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# Empathy, Ethics, and Empowerment: Supervising the Transpersonal Therapist

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## Supervising the Transpersonal Therapist

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This grounded theory study addressed the question What model explains the essential qualities, skills, and competencies of an effective supervisory relationship for transpersonal therapists in training? It emerged out of a recognition that current training models for supervisors were not inclusive of competencies to address the needs of therapist trainees who are oriented toward a transpersonal approach to psychotherapy. The results of 22 interviews with trainees and supervisors surfaced a fundamental tension within the supervisory relationship in the distinction among the primary responsibility of the supervisor for ensuring client welfare, and encouraging supervisees to develop their personal therapeutic orientation and the self of the therapist. Emergent themes describe the nature of a supervisory relationship that encourages development of all of the gifts of the therapist while training for competence.

*Keywords: supervision, transpersonal therapy, holistic, therapeutic relationship, mental health, spirituality*

There are many dimensions to the roles and responsibilities of a clinical supervisor, including consultant, mentor, coach, and instructor (Caldwell, 2016; Falender & Shafranski, 2021). Given that the art and practice of psychotherapy are foundationally an intimate, human transaction, the interpersonal nature of supervision can be a powerful venue for the training of psychotherapists (Palomo et al., 2010). As the cornerstone of training mental health clinicians, supervision serves the twin functions of developing trainee competence while ensuring client welfare (Crunk & Barden, 2017).

In conducting research on supervisory models, little to no specific research was evident for theoretical models or guidance for supervisors working with therapist trainees who are transpersonally oriented. This is not surprising given that many new models and approaches to psychotherapy have emerged in the past two decades. What this absence suggests is that models of supervision have not kept pace with recent expansion of therapeutic approaches (Clarke et al., 2015; Kaklauskas et al., 2016). The limitation in models of supervision speaks to a need for a specific focus on supervision of transpersonal

psychotherapists and provides the rationale and motivation for this study. The grounded theory study described here emerged out of a necessity to explore the experience of therapist trainees, interns, and associates who are oriented toward a transpersonal approach to psychotherapy and in need of competent supervisors who are in alignment with, or at least sensitive to, their therapeutic aspirations. Prior to describing the details of the study, an overview of supervision models will be presented along with a detailed description of transpersonal psychotherapy.

Research on the efficacy of mental health treatment is challenging owing to the varied theoretical orientations and therapeutic approaches to treatment. Because of this variety, research has frequently targeted the features common to all treatment methods (Wampold, 2015; Wampold & Budge, 2012). The development of a *common factors* approach to therapeutic treatment evolved from research suggesting that various approaches to psychotherapy resulted in equivalent outcomes. These findings prompted a shift in focus away from determining the differences in clinical approaches to what treatments had in common, independent

of theoretical approach. Wampold's landmark 2001 study revealed that, rather than specific clinical techniques, the relational components of the therapeutic alliance accounted for more variability in treatment results (Lambert & Barley, 2001; Wampold, 2015; Norcross & Lambert, 2018). "The relational ambience of psychotherapy and responsiveness to patients prove typically more powerful than the particular therapeutic method or strategy" (Norcross & Wampold, 2018, p. 1892). It can be challenging to distinguish the variable of treatment effects from relational effects, making outcome research for a particular treatment method challenging. Relational issues that affect positive outcomes are qualities such as therapeutic resonance, collaboration, positive regard, genuineness, and empathy (Norcross & Lambert, 2011). Beyond the therapist/client relationship, additional factors that seem to influence therapeutic outcomes are issues directly related to the client and the environment; placebo, hope, and expectancy factors; and techniques of the various therapies (Crunk & Barden, 2017).

Though there are challenges by some researchers to common factors research and the primacy of relational factors over specific techniques, the therapist/client relationship must be a central focus of the supervision process, since the impact of that relationship is linked to outcome success (Norcross & Wampold, 2018). Wampold and Budge (2012) defined three relationship pathways that are the primary mechanisms of change:

> The first pathway involves the real relationship between therapist and client. The second pathway works to create expectation through explanation and treatment. The third pathway uses the specific ingredients of treatment to induce the client to participate in healthy actions. (p. 604)

If this premise is taken as a starting point, development of a trainee's therapeutic skill should involve the ability to create a working relationship of trust, safety, and develop client motivation and expectancy.

Given the multiple sources of evidence that indicate that "the person of the psychotherapist is inextricably intertwined with the outcome of psychotherapy" (Norcross & Lambert, 2018, p. 307),

it seems logical then that the relationship between supervisor/supervisee would be an ideal crucible or medium for trainee development. Milne (2006) made a case for extrapolating from psychotherapy to supervision. He identified the parallels between the therapeutic relationship and supervisory relationship by identifying the common areas of overlap and the features evident in both. In contrast to therapy, the supervisory relationship is often involuntary, and the hierarchy or power differential is focused on training and competence. There is more disclosure on the part of the supervisor than by a therapist to a client, and the supervisory relationship becomes more collegial as it progresses. The role of evaluation is unique to the supervisory relationship in that gatekeeping of the profession is an additional goal of supervision. The goal is not the diagnosis and treatment of the supervisee, but to utilize the relationship to model and explore the potential for therapeutic alliance with a client and to empower that relationship.

MacKay and Brown (2014) pointed out that some aspects of the supervisor/supervisee relationship are collaborative in nature, while others require elements of direct instruction. In support of this, Palomo et al. (2010) found a similar distinction in the development of the Supervisory Relationship Questionnaire. Validation of the measure revealed that the strongest three of the six subscales related to the strength of the supervisory relationship, with the remaining three subscales emphasizing education and modeling. A goal of the relationship should be supervisee *differentiation of self* (MacKay & Brown, 2014) defined as "the capacity to think, feel and act for self while in connection with important others; and it includes the capacity to integrate both thinking and feelings to assist in self-regulation" (p. 329). In a study by Noor (2019), a more authoritarian style on the part of the supervisor was associated with a lower degree of supervisee differentiation of self. It is expected that ongoing differentiation of the clinician will continue beyond supervision, given that therapists are encouraged to maintain ongoing peer supervision throughout their career.

Much more attention has been given to the training of psychotherapists and other mental health clinicians than that of their supervisors (Granello et

al., 2008), and there is an absence of convincing evidence that one model is more effective than another (Crunk & Barden, 2017). Given the obvious parallels between the therapist/client relationship and the supervisor/supervisee relationship, it has been tempting to construct models of supervision that mirror the same. Early models constructed supervisory approaches as an extension of approaches to therapy. Thus, supervision for psychodynamic therapy would focus on countertransference and projections, and supervision for cognitive behavioral therapy would emphasize the trainee thought process and schemas (Palomo et al., 2010). Watkins et al. (2015) identified three broad approaches to supervision. Psychotherapy focused approaches emphasize competence in a specific treatment modality, such as humanistic, psychodynamic, or cognitive. Developmental models of supervision focus on the developmental needs of the supervisee and the growth process across several stages of development. Social role or process approaches identify the learning needs of the supervisee, and the supervisor assumes the appropriate role to meet that need, such as mentor, teacher, or coach (Crunk & Barden, 2017; Watkins et al., 2015; Watkins & Milne, 2014).

Given the value of identifying common factors that support positive outcomes among therapeutic approaches, it is tempting to apply a similar approach to identify the shared elements across various models of supervision. This effort has precipitated a search for common factors as the "core ingredients (most of which are relationship factors) that are transtheoretical, being shared across different supervision perspectives. Some common supervision relationship factors are the supervisory (or learning) alliance, real relationship, empathic understanding, and instillation of hope" (Watkins, 2016, p. 216). Rather than highlighting differences, there is a need to identify the effective elements from various models into a cohesive approach that also integrates the specific elements of a supervisory model (Crunk & Barden, 2017). Falender and Shafranske (2012) have promoted the importance of a competency-based approach to supervision, with an emphasis on identifying and teaching the knowledge, skills, and attitudes that includes ongoing competency assessment.

Traditional psychotherapy treats psychopathologies and mental conditions within the framework of ego development (Johnstone et al., 2018). A clinician will diagnose the client against a pre-established model of mental disorders or pathology and apply a treatment. A variety of evidence-based interventions are utilized to help the client achieve a level of functionality in cognitive and emotional development and interpersonal relationships. They may target mood disorders, substance abuse, traumatic experiences, and relationship challenges. Many training programs for psychotherapists are based on a medical model of therapy, using the *Diagnostic Manual of Mental Disorders* 5th edition (DSM-5; American Psychiatric Association, 2013*)* as the primary diagnostic tool. For example, the National Licensing Examination for Marriage Family Therapists uses the DSM-5 as the primary diagnostic tool. A significant feature of the medical model is that human pathology is understood to be confined to the individual and focuses on biological explanations and cures (Johnstone et al. 2018). Less emphasis is placed on environmental, contextual, and cultural factors that contribute to mental distress. Spiritual emergence is only addressed peripherally and symptoms of spiritual emergency are commonly pathologized (Kaminker & Lukoff, 2015).

Transpersonal psychotherapy makes different assumptions about the nature of the psyche and models of human potential and pathology than traditional approaches (Grof, 1998), taking a holistic approach to the psyche that includes all dimensions of human experience including the perinatal and transpersonal. Transpersonal psychotherapy places consciousness at the center of human experience (Rodrigues & Friedman, 2015). The conscious, unconscious, and collective unconscious dimensions of experience may be explored in addition to spiritual or transcendent states of consciousness. Rather than pathologize spirituality, transcendent states, or exceptional human experiences such as psi phenomena and visions, such experiences are considered worthy of attention and central to mental health treatment (Kaminker & Lukoff, 2015). Transpersonal psychotherapists also focus on personal growth,

integration, and development beyond the rehabilitation of mental distress (Wall et al., 2015).

It is also important to note that transpersonal psychotherapy is not a prescriptive set of techniques or approaches to diagnose and treat specific pathologies. All techniques are used in the service of personal healing, wellness, and growth at a transpersonal or holistic level. Training for transpersonal psychotherapists involves having the therapist experience the techniques with the goal of focusing on personal growth of the psychotherapist as a way to enhance professional efficacy (Rodrigues & Friedman, 2015).

Trends in mainstream psychological approaches being utilized by therapists have recently opened into more transpersonal territory (Kaklauskas et al., 2016). Mindfulness, originally a meditation technique associated with certain spiritual systems, has become a household word in therapeutic circles and is integral to Acceptance and Commitment Therapy, Mindfulness-Based Cognitive Therapy, and Self-Compassion Based Mindfulness (Yi, 2017). Recognition of the value of psychedelic substances is transforming options for treating trauma and addiction as well as enhancing spiritual development (Grob & Grigsby, 2021). Ecotherapy, somatic approaches to mental health, and spiritual approaches to the treatment of trauma, all of which have been within the purview of transpersonal psychotherapy for many years, are becoming more common (Buzzell & Chalquist, 2009; Vieten & Lukoff, 2022). In recognizing a wider context for human behavior, transpersonal psychotherapy also recognizes the contribution of Indigenous approaches and the role of culture, colonialism, and social construction to mental health (Lucana & Elfers, 2020). These trends in therapeutic practice have increasingly distanced the discipline from a medical model of mental health, maintaining an openness and preference for alternative approaches. These emerging trends also hold profound implications for the education and training of transpersonal psychotherapists and, in particular, the pivotal role of supervision.

Training in diversity and multiculturalism for psychotherapists has become more prominent, with an increasing recognition of the role of psychosocial determinants of mental health that plague margin-alized populations (Caldwell, 2016; Falender & Shanfranske, 2021; Lassiter et al., 2008). However, training in the role of spirituality and religion lags behind a focus on multicultural competence (Allen-Wilson, 2016; Hage et al., 2006; Shafranske, 2014; Shafranske, 2016, Vieten & Lukoff, 2022). Questions about religion or spiritual history and experience are rarely part of client intakes or assessments. The field of transpersonal psychology is one exception, where transcendent experience and religious history have a more central role. "Spiritual and religious background, beliefs, and practices (SRBBPs) are an important aspect of most people's psychological functioning, and a robust body of evidence indicates that SRBBPs play a role in psychological well-being" (Vieten & Lukoff, 2022, p. 3).

As the profession and clientele of psychotherapy become more diverse, a focus on cultural issues, including spiritual and religious practices, is critical (Hall et al., 2004; Lassiter et al., 2008). In terms of training, supervisees would be expected to examine their personal biases and presuppositions about gender, race, culture, and ethnicity (Caldwell, 2016). Lassiter et al. (2008) found evidence that peer-group supervision focused on multicultural issues was successful and concluded that training must be more than a surface endeavor, involving self-reflection and practice through roleplay. Frazier and Hansen (2009) found that "the greater the practitioners' religious/spiritual self-identification, the more likely they were to report using these behaviors in psychotherapy" (p. 81). Shafranske (2016) noted that, in general, psychologists are less religious than the average person in the general population. He emphasized the importance of supervisors creating a safe space for supervisees to explore their personal relationship to spirituality and include the "clinical competence and skills…required to foster the creation of a supervisory relationship in which the spiritual dimension can fully be considered for the benefit of the client" (p. 21). In developing the Spiritual Issues in Supervision Scale, Miller et al. (2006) asserted that the *self of the therapist* is critical to the training of clinicians and the spirituality of the therapist should be a part of the supervisory process. They found that spirituality and multicultural diversity

intersect on multiple levels, from the experiential to the existential, and spirituality may have a positive impact on the way clinicians approach diversity. Thus, they placed exploration of the trainee's spirituality central to the supervisory relationship.

## Methods

This study explored the status of clinical supervision in the training for licensure of transpersonal psychotherapists and sought to identify best practices for incorporating supervision into existing models. This study addressed the question *What model explains the essential qualities, skills, and competencies of an effective supervisory relationship for transpersonal therapists in training?* The specific method employed to answer this question was constructivist grounded theory as defined by Charmaz (2014, 2021). Transpersonal psychotherapists in training and supervisors were interviewed about their experience with supervision using a semi-structured interview protocol. An additional protocol was used for supervisors.

Grounded theory as a qualitative method is appropriate when little is known about a topic and there are no existing theories to explain processes or relationships, making it an ideal method for this study (Lyons & Coyle, 2016). Constructivist grounded theory employs an inductive approach to theory development that incorporates the subjectivity of the researchers and is grounded in the data rather than employing hypothesis testing (Charmaz, 2021). Given that the researchers are both transpersonally oriented psychotherapists and have over a decade of experience as supervisors, their subjectivity was an asset to all phases of this study, including theory-building.

### Participants

Two groups of participants were recruited for this study. The first were current trainees (*n* = 14). Inclusion criteria for this group included (a) an active therapist trainee currently gaining hours toward licensure, and (b) self-identifying as having a transpersonal orientation to therapy based on the definition of transpersonal psychotherapy described above. The second group was currently active supervisors of trainees (*n* = 8). Inclusion criteria for this group included (a) currently active as a

supervisor of therapist trainees, (b) a minimum of five years of supervision experience, and (c) self-identifying as having a transpersonal orientation to therapy and supervision based on the definition of transpersonal psychotherapy described above. None of the supervisors interviewed were in an active supervisory relationship with a trainee in this study. It is important to note that supervisors also shared their experience as a trainee being supervised and how this informed their later approach to supervision and these data were included in the study.

Of the 8 supervisors, 5 identified as women and 3 as men. Ages ranged from 41–55 (*n* = 6), and > 55 (*n* = 2). The clinical licenses held were LMFT (*n* = 5), LCSW (*n* = 2), and Clinical Psychologist (*n* = 1). Ethnic identification was Asian (*n* = 2), Indigenous (*n* = 1), and White (*n* = 5).

Of the 14 trainees interviewed for the study, 12 identified as women, 2 as men. Ages ranged from 25–40 (*n* = 8), 41–55 (*n* = 3), and > 55 (*n* = 3). The clinical licenses being pursued were LMFT (*n* = 9), LPCC (*n* = 4), and Clinical Psychologist (*n* = 1). Ethnic identification was Asian (*n* = 1), Latino (*n* = 2), Jewish (*n* = 1), Black, (*n* = 2), and White (*n* = 8).

### Recruitment

Participants were recruited through referrals from professional colleagues and instructors in university programs training marriage family therapists, clinical social workers, and professional counselors. The researchers contacted colleagues to solicit the initial referrals and then used snowball techniques for additional recruitment. Grounded theory does not strive to be representative of a population in order to generalize. Rather samples are chosen strategically to widen and deepen the lens on the topic of investigation. Initial participants were chosen based on inclusion criteria. Later participants were solicited based on inclusion criteria plus specific professional experience with supervision either as a supervisor or trainee. For example, supervisors who were employed by non-profit agencies were recruited for that specific background.

### Procedure

Potential candidates were contacted by phone and email. A screening interview was conducted with each candidate who were subsequently enrolled based on a willingness

to participate in a one-hour interview. Informed consents were signed guaranteeing confidentiality and secure protection of the data. Interviews were conducted over a secure videoconferencing system (Zoom: see: https://zoom.us/legal for the privacy policy) and audio files and transcripts were password protected. If additional information or clarification of the interview data was needed, participants were contacted for an additional brief interview. Completing the interview fulfilled the participant requirements for the study.

The semi-structured interview protocol for psychotherapist trainees gathered demographic data in addition to (a) details about the relationship with the assigned supervisor; (b) nature of the relationship in terms of quality and support; (c) supervisor availability; (d) supervisor orientation to psychotherapy; (e) development of self of the therapist, personal disclosure, intuition, somatic approaches, and spirituality; and (f) ethical issues. Both supervisees and supervisors ($n$ = 22) responded to questions from the trainee protocol since all had experience being supervised in the profession. Supervisors responded to an additional protocol of semi-structured questions that gathered data on (a) training as a supervisor, (b) theoretical orientation to supervision, (c) role and nature of the supervisor/supervisee relationship and disclosure, (d) therapeutic orientation, and (e) supervisor support.

**Treatment of Data**

Data for this study were limited to interview transcripts of the 22 participants. All interviews were audio-recorded and transcribed by the researchers. Participants chose individual pseudonyms to protect their identity and these were used throughout the analyses. Open coding and memo-writing were conducted using DeDoose© (version 9.0.81) qualitative data analysis software. Coding of transcript data was conducted after each interview and was continuous throughout the duration of the study creating ongoing iterations between analysis and data collection. Different codes were used for trainee interview data versus data from supervisor interviews that focused on supervisory experience. Coding data in this way was a heuristic device that simultaneously allowed the researchers to broaden their understanding and

conceptualize the data in a new way (Charmaz, 2014, 2021; Lyons & Coyle, 2016).

As recommended by Charmaz (2021) open coding was followed by a round of focused coding, designed to identify the relationships among and codes. In order to prepare for the final phase of theoretical coding, time was spent in identifying the nuances of the multiple relationships inherent to the therapeutic and professional relationships among client, therapist trainee and supervisor. There were multiple overlapping intersections among these relationships and these needed to be carefully studied and organized in preparation for theoretical coding. The technique of constant comparison was employed during this phase to tease out these relationships as they were decontextualized and grouped into broader categories for theoretical analysis (Vann-Ward et al., 2021). Constant comparison also guarantees that the emergent theoretical model was grounded in the data (Lyons & Coyle, 2016).

Several possible schemas for the organization of a visual model and theory were considered until the most elegant and visually simple one emerged. The categories, subcategories, and theoretical model constructed from this process are presented next along with direct quotes from participants to provide necessary evidence.

## Results

Table 1 summarizes the major categories of codes that emerged from the interview data. These overall findings are organized under the categories that reflected a *supervisor/supervisee relationship* and the critical importance of *self of the therapist*, *ethical concerns*, and *supervisor supportive behaviors*. The number of participants contributing to each category are presented along with the percentage of total codes.

The first category was labeled supervisor/supervisee relationship and had two subcategories: feelings of safety and unhelpful supervisor behaviors narrative. The second category was labeled self of the therapist and had two subcategories: developing therapeutic orientation and limited supervision focus. The third category was labeled ethical concerns and had three subcategories: DSM

diagnosis: medical model, systemic issues and concerns and discouraged about the profession. The fourth category was labeled supervisor supportive behaviors and had seven subcategories: multicultural context in therapy, therapist attempt at empowerment narrative, incorporating transpersonal themes and approaches, intuition narrative, mind-body narrative, spiritual orientation narrative, trainee self-identified helpful attitudes, and dealing with challenges.

Figure 1 presents a visual image that describes the study's findings in relation to the research question: *What model explains the essential qualities, skills, and competencies of an effective supervisory relationship for transpersonal therapists in training?* Moving from left to right, the figure first illustrates the collaborative relationship between supervisor and therapist in training, describing the roles and competencies that define that relationship. The supervisor may represent a particular therapeutic tradition and lineage, as well as being a professional representative of licensing boards and the profession as a whole. The tradition and mentoring of the supervisor will also have implications for passing on that same lineage as a trainee matures in the profession and, if they choose to become a supervisor in the future, and pass that wisdom forward. Several supervisors in this study commented that they benefited from the modeling of their supervisors and used that as a foundation for their own technique in supervision.

While assuming many roles and developing trainee competence, the care and concern of the supervisor extends to the client where safety and ethics are the primary concern. This is accomplished through the intimate nature of the supervisor/supervisee relationship that supports the trainee in the embodiment of the knowledge,

skills, attitudes, and competencies for becoming an effective therapist. Cultural competence and self of the therapist are critical areas that were often neglected for participants in this study. Finally, Figure 1 demonstrates that the supervisor/supervisee relationship has a direct impact on client growth and development through the ability of the therapist to form a strong working relationship and supporting the client's growth and transformation.

### Category 1: Supervisor/Supervisee Relationship

The findings of this study surfaced a central tension in the supervisor/supervisee relationship. This tension rests in the distinction between the primary responsibility of the supervisor for ensuring client safety and welfare, and the importance of encouraging supervisees to develop their personal therapeutic orientation and the self of the therapist. One supervisor participant, Barry, noted that ultimate focus on the welfare of the client must be a central guiding and defining feature of how the relationship unfolds, and it demands adherence to legal and ethical practices. In this regard, it is vital to acknowledge the authority of the supervisor's role, since an associate works under the clinical license of the supervisor. Some trainees were intimidated by the authority, and thus supervisors need to be conscious of how they embody their role and position, and use it for the good of the client, but also not go overboard into authoritarianism. How supervisors managed this tension between a posture of authority, safety, and adherence to a specific therapeutic model, and guiding the trainee in nurturing their individual gifts and therapeutic orientation, was a primary determinant of perceived satisfaction on the part of supervisees.

In general, transpersonal supervisors interviewed for this study stressed that they encouraged supervisees to develop their

| Categories | Supervisor/ Supervisee Relationship | Self of the Therapist | Ethical Concerns | Supervisor Supportive Behavior |
|---|---|---|---|---|
| Participants Contributing | 100% (*N* = 22) | 86% (*n* = 19) | 81% (*n* = 18) | 91% (*n* = 20) |
| % Total Codes | 12.8% | 28.7% | 25.3% | 38.4% |

**Table 1.** *Code Categories from Qualitative Data*

therapeutic orientation and supported them in that endeavor. Once fundamental therapeutic skills were in evidence, inviting trainees to creatively and intuitively explore approaches that interested them was important. This was consistent with also supporting the self of the therapist as a way to grow in the profession. A supervisor participant, MCL, articulated this tension in commenting on the importance of meeting supervisees where they are:

> I would characterize that relationship as fluidity, constant fluidity of roles in terms of sometimes being mentor, teacher, sometimes being colleague, sometimes therapist, sometimes people use the word healer. It can be very professional, and it can be very personal.

There was consensus among supervisors and supervisees that there should be initial transparency regarding the supervisor's background and approach to therapy and supervision, especially around therapeutic assumptions implicit in their work. Participants also felt it was important to acknowledge cultural and diversity differences and name those. As Tawny shared: "Naming the humility that I have, being a white, middle-aged woman, was essential to creating an open and transparent working relationship with supervisees."

Utica shared that while he has a liberal and permissive supervision style, he expected his supervisees to come to a session on time and, if late, to provide notice ahead of time. He also expected his associates to be prepared and ready to present their most challenging cases in the session. Other supervisors expressed a clear expectation that their supervisees be prepared and present. Issues such as supervisees being distracted by cell phones or multitasking during virtual supervision were considered detrimental to the relationship.

Both supervisors and supervisees pointed to the important role of self-disclosure as a way to model therapy. MCL noted, "I think personal self-disclosure is powerful, especially if it involves how
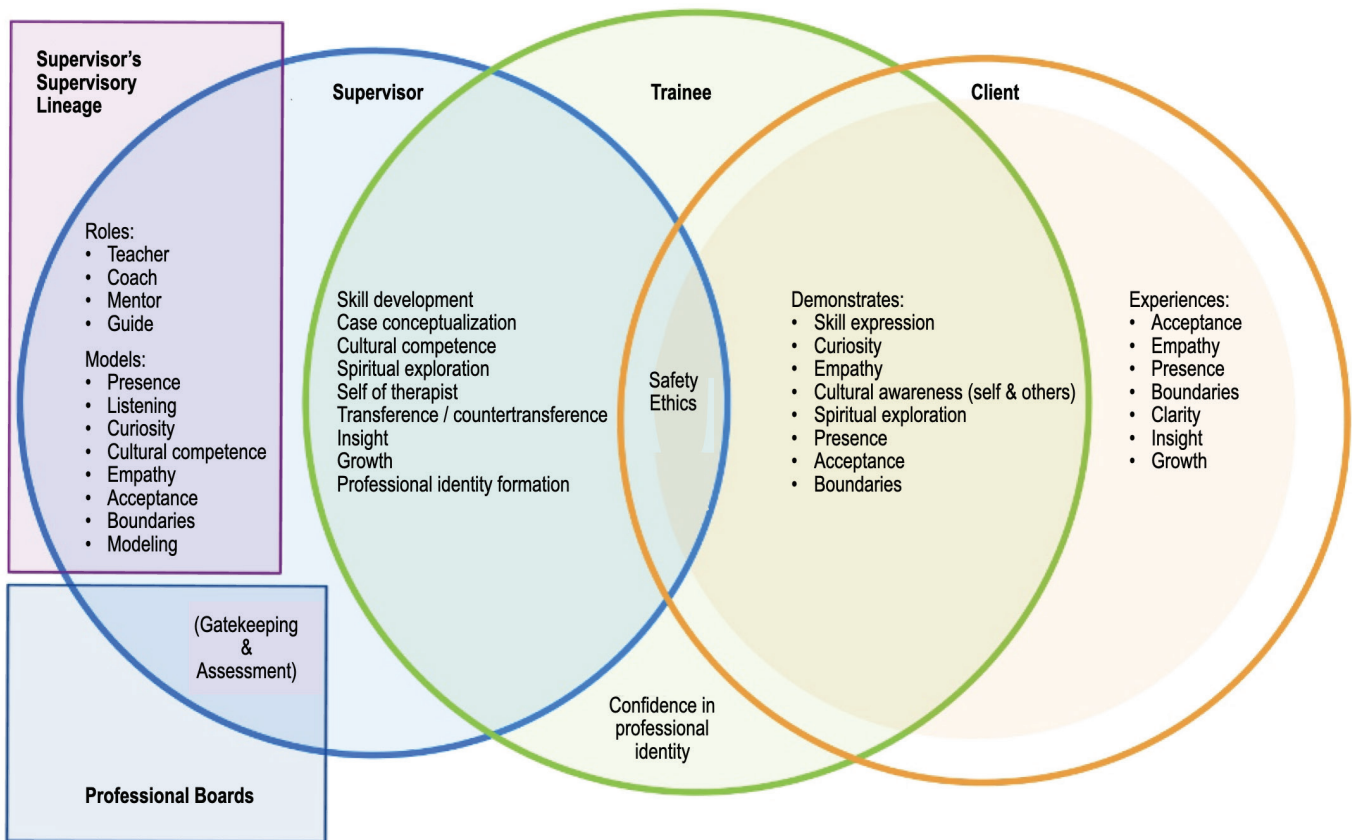


**Figure 1.** *Transpersonal Supervisor / Supervisee Collaborative Relationship*

you failed and what sort of parts of the problem, how did you piece that back together, and how did you move forward." To model that it is okay to make mistakes, MCL shared, "I will often disclose clients that I've messed up with and to talk about that whole process." Similarly, Barry noted that some of the feedback he received from former supervisees was that self-disclosure was some of the most beneficial features of supervision.

### Feelings of Safety

A subcategory that emerged throughout the interviews regarding the supervisory relationship was the importance of safety. Safety was understood as the experience of comfort and acceptance to ask questions, voice opinions, share ideas, express emotions in response to client interactions and outcomes, and take risks in trying new skills without fear of negative repercussions or judgment.

For many supervisees, the supervision sessions were described as an unsafe place to explore who they were becoming as clinicians, with examples ranging from unprofessional behaviors to dismissal of supervisee questions. Koan described safety in the supervisory relationship as the most valuable part of her experience and offered contrasting experiences with her current and previous supervisors. Of her current supervisor, she noted, "The safety for me . . . is to be able to ask for what's needed, to say, I don't understand or, can you guide me through this, or what am I seeing here?" She contrasted this to her experience with a previous supervisor:

> I had to protect myself every time I went into session. There was not a time where I didn't have to. She did not have boundaries; whether it was the way she dressed, or emotionally, or physically there were many times she was in my face. Many times she called me names. It didn't feel like a very safe space to explore your development.

Supervisees unanimously agreed that feeling safe in the context of the supervisory relationship was an essential element of effective supervision. However, many noted that they did not experience safety with many, if any, of their supervisors, noting that often supervisors would be outwardly dismissive of questions, sigh loudly, or watch the clock throughout the supervision hour. One supervisee noted: "The message I received was, this was burdensome being a supervisor."

### Unhelpful Supervisor
### Behaviors Narrative

Supervisees described a litany of supervisor behaviors that were unhelpful, with some bordering on the unethical:

- "Clinging to me in social situations."
- "She spoke for me a lot. She did not have good boundaries."
- "I had to protect myself every time I went into session."
- "She disrespected my graduate school."
- "Sitting with her feet up, chewing gum, and blowing bubbles through half of the supervision session."
- "Going through the motions and signing off hours."
- "I was expected to adjust my treatment plan and notes to expedite billing."
- "My supervisor was vaping during sessions, and I was breathing in all of the smoke."

Ann noted a missed opportunity for a therapeutic alliance. She was expected to provide the correct answers and would be judged for anything nontraditional: "In order to be taken seriously, I had to conform to that way of thinking." In order to truly address client needs Luna noted, "What [the clients] need is your approach and intervention aligned with their needs, their beliefs, their values. But we were trained to follow the protocol."

### Category 2: Self of the Therapist

A second primary category of issues around self of the therapist emerged from the data, along with several subcategories. Self of the therapist is awareness of the therapist's internal process. This is also referred to as person of the therapist, which Norcross and Lambert (2018) cited as critical to the outcome of psychotherapy. This includes the therapist's ability to reflect on somatic and inner experience in the context of the therapeutic relationship, recognize the presence of countertransference, and be aware of biases and potential blind spots in their work with clients.

Practical self-of-the-therapist work supports the therapist in developing presence and fostering effective relationships with their clients. Self-of-the-therapist work seemed to be most present within transpersonal supervision and notably less present in supervision within the framework of the medical model settings. Supervisees reported that the lack of self-of-the-therapist themes in their supervision presented a significant gap in their training and professional development.

When self-of-the-therapist work was included in the supervisory dialogue, supervisees expressed feelings of gratitude, hope, and inspiration, both in their work with clients and in the profession. They described feeling more confident in their ability to be with clients and navigate a greater variety of presenting issues. Supervisees also noted experiencing greater self-awareness that helped facilitate more effective self-care, supporting the prevention of burnout in their work.

Supervisees who did not receive much, if any, self-of-the-therapist work noted this as a gap in their learning and professional development. Some supervisees chose to explore this personal/professional development area independently outside of assigned supervision through reading, peer support groups, and additional education.

### Developing Therapeutic Orientation

Developing a therapeutic orientation both in conceptualization and skill formation is an essential component of the clinical supervision process for the aspiring therapist. A transpersonal orientation holds qualities of the client's spiritual dimensions and human values as essential elements in the facilitation of healing and growth. What emerged from the interviews was a common theme of experiencing a lack of either knowledge of this therapeutic orientation, or dismissal of transpersonal psychotherapy as a valid or relevant approach to working with clients. Supervisees expressed feeling as though they were unable to discuss, seek support, or explore transpersonal themes in supervision and voiced feeling less confident in their skills and ability to identify as a transpersonal therapist. The experience of being required to learn and adhere to a particular framework was common. For example, Barry described his supervision experience as "more like they were training me in their particular style." Joan shared, "I felt this pressure like in order to be taken seriously, I had to conform to that way of thinking."

Some supervisees voiced positive experiences in supervision regarding their therapeutic orientation. For example, Tawny asserted that her supervisors "helped me kind of put some frames and theoretical frame around what I was doing and how I was applying it clinically in my work." In addition to exploratory guidance regarding theory and application in session, modeling and supportive resources emerged as beneficial in developing theoretical orientation. For example, supervisees expressed feeling inspired and supported when a supervisor would bring in a journal article or supplemental reading that pertained superficially to a client case or theme.

### Limited Supervision Focus

Supervisees discussed gaps in their supervision experience, noting limitations in what was addressed or available in their supervision sessions. Some voiced notable neglect of the self-of-the-therapist work or themes in their supervision, expressing a dominance in focusing primarily on client diagnosis. Some supervisees noted that consideration of the therapist's role in the therapeutic process was seldom, if ever, acknowledged in supervision when discussing cases. Anne noted, "it was almost as if in a lot of cases I was not in the room."

Supervisees described that supervision focus tended toward clinical diagnosis and pragmatic agency goals over exploring interventions, transpersonal themes, skill development, spiritual, or cultural considerations. They expressed that the limited focus in supervision resulted in gaps in cultural awareness, therapeutic knowledge and flexibility, skill development, and professional growth. For example, Luna noted that during her graduate school supervision, "two supervisors were very helpful clinically, but anything in the transpersonal realm was outwardly dismissed."

Experiencing a limited range of clinical approaches in supervision was common across supervisees as evident in the following responses:

- "There was a piece there where there wasn't a lot of support for anything other than focusing on cognitive-behavioral intervention. The whole system was based around that. I was just kind of learning their models, which is fine, but I would say, something was missing because of that."
- "They were great in CBT [Cognitive Behavioral Therapy]. Oh yeah. And that was the extent of what they sort of had in their toolbox."
- "The supervision I've gotten through actual employment was very structured . . . you didn't really get to voice a lot of the things that you were dealing with because there was an agenda already in place."
- "We only learned how to diagnose, the cycle, the mental disorders, or with DSM-5 [Diagnostic and Statistical Manual of Mental Disorders, 5th edition]. They will talk about the theories, but not the practical thing. Because the supervisor doesn't know that."
- "They're just focused on skills and hours and doing all the things, but not to really keeping in touch with self and, and self-care as well."
- "We would always focus more on the Eurocentric part of therapy."

**Category 3: Ethical Concerns**

Issues related to ethical concerns was a third major category that emerged from the data. The discussion and modeling of ethics is an essential component of effective clinical supervision. The practice of supervision is designed to ensure that new therapists are providing services competently and ethically, and that interventions are not resulting in harm or violation of the client. While ethics in clinical practice includes clinical interventions and skills, it also includes areas of documentation, confidentiality and consent practices, and legal practices. Participants universally expressed the importance of ethical awareness in practice and supervision. However, some supervisees noted that ethics were seldom addressed in their supervision sessions. Supervisees mostly expressed this in the context of the limited cultural awareness of the supervisors.

Ethical concerns expressed by supervisees included questionable agency practices, particularly regarding referrals, diagnostics, medications, and employee expectations, as well as poor boundaries in the supervisory relationship:

- "I felt like I was the therapist a lot of the time. To me, [as a supervisor], you don't come to session saying I'm suicidal right now."
- "It wouldn't be uncommon for me to have a supervisor talk about their personal life for half of the time."
- "Eighty percent of the time did not inform me as a therapist as to how to proceed with a client."
- "I called the supervisor on it and sort of expressed to her, I said, I haven't had supervision in 2 weeks."
- "My supervisor was completely indifferent. I would ask for guidance. She's like, 'I don't have time for that. So just figure it out. We trust you to do it.' The message was always, 'I don't have time for that.'"
- "Even though [the client] was so healthy, my supervisor told me we have to give a diagnosis so that we can claim money from the insurance company."

Supervisees also offered examples of helpful and supportive experiences in supervision. For example, participants expressed that supervisors who modeled ethical behavior asked exploratory questions, helped supervisees examine and define boundaries, explored and worked through countertransference, and took a more directive role were particularly helpful in developing ethical awareness in clinical practice practices. Supervisors also spoke about the importance of helping new therapists define and clarify boundaries with clients, particularly around technology and in-home therapy, as essential elements of ethics within clinical supervision.

*DSM Diagnosis: Medical Model*

Supervisees expressed challenges in finding a balance between navigating the dominant paradigm of the medical model approach to mental health and diagnosis with a transpersonal approach. Supervisees at clinical sites and agencies rooted in the medical model received supervision

that focused predominantly on evidence-based approaches, most commonly cognitive-behavioral therapies and DSM-5 diagnostics. These supervisees broadly expressed experiencing limitations both when working with their clients and in the context of their supervisory sessions.

One of the recurrent themes described by participants was the disconnection between didactic learning and practical skill development. As one participant expressed,

What I got from them was concrete information about how to write a case note, a complex case note, a short case note, a diagnostic assessment, what information needs to go in, what doesn't, how to filter that out, and how to work with the DSM. So it was very pragmatic, very practical, not much else. It didn't help me in the therapy room at all. Like knowing how to use the DSM doesn't help me to be safe with a client.

Other participants described the challenges of working with clients whose cultural worldviews were outside the mainstream medical model, noting that clinical supervision would often minimize discussion of the cultural context in favor of identifying a billable diagnosis through the DSM-5.

Supervisees who had supervisors that identified as transpersonal in their orientation voiced an absence of clinical diagnostic dialogue in their supervision sessions overall. Supervisors shared that they used the DSM in supervisory sessions predominantly when a supervisee would express a question specific to a diagnosis or challenge a supervisee in describing a client by a diagnosis. Additionally, in the context of supporting the supervisee in preparation for the licensure exams, the DSM would enter into the dialogues.

Supervisors shared experiencing a challenge in finding the balance between managing agency expectations, third-party payer agreements, and the developmental needs of their supervisees. Feelings of pressure to emphasize the medical model due to the financial reimbursement needs of the agencies often took precedence. A consensus among supervisees and supervisors alike was the value of having space to explore the functional benefits of providing a diagnosis and the space to explore root concerns, content, and cultural frameworks. Lucy described this well, asserting:

I think that taps into the transpersonal as well, and this holistic like looking at the society and how this service is so needed and the diagnosis is important. Yet, let's not make that, like the only thing, you know, again, back to that black and white. How can we hold this diagnosis kind of loosely and maintain an ethical clinical presence that goes beyond the diagnosis?

### Systemic Issues and Concerns

A contributing factor to participants' discouragement in the profession was the lack of availability of resources in many of the community agencies, including time and support from supervisors. It was interesting to note that this experience was voiced by supervisees across states and licensure pursuits, pointing to more significant supervisory challenges within the context of the overall mental health system of care. Supervisees described being very aware of the time constraints of supervisors and noted hesitancy to ask many questions regarding self-of-the therapist, therapeutic orientation, or skill development. Three supervisees spoke of supervisors frequently canceling supervision sessions, citing lack of time as the reason. Supervisees also spoke about the caseload and documentation requirements, which were described as difficult to manage and a hindrance to client care. Several supervisees identified the high workloads as contributing factors to the lack of time available for supervision and the need for more support as a trainee.

Another systemic concern vocalized by several supervisees was that of the culture within the agencies, including therapeutic frameworks, perceptions of clients, and the expression of the values of the agencies. For example, Anne described her experience in group supervision as an unsafe place to express her theoretical perceptions or ask questions about cases outside the primary treatment model. She noted: "even if they don't explicitly state it, there is kind of a knowingness that this is how you have to present yourself, or this is how other people in the group are presenting themselves."

### Discouraged About the Profession

Individuals pursue a career as a therapist for a variety of reasons, including the desire to be of service and help others. They spend 2–3 years in school learning theories and diagnostic criteria, as well as foundational skills to help them become effective clinicians. The clinical supervision period following graduation from coursework is intended to hone their skills and prepare them for a career in the profession. In conducting interviews regarding supervision experiences, a theme of becoming discouraged about the profession emerged. The lofty, idealistic motivation that drew them to the profession crashed against the reality of perceiving the profession as driven by the financial needs of the agencies with minimal support for clinical staff. A secondary category of a lack of support specific to the theoretical framework of transpersonal psychotherapy emerged.

Supervisees offered examples of feeling unseen and unvalued by the agencies in which they worked. For example, three supervisees described their experience as trainees as "exploitative." Supervisees observed a general lack of support from clinicians and staff in community agencies. As already mentioned, several supervisees voiced that their supervisors had minimal time available to provide supervision.

### Category 4: Supervisor
### Supportive Behaviors

A major category emerged from the data, along with several subcategories, that described the many supportive behaviors that supervisees felt to be supportive and empowering. Along with identifying helpful behaviors, some identified behaviors that were unsupportive or missing from the relationship. Openness, honesty, authenticity, transparency, being vulnerable, and supportive, were some of the terms used to describe the nature of a positive supervisory relationship. Nevertheless, participants clearly distinguished that this was in the context of a professional relationship targeted toward enhancing therapeutic skills. Participants identified specific behaviors by supervisors that were the most helpful. Creating an atmosphere of safety was critical, just as safety is central to the therapeutic relationship. Anne shared, "I had to be able to voice whatever was coming up so that I could process it."

Helping the trainee feel validated was also central to building confidence and competence. Supervisors accomplished this by variously modeling the messages, being vulnerable, emotional, and authentic, and even allowing the supervisee to practice therapeutic interventions on them. Encouraging trainees to talk through their countertransference was also important. Other behaviors noted were encouraging awareness of social justice issues and suggesting books relevant to client issues. Tawny noted that effective supervisors, "knew when to listen, when to step in and be a mentor, when to say 'stop there is a legal or ethical issue here,' and even take the driver's seat for a second." Thus, knowing when to be directive and when not to was important. Other participants noted the importance of helping supervisees understand their strengths as clinicians and build upon them to generate more confidence. Others noted the value of having the supervisor get to know them as a therapist and to believe in them.

### Multicultural Context in Therapy

Several supervisees expressed concern that their supervisory experience did not encourage them, or even permit them, to explore gender, familial, and cultural issues with their clients. Alexa, who identifies as Indigenous and works with monolingual Spanish-speaking populations, shared that when her clients had dreams and visitations when grieving lost loved ones, she was discouraged from using culturally appropriate interventions such as dream work that would have validated and utilized such occurrences. Instead, she was instructed to refer the client for psychotropic medication. Alexa admitted that now that she is licensed, "I usually bring my Jungian psychology tarot cards into session."

Several supervisees who work with clients with a history of trauma shared that the cultural roots of historical trauma were never part of the discussion. Issues around gender identity and sexual orientation were generally not discussed as part of supervision; in particular, issues around gender differences between therapist and client. The absence spoke to a reluctance to address the role of intersectionality and cultural elements in the therapeutic context.

### Therapist Attempt at
### Empowerment Narrative

Participants described the tension between needing to take active responsibility for professional growth as an associate while also feeling the need for support from others. Having some support from others, whether supervisor or peer, was critical to their professional growth. Rose shared that she felt like she had no supervision in her situation and was thus essentially self-taught, while others complained of an authoritarian style as a barrier. These issues resulted from the inability to have a choice of supervisor. One participant shared:

> I had to deal with the distress of having somebody that's supposed to model appropriate behavior behaving unethically. And then how do I go through the process realizing that I'm responsible to speak out for myself.

Several associates noted that what was most empowering was the help in "determining [their] therapeutic gifts and specialty," along with a recognition of the competencies they brought with them into the profession, and the ability to talk about personal and spiritual growth. In addition, several participants noted the quality of their transpersonal educational program as very empowering.

### Incorporating Transpersonal
### Themes and Approaches

Participants were unanimous in expressing the value of integrating transpersonal themes and approaches into the supervisory process. However, for many, this experience was not available in the framework of their supervision experience. For others, transpersonal practices were integrated yet not named as such. Participants who experienced transpersonal themes and approaches in the context of supervisions sessions described practices such as:

- including meditations and self-reflective practices
- asking about spiritual practices and values
- integrating gratitude reflections into check-ins
- bringing dreamwork into clinical work
- integrating creative expression exercises
- use of tarot or astrological data

Supervisees and supervisors alike noted the necessity of assessing the relevance of the intervention and approach to the client's worldview and therapeutic needs. One participant asserted feeling supported by her supervisor to welcome into her sessions: "whatever gives them a sense of meaning and purpose, if it's Buddhism, or if it's astrology, or if it's Wicca." Another supervisee expressed appreciation for having the space to explore rituals in the context of the cultural framework of her clients: "we talk about how ritual, especially in the LatinX community, how dark traditions and especially with the more different cultures, just knowing the difference of the rituals."

Many of the supervisees described the inclusion of body awareness and somatic interventions as particularly powerful in their supervision. In addition, supervisees shared appreciation for being guided into self-reflection through the development of body awareness in their supervision session. Experiences of anxiety and uncertainty were expressed by supervisees, acknowledging awareness of transpersonal practices as outside the common knowledgebase of traditional therapy models. Without modeling or encouragement from their supervisors in developing these skills, supervisees often sought additional training outside their supervision.

### Intuition Narrative

If trust is a fundamental position from which to become a confident, competent therapist, trusting in one's confidence as a clinician means to facilitate intuitive decision-making. For many supervisees, the role or value of intuition was either not mentioned or was discounted outright as something to be avoided. Some supervisees had to "prove" that their intuitions were valuable and may have only found validation from their peers and not their supervisor. The message was that it was more important to trust in the "method" or traditional diagnostic categories being used (likely an evidence-based method) rather than messages arising from the body. Alexa was told: "That's not how we do clinical work. You don't use that." Tawny, who was encouraged to use intuition, shared:

> Supervisors wanted you to come in a session with a completely blank mind and just be in

a therapeutic presence and follow the clients and birth the intervention from the natural, spontaneous occurrence of what's going on in the moment.

A fundamental distinction is whether conducting therapy is a cognitive process or a whole-therapist process. If a therapist is encouraged to see the client from a holistic frame–including their somatic, psychological, emotional, spiritual, historical, and contextual dimensions—should the therapist not bring all of those dimensions of the self to the therapeutic relationship as well?

The client is much more than a set of beliefs, attitudes, and thoughts, as is the therapist. When Joan shared that "the number one thing with therapy is making the client feel that you're completely attuned with them," she pointed to the importance of being that "whole" therapist in the room. Several participants noted that the profession lacks a theoretical model for how and when to use intuition and develop it as a tool, and that doing so would help to formalize the importance of facilitating intuition as part of supervision. Barry noted, "intuition is a central part of what I teach. That to me, that's attunement."

### Mind-Body Narrative

If a therapist is disconnected from their body, how holistic can they be? For many supervisees, the body of the client or the therapist was not discussed, nor was it considered a central element in therapy. The supervisor needs to model the importance of the mind-body connection and using the body as a therapeutic tool. For instance, how does body language and gestures impact the therapeutic relationship? One participant shared that her supervisor made her name and connect to somatic feelings: "What would the body say right now?" Checking in with the body to notice countertransference and where the therapist is getting stuck was noted as beneficial. Some interns brought in yoga to involve the body in therapy. However, the goal should move beyond the mind-body connection to mind-body-spirit integration. Managing physical touch or avoiding touch can be a key decision for an emerging therapist—several participants shared examples of how even a hand on the shoulder or the knee was reassuring to clients.

Several supervisors noted that they made somatic feeling a central part of the supervision process to model what a therapist might do with a client and help trainees become more attuned to their personal process, felt sense, and intuitive sense. Doing roleplays, teaching mindfulness, or gestalt empty chair work were also mentioned as ways to enhance the mind-body connection.

### Spiritual Orientation Narrative

One participant inquired whether their supervisor saw them as a whole person by explaining, "My spirituality has a bearing on how I approach the client." Rose similarly shared, "My first interview with my supervisor was very spiritual." Some shared that being in touch with their spirituality was essential to working with clients with strong spiritual beliefs. Justice echoed this when she shared that "[her] spirituality is stories" and that her agency had no place for sharing stories as part of therapy. Others noted that in recovery circles or substance use treatment, discussing spirituality was more integral to the culture and therefore accepted.

### Trainee Self-Identified Helpful Attitudes: Dealing with Challenges

Trainees identified challenges requiring shifts in behavior or attitude or looking outside the supervisory relationship for support. Some chose to seek guidance outside of supervision in books and other places, while many acknowledged that they had to do their healing work and develop self-awareness. For example, one trainee commented that seeing her personal therapist was helpful in discussing the challenge of having a supervisor who was vaping during sessions, and she was breathing in all of the smoke. One associate shared, "I had something to learn from each of my supervisors and that helped me to question and stay present."

### Voices of Supervisors

In reviewing the data, additional perspectives emerged specific to the transpersonal-oriented supervisors, including the motivation to supervise and the support available to them as supervisors. These data were more anecdotal and so did not necessarily fall into the major categories of the findings. Those are noted here.

### Motivation to Supervise

Supervisors identified a variety of motiva-tions for engaging in supervision. For some, the process helped make them better therapists by staying abreast of current approaches, exploring ethical issues, and remaining regenerative. Others noted that it was a way to give back to the profession. Some supervisors specifically identified feeling like they were a part of a lineage: "I feel like I call upon my supervisors, some of my guides, when I'm offering supervision." MCL pointedly stated: "What really motivates me is exploring this whole terrain, this whole fluidity of this connection around all of our humanness, no matter . . . where you are on this learning curve."

### Supervisor Support

Supervisors noted that their primary form of support as a supervisor, outside of a typical self-care regimen, was meeting with colleagues to share experiences and offer mutual support. For example, MCL noted that it helped her use a beginner's mind to remind herself that supervisees are just coming into the profession: "it's a reminder of that sort of freshness that kind of doesn't matter how long I've been doing this." Others noted that offering group supervision was a source of inspiration since the dynamic interaction of many therapists-in-training helped keep the process fresh and alive.

### Discussion

The importance of the relationship between supervisor and supervisee cannot be overstated. It is the crucible in which the skill and competence needed to nurture the care of those who are suffering and distressed are internalized. Once the academic training has been completed, the textbooks placed on the shelf, every therapist trainee must sit in the chair and engage in a very special and intimate relationship with a client. The most appropriate vehicle for modeling that requisite skill and confidence is through an interpersonal relationship with a skilled clinician. How that relationship is handled and addressed helps to determine the future of a trainee's career, and in truth, the future of the profession.

Consistent with current models of super-vision, the relationship between the supervisor and supervisee emerged as the primary vehicle for gaining competence and confidence as a therapist.

Supervisees acknowledged that the nature of the relationship with their supervisor was of a different character from the therapist/client relationship. However, there was the clear acknowledgement by participants that the supervisory relationship was an ideal medium for reflecting, modeling, and exploring the relational dimension of the client/therapist relationship that is so crucial to effective therapy. This includes the ability to develop a therapeutic alliance, establish and hold boundaries, and create a safe space for disclosure. In other words, the many experiential and relational dimensions of therapy cannot be taught through reading and instruction and were best learned through the medium of a relationship. This makes the supervisor/supervisee relationship a critical and central feature of therapist training.

Supervisors in this study were also quick to make clear distinctions between the supervisory relationship and that which is cultivated with a client in the therapy room. There is a boundary that the supervisor must honor in terms of their approach and style. The hierarchical nature of supervision placed responsibility on the supervisor to be clear about the multiplicity of roles demanded by the position, including instructor, mentor, guide, and model psychotherapist.

Scholarship over several decades has repeatedly reaffirmed that the therapist/client relationship has the most powerful influence on the outcome of therapy, even more than the outcome associated with a particular theoretical orientation or method used. It can be claimed with confidence that the value of a strong, working therapeutic relationship is evidence based. Learning to be a skilled clinician is not the result of academics alone. The competent clinician must be self-attuned, intuitive, reflective, attuned to the client, and engaged in self-care.

The holistic therapist sees the client as more than mind and body, but opens the relationship to the entire realm of human experience including the context of family and culture, exceptional experiences, spirituality, altered states, and intuition. Being a transpersonally-oriented therapist means that the clinician must bring the total self—the self of the therapist—into the clinical setting in a strategic and effective manner. Training such clinicians places great demands and responsibility on the supervisor,

who must model effective transpersonal therapy and nurture the whole clinician.

It is worthwhile noting that supervisees did not express concern about the legal and ethical requirements associated with learning therapy. They welcomed the guidance and direction from their supervisor. In fact, a few had concerns about not receiving guidance, or about their supervisor engaging in clear unethical behavior. What trainees craved more than anything was direction and guidance in exploring their personal gifts as a therapist, encouragement to be creative in exploring therapeutic approaches, guidance in forming a strong therapeutic alliance with a client, providing a mirror for exploring their countertransference, their somatic reactions, and how to address issues of culture and spirituality.

Overall, trainees who worked in agency settings where one specific model of therapy was applied to all clients regardless of symptoms were confused and challenged. When confronted with the values that diagnosis and billing were more important than client healing, trainees were discouraged and even considered leaving the profession. Whatever idealism or vision that drew them into the profession seemed to vaporize in the emphasis on funding and finances. In a word, participants expressed their disappointment with the sentiment, "This is not what I signed up for." While effective therapy must go far beyond idealism and the naivete of the beginner, trainees universally came into the profession with the expectation that their creativity, devotion, commitment, and idealism would be nurtured in such a way that they could make a difference in the lives of their clients and make a contribution to the world.

This study identified many gaps in some of the common attitudes and practices of supervisors. This alone is sufficient to identify a need for training-increased efficacy and competence on the part of supervisors. But there is a wider gap for those therapists who identify as transpersonal and who have a passion for addressing the whole of the client, who intuitively sense the limitations of mainstream approaches to therapy and have a vision for something better. These trainees need the care and skill of a supervisor who is also committed to the same values and is capable of holding the essential demands of the profession around the care and welfare of the client, while encouraging creative and cutting-edge approaches.

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## About the Journal

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