with their supervisors (Geller, Farber, & Schaffer, [10]; Romei, [19]). One way in which supervisees may gradually become more comfortable taking on the identity of a therapist is via their IRs of their supervisors. While some research has examined this phenomenon (Geller et al., [10]; Romei, [19]), in-depth investigations of how these representations are actually experienced and how they affect trainees have not yet been undertaken.

Internal representations (IRs) refer to someone experiencing the presence of another individual in that individual's absence. Knox and colleagues defined IRs as internalized "images" (whether visual, auditory, felt presence, or combined forms) of an important personal figure that are brought to awareness in that individual's absence (Knox, Goldberg, Woodhouse, & Hill, [14]), while Geller and colleagues described IRs as being inferred from the ways in which important personal figures reappear in fantasies or conscious memories without being objectively present (Geller et al., [10]). Orlinsky, Geller, Tarragona, and Farber ([18]), on the other hand, defined IRs more broadly as ideational events that are open to self-report and conscious introspection, but that does not require immediate sensory input. All of these authors are describing experiences such as imagery, thoughts, fantasies, and physical sensations that arise from an internal source rather than an external stimulus. In the context of supervision, a supervisee's ability to describe and reflect upon her/his IRs provides access to learning more about how transmission of supervisory knowledge may take place.

In terms of form, these representational experiences have typically been divided into visual, auditory, and kinesthetic categories. For instance, participants have described seeing an image of their therapist, or visualizing the room in which therapy is conducted; they have also described hearing the words of their therapist, or engaging in an internal dialogue with their therapist; and they have described feeling the physical presence of their therapist, whether as an external presence in the room or through taking on physical or facial

characteristics of their therapist (Geller & Farber, [9]; Geller, Smith-Behrends, & Hartley, [8]; Knox et al., [14]; Rosenzweig, Farber, & Geller, [21]).

Much of the research on IRs comes from the work of Geller, Farber, Orlinsky, and their colleagues. These researchers initially investigated clients' IRs of their therapists (Geller & Farber, [9]; Geller et al., [8]; Knox et al., [14]; Rosenzweig et al., [21]; Wzontek, Geller, & Farber, [25]), and have also examined therapists' representations of their clients (Beitel, Geller, Hutz, & Farber, [1]; Geller, Lehman, & Farber, [11]).

IRs are not confined to the therapy relationship, however, but extend into many important developmental relationships, including that between supervisee and supervisor. Some empirical evidence for supervisees' internalization of their supervisors does exist. For example, Romei ([19]) found that trainees' internalization of formal properties of their supervisors (visual, auditory, and kinesthetic) decreased over time, as did their involvement with thoughts of their supervisors. It could be, then, that as trainees' therapeutic identity coalesces and their self-efficacy as therapists increases, they need to rely less on IRs for guidance and support.

In an effort to measure some of the properties of supervisees' IRs of supervisors, Geller and colleagues developed the Supervisor Representation Inventory (SRI), a modified version of the earlier Therapist Representation Inventory; Geller et al., [8]), and found that supervisees experience and utilize IRs of their supervisors (Geller et al., [10]) in a markedly similar manner to the way therapists use representations of their clients (Geller et al., [11]): to review past sessions and to formulate future interventions. Supervisees tend to evoke the actual words and vocal qualities of their supervisors, as well as the settings in which they have met, especially when attempting to formulate clinical interventions they view as potentially challenging or painful for their clients.

While the results of these two studies, only one of which was published, provide the beginnings of an understanding of how supervisees experience their representations of their supervisors, they nevertheless contain limitations, which our research hopes to address. First, the participants in these studies were largely drawn from East-Coast training sites and were primarily psychodynamic in orientation. Given the attention paid to the process of internalization within the psychodynamic tradition, it is possible that these findings were "primed" in that such trainees expect, look for, and generate representations in ways non-psychodynamic clinicians would not. Second, while the SRI (Geller et al., [10]) appears to be a valid and reliable means for quantifying these experiences, the structure of such an instrument inherently limits what can emerge regarding the actual lived experience of this phenomenon. Geller et al. ([10]) acknowledged this limitation, noting that their results would benefit from more in-depth qualitative approaches to clarify the ways in which supervisees experience and use their representations.

The current study thus sought to expand our understanding of supervisees' IRs of their supervisors. We were interested in allowing the richness and complexity of the ways in which trainees experience these representations to emerge inductively, with fewer restraints than those necessarily imposed when using an instrument such as the SRI. Thus, our intention was to explore the form, content, and contexts of these experiences, and also to examine how participants are affected by such representations. More specifically, our research sought to address the following questions: What are the contexts and precipitants for supervisees' representations of supervisors, and what forms do these representations take? What impact do these representations have on supervisees? And finally, how have participants been trained to think about these experiences?

Method

Participants

Supervisees

Eleven (9 women, 2 men; 9 Caucasian/European American, 1 Arab American, 1 Hispanic) supervisees from across the US took part in this study, ranging in age from 27 to 50 years (*M* = 31.27, SD = 6.4). Eight were clinical psychology and three were counseling psychology doctoral students; seven were pursuing a PhD and four a PsyD degree. With regard to theoretical orientation (non-mutually exclusive), four identified as cognitive behavioral, four as integrative, three as psychodynamic, two as attachment, two as humanistic, one as biopsychosocial, and one as existential/phenomenological. They had seen clients and been supervised in the following settings (non-mutually exclusive): hospitals/medical centers/VAs (8), outpatient/community mental health clinics (8), university counseling centers (8), inpatient psychiatric units (3), private practices (3), schools (3), long-term residential settings (2), department clinics (1), and juvenile court services units (1). They had received between 8 and 18 academic terms (semesters/quarters) of individual supervision (*M* = 11.27; SD = 3.82), had worked with between 4 and 14 individual supervisors during that time (*M* = 9.1; SD = 3.48), and had received between 36 and 400 weekly individual supervision sessions (*M* = 274.55; SD = 161.97). Participants had been in individual supervision with the supervisor of whom they had the IR for between six months and five years (*M* = 2 years; SD = 1.36). Eight of the IRs occurred when supervisees were still in supervision with the supervisor; three occurred after the supervision had ended.

Supervisors

Participants also described the supervisors of whom they had the IR (not all participants reported all data). Nine supervisors were PhDs and two were PsyDs; six were clinical psychologists and one was a counseling psychologist. Nine were identified (non-mutually exclusive) as White/European American, one as African-American/Native American, one as Hispanic, one as Indian/Asian, and one as Japanese American; three were identified as female and one as male (the genders of the others were not specifically identified). In terms of theoretical orientation (non-mutually exclusive), five were identified as psychodynamic; four as cognitive behavioral; and one each as bio-behavioral, humanistic, integrative, and systems/feminist. Their ages were reported to be between the early 30s and the 50s.

Interviewers and judges

Three researchers interviewed participants and served as judges on the primary team. One was a female counseling psychology professor (a 51-year-old European American), and two were European American male students in a counseling psychology doctoral program, one 32 and the other 39 years old. A 36-year-old European American counseling psychologist working at a university counseling center served as the auditor. All were authors of the study. All but one of the graduate students had prior experience with CQR, although this graduate student had completed a course in qualitative research, in which CQR was addressed. Three of the four authors had worked together on prior research; the two graduate students attended the doctoral program with which the first author was affiliated. The team thus had good professional relationships with each other. The authors' biases appear in Appendix 1.

Measures

Demographic form

The demographic form asked for age, sex, race/ethnicity, doctoral program information (i.e. clinical or counseling psychology; PhD or PsyD), and participants' theoretical orientation. Participants were also asked to describe the types of settings in which they had seen clients, the number of academic terms they had been in individual supervision, the number of supervisors with whom they had worked in individual supervision, the frequency of these supervision meetings, and the estimated total number of individual supervision sessions they

had received. Finally, participants were asked to give their name, phone number, and email address so that a researcher could contact them to schedule the interview.

Interview protocol

All researchers helped develop the protocol. The preliminary protocol was first piloted on two non-participant volunteers who met the participation criteria (see below), and then altered based on the feedback. The resulting semi-structured protocol (i.e. each participant responds to a standard set of questions, and researchers pursue additional topics based on participant answers) opened by asking participants how they define IRs, what exposure to IRs they may have had in their training, and their general experiences with IRs. The next set of questions asked participants to describe one particular IR experience they had of a supervisor who provided them with individual supervision. More specifically, participants were asked to describe this supervision relationship, the focus of the supervision, and the IR itself (e.g. what was occurring just prior to the IR, the impact of the IR, why the participant thought s/he had the IR, any discussion of the IR). The interview closed by asking participants what they would want others to know about IRs, and also gathered information about the supervision and supervisor (e.g. duration of supervision, supervisor demographics). See Appendix 2 for the complete protocol.

Procedures for collecting data

Recruiting clients

We recruited participants through internet postings (e.g. APPIC), emails to professional contacts, and snowball sampling. In each of these venues, we provided information about the study and participation criteria (i.e. clinical or counseling psychology doctoral students in the US who had experienced an IR of their supervisor, had completed at least two academic terms of clinical practicum and at least two academic terms of practicum supervision as a supervisee; had worked with the supervisor of whom they had the IR for at least three months). The professional contacts to whom we sent this information were asked to distribute the information to appropriate persons in their own professional networks. All of those interested in the study were directed to contact the primary investigator, who then emailed them the demographic and consent forms, and the interview protocol. When the completed demographic and consent forms had been received, a member of the primary team contacted the participant and arranged for the first interview.

Interviewing

Each of the three members of the primary team conducted the ~50-min audiotaped phone interviews with three to four participants. No participants had any direct affiliation with the researchers' graduate programs.

Transcripts

All interviews were transcribed verbatim (other than minimal encouragers, silences, or stutters). Any potentially identifying information was removed, and each participant was given a code number to protect confidentiality.

Procedures for analyzing data

Data were analyzed using consensual qualitative research (CQR; Hill et al., [12]; Hill, Thompson, & Williams, [13]). In CQR, research team members come to consensus through open discussion of data classification and interpretation as they complete the three steps of analysis (domain coding, in which data are organized into topic areas; core ideas, in which data in each domain for each participant are abstracted to capture their essence; cross-analysis, in which core ideas within each domain but across cases are compared to illuminate common themes); the auditor reviewed each step.

Draft of results

All participants received a draft of the study's results and were asked to ensure that their confidentiality had been maintained. Four participants responded: As appropriate, their remarks were incorporated into the manuscript, though none suggested substantial changes.

Results

We followed CQR guidelines in labeling category frequencies. Findings that emerged in all or all but one case were labeled general categories, those that emerged in more than half and up to the cut-off for general were labeled typical, and those that emerged in a least two but in no more than half of the cases were labeled variant.

Contextual findings

We first present findings that emerged when participants discussed their overall experiences with IRs (i.e. not related to a specific IR event; see also Table 1).

Table 1. Supervisees' IRs of supervisors: Contextual findings.

Domain/category	Frequency
Exposure to concept of IRs	
Via off-site practicum experiences	Typical
Via coursework in graduate program	Variant
In P's personal therapy/professional development	Variant
Not labeled IRs, but some conversations about phenomenon	Variant
No formal exposure	Variant
Overall experience of IRs	
Form	
Auditory	Typical
Visual	Variant
Felt presence	Variant
"Channeling" SR	Variant
Spontaneous vs. intentional	
Both spontaneous and intentional	
Predominantly spontaneous	
Precipitant/stimulus of IRs	
Clinical work	General
General clinical work	Typical
Challenging/intense moments	Variant
Case conceptualization/paperwork	Variant
Impact/use of IR	
Guide/Improve clinical performance	General
Develop clinical style/consolidate clinical identity	Variant
Comfort/ground self	Variant
Negative impact	Variant
Why IRs occur	
Inherent part of participant's development	Typical
Because of participant's awareness of IRs	Variant
Because of impact of supervisor/supervision relationship	Variant

1 Notes: general = 10–11 cases, typical = 6–9 cases, variant = 2–5 cases.

Exposure to concept of IRs

One typical and four variant categories emerged here. Participants were typically exposed to the concept of IRs via off-site practicum experiences. One participant, for instance, remarked that in her second year of grad school, she completed an interpersonally-oriented practicum in which she was trained in psychodynamic therapy; through this training, she was exposed to "what it means to act like someone else ... or take the perspective of someone else." Another participant noted that discussions of IRs occurred a few times in supervision, during which the supervisor commented that the participant's experience of the IR was "a sign of positive growth."

Variantly, participants stated that they were exposed to IRs via their graduate coursework. As an example, one participant stated that he had a lot of exposure to the concept during therapy classes in his psychodynamically-oriented graduate program. In addition, participants variantly reported that they were exposed to IRs in their own personal therapy or professional development. For instance, one person commented that her graduate program required that students be in therapy, and IRs were "a substantial part" of her therapeutic experience. Participants also variantly commented that although IRs were not specifically labeled as such, there were conversations about the IR phenomenon. As an illustration, a participant reported that she and her peers talked about the idea of "bringing the supervisor" into the room when providing therapy, but there was no formal discussion of this experience as an IR. Finally, participants variantly noted that they had no formal exposure to IRs. One person, as an illustration, stated that he had "no word for the concept" before learning of the study, but had experienced IRs.

Overall experiences of IRs

Form

One typical and three variant categories emerged here; we note, as well, that these categories are not mutually exclusive. Typically, participants' IRs included an auditory element. In one case, the participant would hear how her supervisor phrased something, delivered an intervention, or asked questions. Another participant described hearing his supervisor's metaphors, figures of speech, words of wisdom, and "anything that [went] beyond regular supervisory advice."

Variantly, the IRs included a visual element, with one participant stating that her IRs consisted of "visual images." Participants' IRs also variantly included the felt presence of the supervisor. For example, a participant noted that she would occasionally call on the "felt presence" of her supervisor. Finally, participants variantly described the form of the IR as "channeling" the supervisor. As an illustration, a participant reported that he "tried to channel" his supervisor, and another participant similarly noted that she "channeled" her supervisor.

Spontaneous vs. intentional

The IRs typically occurred both spontaneously and intentionally. One participant indicated that her IRs used to happen spontaneously; she later became aware, however, that she was "more choiceful and purposeful" about how she invoked her IRs and could summon them when needed. Another participant stated that after having spontaneous IRs a few times, she now "translated" them into something more intentional. Variantly, however, the IRs were predominantly experienced spontaneously. As stated by one participant, the IRs occurred "without prompting" and often surprised the participant when they occurred.

Precipitants/stimulus of IRs

Generally, the IRs were precipitated or stimulated by participants' clinical work, an overarching category with one typical and two variant subcategories. Typically, then, the IRs were precipitated by non-specific clinical moments. As an example, participants reported that their IRs occurred when doing therapy or delivering an intervention, or when working with a new client population. The IRs were variantly stimulated by challenging or intense clinical moments. For instance, one participant noted that his IRs happened when he had a very hard

session and was feeling stuck, uncertain, our doubting himself; another commented that her IRs occurred when she was at a "tipping point" and needed a "little nudge." Finally, the IRs occurred when participants were conceptualizing cases or completing paperwork. As an example, one participant stated that his IRs arose when he reflected on his cases, processed them, and considered how to plan treatment.

Impact/use of IRs

One general and three variant categories emerged here. Generally, participants reported that they used their IRs to guide or improve their clinical performance. As one participant expressed, his IRs were a way to learn something new through modeling. Another reported that her IRs helped improve her clinical performance; a third noted that his IRs added to his clinical skills. Participants variantly used their IRs to develop their clinical style or consolidate their clinical identity. One participant asserted that her IRs helped her create her own philosophy "about the psychologist [I] wanted to be." Another likened his IRs to "transitional objects" that helped him feel more competent and less of a fraud. Participants also variantly stated that they used their IRs to comfort and ground themselves. One participant, for instance, commented that her IRs provided "reassurance, comfort, and peace;" another remarked that after she had an IR, she was able to be more mindful, less anxious, and more present. Variantly, participants noted that their IRs had a negative impact. As an example, one person stated that her IRs early in training would "derail" therapy and lead her to act like someone else wanted her to act. Another noted that his IRs evoked a negative comparison between himself and his supervisor, which left the participant wondering, "Am I ever going to sound this good?"

Why IRs occur

One typical and two variant categories emerged here. Typically, participants felt that they experienced IRs because doing so was an inherent part of their development. For instance, one person reported that IRs were part of her learning experience; another noted that as a way of finding her own voice as a therapist, she "took in" experiences of supervisors to use as models to develop her own style. Participants variantly noted that they had IRs because they were aware of them. As stated by one participant, "I think they occurred because I knew what they were." Finally, participants variantly reported that they had IRs because of the impact of their supervisor or the supervision relationship. For example, one participant remarked that her IRs were of supervisors with whom she felt "extremely safe." Another reported that his IRs occurred because his supervisor and some supervision moments made an impression on him.

Specific event findings

We now present findings that emerged when participants discussed a specific IR experience (see also Table 2).

Table 2. Supervisees' IRs of supervisors: Specific event findings.

Domain/category	Frequency
Relationship with supervisor	
Positive	Typical
Difficult	Variant
Focus of supervision	
Skills/clinical interventions	General
Participants' intrapersonal reactions/development	Variant
Case conceptualization	Variant
Form of IR	
Auditory/verbal	General
Visual	Variant
Felt presence	Variant
Content of IR	

Supervisor instructing/supporting participant	Typical
Supervisor critical presence toward participant	Variant
Precipitant/stimulus for IR	
When participant doubting self/feeling challenged clinically	Typical
During intense clinical moments	Variant
Impact of IR	
Positive	General
Negative	Variant
Discussion of IR with others	
No direct discussion with supervisor	Typical
Discussed IR with supervisor	Variant
Discussed with colleagues/therapist	Variant
Why IR occurred	
Because of participant's self-doubt	Typical
Because of nature of supervisory relationship	Variant
Because of stress	Variant
Duration of IR	
Brief (seconds)	Typical
Longer period of time (minutes)	Variant
Reflecting on IR lasted longer than IR itself	Variant
Vividness of IR	
High	General
Spontaneous vs. intentional	
Spontaneous	Typical

2 Notes: general = 10–11 cases, typical = 6–9 cases, variant = 2–5 cases.

Relationship with supervisor

Participants typically reported enjoying a positive relationship with the supervisor of whom they had the IR. One participant, for instance, noted that the supervision relationship was "great" and that the supervisor "was the best [he] had ever had." Another described a "very positive, strong, close, wonderful, professional" relationship with her supervisor, a relationship that was "more significant" for the supervisee than past such relationships had been. Variantly, however, participants reported a difficult supervisory relationship. In one case, a participant noted that his supervisor, whom the participant experienced as authoritarian rather than collegial, made him feel "crappy" because supervision usually focused on what the supervisee did wrong.

Focus of supervision

When describing the specific IR experience, participants noted that the supervision generally focused on skills or clinical interventions. As an illustration, one participant stated that his supervision focused on interventions appropriate for the population with which the participant was working; another remarked that the supervision addressed "how to listen" to both the manifest and latent content; a third stated that supervision attended to how to work through barriers or resolve problems in the supervisee's cases. Supervision also variantly addressed participants' intrapersonal reactions and development. As described by one participant, the supervision included more "soul searching" than any prior supervision had, which felt appropriate and useful; another stated that the supervision addressed more "general ideas about what to do and not do in therapy" rather than cognitive skills training. Finally, participants variantly noted that supervision focused on case conceptualization. One participant remarked, for example, that she and her supervisor would review videotapes of sessions and conceptualize the case from a particular theoretical model.

Form of IR

In non-mutually exclusive categories, the form of the IRs generally included an auditory or verbal component. For instance, one participant "could almost hear [her] supervisor's voice in her head," and another recalled different things that his supervisor had said. The IRs variantly included visual content. In one case, the participant described experiencing the image of his supervisor's "critical facial expressions [and] 'stink eye.'" The IRs also variantly were experienced as a felt presence, as well, as noted by the participant who stated that she felt her supervisor's "stoic, calm, powerful" presence in the therapy room with her.

Content of IR

The specific content of the IR typically involved the supervisor instructing or supporting the participant. For example, one participant described her IR as "like a little angel over [her] shoulder" saying "ethical psychologists do what's right even if nobody is looking." In another case, a participant experienced the felt presence or words of her supervisor assuring the participant that he was "good enough" and that what he was offering to his clients was likewise good enough. Variantly, however, the IR content involved the supervisor's critical presence toward the participant. As described by one participant, the supervisor's "stink eye" expression implied to the participant that the participant was stupid and had no idea what he was doing.

Precipitant/stimulus for IR

The precipitant or stimulus for the IR was typically a time when the participant doubted her/himself or felt clinically challenged. As an illustration, one participant stated that her IRs occurred when she was "out of rhythm" therapeutically, and another commented that his IRs occurred when he was facing an ethical dilemma. Variantly, the IRs arose amid particularly intense clinical moments. In one case, for instance, the participant was working with a child who had experienced trauma. During non-directed play therapy, the child made the participant play the role of a kidnapped person, which the participant interpreted as a reenactment of the child's own trauma history. This "ramping up" of the traumatic play triggered the participant to summon her supervisor, via the IR, because the participant thought, "Oh, I need help here."

Impact of IR

Participants generally reported that the IRs had a positive impact. One participant commented that her IR helped her determine how to behave therapeutically even when not being supervised; another remarked that his IR helped him navigate and make sense of inevitable clinical difficulties; a third noted that her IRs enabled her to trust herself more and be ok with not feeling 100% confident. Variantly, however, the IRs had a negative impact. One participant acknowledged that his IR made him "afraid to do things ... froze [him] ... for fear that he would 'screw up.'" Similarly, another participant stated that her IRs made her feel "really bad" and prevented her from enjoying the training experience, leading her to believe that she was "not good enough, not doing things right" because her supervisor "went out of her way" to let the participant know that the participant was not as good as expected.

Discussion of IR with others

Typically, participants had no direct discussion of the IR with their supervisor. For example, one participant stated that he "suppressed the heck out of it," and another simply stated that she did not discuss the IR with her supervisor. Only variantly were the IRs discussed with supervisors, as illustrated by the participant who described sharing with her supervisor that when she was having a hard time providing therapy, she "heard" what her supervisor had told her. Finally, the IRs were variantly discussed with colleagues or participants' own therapists. One participant, for instance, told his own therapist about his IR of his supervisor, and another described his IR experience with colleagues and friends.

Why IR occurred

Typically, participants believed that their IR experiences occurred because of their own self-doubt. For instance, one participant acknowledged that he was working with a client with significant need for "solid clinical advice," and the participant doubted his ability to deliver such advice as a trainee. In another case, a participant remarked that she did not know what to do, and so called upon someone who did via her IR. Variantly, participants asserted that their IRs occurred because of the nature of the supervision relationship. One participant, for example, experienced representations of the IR'd supervisor more than prior supervisors because of the supervisor's significant impact on the participant's development. Finally, participants believed that the IR experiences arose because of stress, as exemplified by the participant who stated that the IR occurred during a particularly stressful time in the program.

Duration of IR

Typically the IRs were quite brief, lasting only a few seconds (i.e. "the IR was fleeting," "a few seconds"). Only variantly did the IRs endure for a longer period of time (i.e. "about five minutes"). Variantly, as well, participants' reflection on the IRs lasted longer than the IR itself (i.e. "the feeling the IR evokes lasts longer").

Vividness of IR

Generally, the IRs were highly vivid. One participant commented that the IR was "intense," and several others rated them as at least a seven on a ten-point scale (where ten = high).

Spontaneous vs. intentional

Participants typically reported that these specific IRs occurred spontaneously (i.e. the IR "pops up," "it occurs so quickly, line an automatic thought").

Illustrative example

To illustrate the collective results, we created a composite example by using findings from a number of different cases; doing so also allows us to protect participant confidentiality. We focus primarily on general and typical findings.

"Sam" [pseudonym] was a 29-year-old, female, European American, clinical psychology doctoral student (PhD) who identified her theoretical orientation as both CBT and integrative. Most of her practicum experiences had been at VAs, community mental health centers, and university counseling centers. Sam had completed 10 academic terms of supervision and 230 individual supervision sessions, during which she was supervised by 10 supervisors. She had worked with the supervisor of whom she had the IR for 1.5 years at the time of the IR, and experienced the IR while still in supervision with this supervisor. "Dr W" [pseudonym], Sam's IR supervisor, was a female, European American, clinical psychologist (PhD) in her mid-40s who followed a psychodynamic orientation.

When discussing her overall IR experiences, Sam reported that she had been exposed to the concept of IRs during some of her practica. Some of the discussions at her practicum sites, for instance, mentioned "taking the supervisor with you" when working with clients, or "bringing the supervisor into the room." Sam's IRs took primarily an auditory form, in which she heard the "same kind of phrases" that her supervisor said to Sam in supervision sessions, or heard the stories her supervisor told her about what to do or say in therapy sessions. These IRs arose both spontaneously and intentionally for Sam: Sometimes, the IR occurred wholly unbidden; at other times, Sam deliberately invoked the IR. The IRs were stimulated by Sam's clinical work, such as when Sam wondered what her supervisor would say or do in a specific therapy situation. Sam used these IRs to enhance her clinical performance, with her IRs providing "a little nudge" to help her be open to doing something in a new way, or to take an appropriate clinical risk with a client. Sam believed that her IRs occurred as an inherent part of her development as a therapist: She acknowledged that she was "in transition" and developing as a person

and a therapist, and thus her IRs served as "transitional objects" and helped her feel more competent and less "like a fraud."

Sam then described a specific IR experience. She noted that she had a positive relationship with Dr W, characterizing their bond as "very close" and Dr W as playing "a very important role" in her life. In fact, Sam noted that Dr W was the most influential supervisor with whom Sam had worked, and that she had learned more from Dr W than she had from any prior supervisor. Their supervision sessions focused on Sam's skills and clinical interventions, including assessment, moment-by-moment processing, ethical dilemmas, and establishing rapport with clients. This specific IR, one that arose spontaneously, lasted just a few seconds, was quite vivid, and occurred as Sam was struggling with how to deliver very difficult news to a client and doubting her ability to do so in a therapeutic way. Sam heard Dr W saying to her, "Because you're there, it's better than it would be. It's still terrible, but you're making it better." The impact of this IR was quite positive: Sam felt calmed, realized that she was capable of delivering devastating news compassionately, began to trust herself more, and was better able to be "in the moment" with the client. In addition, Sam noted that the IR gave her "permission to be where [she] is" developmentally as she "came into her own" as a therapist, and that what she was offering as a therapist was "good enough." She likened the IR to a "transitional object" that she could take with her even after supervision ended, and stated that although she would eventually leave Dr W, she could take Dr W's presence with her in the future. Sam stated that she did not discuss this IR with Dr W.

Discussion

In focusing primarily on the strongest findings (i.e. general and typical categories), what story do these results tell? As depicted by the contextual results, participants' exposure to IRs occurred mainly in their off-site clinical placements. Their predominantly auditory IRs, which both spontaneously arose and were intentionally invoked, were stimulated by their clinical work, and were then used to guide that clinical work, and participants considered their experiencing IRs a normal part of their professional development. In the specific event findings, participants enjoyed a strong supervision relationship, and supervision itself focused on participants' clinical skills. The specific IRs, which were brief but quite vivid, most often took an auditory/verbal form, and usually arose spontaneously when participants were feeling clinically challenged or doubting themselves. The supervisors' IR presence was instructive and supportive, leading to the IR's beneficial impact. Participants rarely discussed the IR with their supervisor.

Such IRs, then, do seem to reflect participants' developing internal focus (Ronnestad & Skovholt, [20]; Worthen & McNeill, [24]) and absorption of supervisors' guidance (Geller & Farber, [9]; Geller et al., [10]; Laplanche & Pontalis, [16]; Romei, [19]), and also their experiencing of their supervisor as providing a safe holding environment (Bruss & Kopala, [3]; Ecklar-Hart, [6]; Friedman & Kaslow, [7]; Lampropoulos, [15]; Mollon, [17]; Watkins, [23]). Paralleling the findings yielded by the SRI (Geller et al., [10]), participants' IRs reflected supervisors' verbal presence; a presence that often arose when supervisees sought guidance during difficult clinical moments.

Intriguingly, however, participants reported little exposure to the concept of IRs outside of their clinical placements, a finding not reported in the extant literature. Although it is certainly reasonable that clinical experiences might indeed stimulate a discussion of IRs, such discussions might prove beneficial in the academic setting as well. A few participants, for instance, reported a sense of relief upon learning that their experiencing an IR of their supervisor was, in fact, not an unusual phenomenon, leading us to wonder if supervisees might experience anxiety when having IRs, especially when this phenomenon is frequently not directly discussed.

We also note that participants most often reported both spontaneous and intentional IRs, and that each helped them manage challenging clinical situations. When deliberately invoking an IR of their supervisor, participants wisely, and internally, reconnected with the counsel of a trustworthy resource, and found that doing so was indeed helpful. Thus, participants made use of an additional tool to benefit their clinical work.

Relatedly, we note the finding, one also not found in the extant literature, that participants' IRs were rarely discussed with supervisors. On one level, such a finding does make sense: If IRs are seldom addressed in participants' academic settings, participants may not have the awareness of the phenomenon, nor the language for such a conversation. As noted above, exposure to the concept of IRs did occur, however, in clinical placements, yet for some reason did not often lead to explicit discussion of participants' actual experience of the phenomena. We wonder if participants were concerned about how their supervisors might respond to the formers' admission that they experience the supervisor outside of supervision settings. If that were the case, supervisees may have feared that any potential benefit of such a discussion was outweighed by potential negative outcomes.

Although rare, a few participants acknowledged that their IRs did not yield positive effects. In two cases, for instance, participants described a tenuous supervision relationship and an equally difficult supervision process, from which they experienced their supervisor in the IR as a criticizing presence. Given that context, it is not surprising that IRs of these supervisors did not yield positive effects, once again illuminating the importance of the relationship in facilitating effective supervision.

These findings thus add to the literature by deepening our understanding of supervisees' IRs of their supervisors, and building upon the extant research. Our national sample is broader than that of much of the existing research, which focused primarily on psychodynamically-oriented participants on the US east coast, thereby allowing us to suggest that the results may translate to trainees in other geographic regions and of other theoretical orientations. Potential concerns about "priming" of participants are thus reduced. The findings here also enrich those provided by the SRI (Geller et al., [10]), for they capture participants' actual lived experience of the phenomenon, and as Geller himself suggested, illuminate how supervisees experience and use their representations. In doing so, we have indeed answered the research questions we posed with regard to the contexts, precipitants, and forms of IRs; their impact on supervisees; and supervisees' training related to IRs.

Limitations

Our sample consisted primarily of female, Caucasian/European American supervisees, and thus we do not know the extent to which the findings might apply to men neither to a more diverse sample, nor to those who are more experienced and fully credentialed. Participants reported a wide range in the number of individual supervision sessions, which may have affected their IR experiences. We also have only supervisees' perspectives here, and relied on their ability to describe their IR experiences in detail. Individual differences (e.g. personality, attachment style, developmental level as a clinician) may also affect participants' IR experiences, and we did not gather data regarding such potential influences. Participants received the protocol prior to the interview so that they could reflect on their IR experiences; those who received the protocol but chose not to take part in the study may have had different IR experiences.

Implications

These findings suggest several implications. First, most of these participants' IRs were quite brief. A few, however, reported IRs of a longer duration. What might explain such differences? And are different length IRs used differently by supervisees and yield different effects? This question merits further exploration.

Participants also reported experiencing both intentional and spontaneous IRs. As with the question regarding IR duration (see above), we wonder if IRs that are deliberately evoked vs. those that "pop up" have distinct antecedents, functions, and effects.

In addition, we note that participants reported little exposure to the concept of IRs outside of their clinical placements, and relatedly, that some expressed relief at knowing that such phenomena are not unusual. Given

these findings, we encourage those involved in training, both in the academic and clinical settings, to consider directly discussing the IR phenomenon with students/supervisees. Doing so may introduce a potentially helpful tool to trainees, while also preemptively allaying concerns that such experiences might be indicative of something awry in supervisees' development. Such discussions might be especially opportune for supervisors: In not only directly addressing, but also normalizing, IRs, they may plant a helpful seed in supervisees, one that supervisees may use when they encounter the inevitable challenges and doubts inherent in clinical work.

Finally, Romei ([19]) proposed that the importance and impact of supervisees' IRs may decrease over time. Although we did not query the evolution of participants' IRs over time, this is an intriguing question, and one worthy of empirical examination. Is there, for instance, a developmental component of IRs, such that more novice trainees more frequently experience and use IRs than do more seasoned clinicians? If so, how might supervisors directly make use of supervisee IRs in supervision itself? Ronnestad and Skovolt ([20]), however, described an experienced therapist referring to a supervisor of some 20 years prior as a continuing "fantasy mentor" (p. 25), suggesting that IRs may persist for quite some time, regardless of developmental level. The question of IR longevity thus also warrants further examination.

In conclusion, supervisees' IRs of their supervisors arise amid the inherent challenges of clinical work, and are then used to help supervisees meet those very challenges. Deemed by supervisees, a normal part of their development, the IRs also provide evidence of supervisors' positive impact even beyond the supervision hour. Despite the contributions of this study to our understanding of IRs, there is more to be learned about this phenomenon, and we encourage other researchers to continue to explore the IR experience.

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Appendix 1. Author biases

The authors shared their expectations and biases regarding the study's focus. Three of the four authors had had no exposure to IRs during their graduate training; one had exposure through seminars s/he pursued while in graduate school that were not part of her/his graduate curriculum. With regard to the authors' own experiences of IRs, all reported having experienced IRs, whether of friends, family, therapists, supervisors, or teachers/professors. These experiences were auditory, visual, and/or felt presence in form, and all were positively valenced. In terms of IRs of supervisors, the authors (as supervisees) recalled comparatively fewer such experiences. When they did occur, they primarily took auditory and/or visual forms, and were reported to be clinically useful; one author expressed surprise that s/he had not experienced IRs of her/his supervisors. The researchers examined their biases by checking themselves internally (e.g. were their interpretations of participants' data clouded by their own experiences?) and by openly questioning each other during data analysis (e.g. members challenged each other if they felt that biases were inappropriately shaping another's understanding of the data).

Appendix 2. Interview protocol

Thank you very much for your participation in this research on supervisees' IRs of their supervisors. Such representations may take different forms in evoking the felt presence of the supervisor in her/his absence. For instance, some people hear the words of their supervisor or imagine their supervisor listening to their own (i.e. the supervisee's) words, and others experience a visual image of their supervisor. Still others experience neither an auditory nor visual component, but experience the presence of their supervisor in a physical or bodily way. It is also possible that people experience an IR of their supervisor in ways that we have not described here. Any representational form, alone or in combination, is fertile territory for this research.

Participants must be clinical or counseling psychology doctoral or postdoctoral students in the US who have experienced an IR of their supervisor. In addition, they must have completed at least two academic terms of clinical practicum, and at least two academic terms of practicum supervision as a supervisee. Finally, they must have worked with the supervisor of whom they had the IR for at least three months.

All information will be kept completely confidential by assigning each participant a code number and deleting any identifiers.

Opening questions

- What, if any, exposure to the concept of IRs have you had in your training?
- Describe in general terms some of the IR experiences you've had:
- Overall experiences of IRs.
- When and where do they occur?
- Are there certain circumstances that seem to elicit IRs more than others?
- What, if any, pattern is there in these IRs?
- Why do you think you have these IRs?
- Are these IRs deliberately invoked, or do they occur spontaneously?

- What was the impact of the IRs?

Specific IR of SR questions

- Please describe the relationship you had with the internally represented SR.
- In general, what was the focus of supervision with this SR?
- Now focusing on one specific IR of this SR:
- Please describe the IR itself.
- What do you recall was happening immediately prior to the IR?
- What was the impact of the IR?
- What meaning did you make of the specific IR?
- Why do you think you had this particular IR at this time?
- What, if any, discussion did you have about this IR?
- If you've had more than one IR of this SR:
- What, if any, pattern is there in these IRs?
- Why did you select this one to discuss?
- What are your thoughts about why you had multiple IRs of this one SR?
- Details of IR: duration of IR, frequency of IR, vividness/intensity of IR [scale of 1 (low) - 10 (high)?], spontaneous or deliberately invoked.

Closing questions

- Given what you said above regarding previous exposure to the concept of IRs, what, if any, influence has that exposure to IRs had on the specific IR event you discussed?
- Based on your experiences of IRs with this SR, what would you want others to know about IRs?
- Demographics of Supervision: How long worked together in sup; when specific IR occurred; clinical setting of sup; SR demographics (gender, age, race, ethnicity, theoretical orientation, degree).