

# Presentations of Self and the Status Dynamics of Psychotherapy and Supervision

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*This article explores basic issues in the status dynamics of psychotherapy and supervision. Self-presentation and status markers create a dynamic that affects the participants in psychotherapy and in its supervision. "Political correctness," at times, makes it difficult for trainees to discuss their feelings and observations about status differences with their supervisors. One of the roles of supervision is the rite of passage, involving moving the trainee from the world of nonpsychologist to membership in the community of psychologists. During supervision, the supervisor's self-disclosure of relevant autobiographical details and problematic thoughts and feeling is recommended as useful, even though such revelations in psychotherapy practice might be inappropriate or hazardous.*

## PRESENTATIONS OF SELF AND THE STATUS DYNAMICS OF PSYCHOTHERAPY AND SUPERVISION

Standard psychotherapy and its supervision involves two people alone in a room, each having a sense of the other's status or place in the social world. Status appraisals or assignments create a dynamic, an unavoidable set of motivations, and this is my topic in the following essay regarding psychotherapy and its supervision. My second focus here will be on the status difference between the therapist-supervisee and the supervisor, especially in those settings in which the supervisee is in the midst of training and has not yet consolidated either his or her sense of self as a fully competent therapist or as a full member of the supervisor's community. Here, I will make use of the nature of degradation and accreditation ceremonies as Peter Ossorio (1978) introduced them in his elaboration of aspects of Harold Garfinkel's (1967) work.

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I want to address issues that follow from what is called, in the tradition of Peter Ossorio's *Descriptive Psychology*, "status dynamics." Our status is the sum or total of our relationships to ourselves and to our worlds. The full picture, if you will. Status defines our relational position to all the key elements of our worlds (Ossorio, 1998). It bears a resemblance to what the ecologist Hutchinson (1957) called "the niche", his "n-dimensional hypervolume," which is defined by all the relevant parameters that affect an organism. Although status refers to the full range of a person's behavior potential or eligibility, in ordinary social practice and encounters, some features are more salient than others are. Race, age, ethnicity, gender, class, speech, and attractiveness count a great deal in everyday interactions.

The way people understand the meanings and significance of their interactions follows largely from the status appraisals and assignments they grant one another. Our place in the world, our social roles and eligibilities, the full set of our motivations, knowledge, and skills, is the context that gives our actions their particular significance. The significance of what we can say to each other is a function of our social eligibility. The judge or clergyman can perform a marriage with the words "I now pronounce you husband and wife," but, except perhaps as a joke, I cannot. But I can say something like, "When your husband didn't call you immediately after your surgery you were angered in ways that echo how awful and alone you felt when your mother died," since it is unsurprising if a psychologist says such a thing.

Since the significance of an actor's action is experienced relative to the appraisals made of the actor, and since appraisals are subject to the varied conditions of perception, memory, expectation and the like, there is room for agreement, disagreement, understanding, acceptance and rejection. People do not necessarily accept the way they are appraised by others, and other people do not necessarily see our behavior as following from our own self-assigned status. There are many ways we feel recognized, understood, misperceived, or misunderstood. We respond to each other as a function of our status, whether we "size each other up" correctly or not. Of course, we get ourselves wrong, too, since self-deception may be a regular feature of our self-status assignments. These issues occupy a great deal of what is talked about during most psychotherapies.

Status appraisals are a social construction. But social constructions are not random or arbitrary, and they are so often conventionally shared that it is negligent not to take certain apparent givens into account. Social constructions develop from social practice, their meaning follow from their

use, which is to say that some people have found them more or less serviceable in their social lives. (I am following Wittgenstein (1953) here, even if the "done thing" and its meanings are no longer accurate or useful or are prejudicial given a particular case). Like it or not, there are average expected social appraisals. This is the case for the social practices of psychotherapy, and it is the case for the supervision of psychotherapy. The facts of appearance, the in-your-face presentation of gender, race, ethnicity, education, age, attraction, fashion, class and privilege, and a host of other features of appearance are central status markers and define key boundaries, opportunities, and dilemmas in our working relationships.

One reminder I want to highlight is how our actions with one another indicates our sense of the other's membership in our various communities. We are members of many communities, defined by collections of related roles, for example, the roles of parent, friend, teacher, scholar, or neighbor. The community can be politically, religiously, ethnically, racially, or gender organized. The professions are clearly communities. Economic class almost always is an organizer. While the community might be some sort of club, whatever its form, communities have (more or less) fixed boundaries with membership defined by particular social practices and eligibilities (see, for example, Putman, 1981).

We often observe and implicitly ask, "is the other person one of us or not, and if he is one of us, is his membership in good standing? If not one of us, is he eligible for membership?" In the service of this set of reminders, I will make use of the social practices of degradation and accreditation ceremonies. Cross culturally, accreditation ceremonies mark the successful passage from one social world to another, marriage ceremonies being a paradigm case. Degradation ceremonies occur when one loses the status or eligibility to participate as a member in good standing in a particular community. The soldier who is dressed out and removed from rank in front of the troops is a classic example of a degradation ceremony. As ceremonies, these rituals have a common formal structure but they can also occur partially, silently, and without any formal trapping. They can be performed unconsciously. Our stance or attitude toward the other can be instantly accrediting or degrading. We can accept or dismiss each other in a heartbeat (Schwartz, 1979).

### RELATIONSHIP AND RELATIONSHIP CHANGE

Status is both a stable and a changeable place. When the social practice is psychotherapy or its supervision, it is useful to know one's place and

how it is assigned, especially if one wants therapeutic change. We need to know where we stand with each other, if we expect to manage effectively our interactions. Interactions reflect, in large part, our self-assigned sense of eligibility to act on the particular relationships in play.

Both psychotherapy and its supervision require that patients and supervisees attempt to disclose salient features of their experience within the context of the psychotherapeutic or supervisory relationship. People are expected to reveal thoughts and feelings that they might not express in their usual lives. Ossorio, as part of his articulation of the concept of intentional action, provided a relationship formula that says,

If a person has a reason to do something he will do it, unless: A) he has a stronger reason to do something else, or B) he doesn't recognize that he has that reason, or C) he is unable to do it, or D) he mistakenly takes it that he is doing it, or E) he miscalculates or his behavior miscarries (1998, p. 37).

The therapist and supervisor need to be concerned with the reasons a patient or supervisee might have for not disclosing his or her position. Both therapist and supervisor require stances and methods to make disclosure more likely. Given that behavior is an expression of eligibility or relationship potential, a corollary of the relationship formula is: if you want a person to have reasons to do something, it is a good policy to treat that person in a manner that invites and establishes eligibility to perform that action. Patients and supervisees require both eligibility and a stronger reason to self-disclose than to do something else. At the very least, it must seem to the patient or supervisee safe enough to speak openly. Conditions of safety are central in psychotherapy and psychoanalysis. (See for example, Roy Schafer, 1983). They are also required for supervision.

The following explores aspects of the situations that both facilitate and impede patient and supervisee self-disclosure.

### **STATUS DYNAMICS IN PSYCHOTHERAPY AND SUPERVISION**

The dynamics of presentational status potentially sets in motion a sort of dance, awkward or flowing, between therapist and patient. Although the status markers that follow appearance form much of the dynamic played out in our interactions, I suspect they often are not acknowledged adequately in the supervisory or psychotherapeutic relationship. We are often too polite, too politically correct, or at times, too embarrassed and ashamed to acknowledge the importance of the variables of appearance and position. We sometimes pretend that these matters are superficial. Usually they are not. We awkwardly stare at these blind spots.

Transference, countertransference, role responsiveness, and enactments in large measure work off our presuppositions and prejudices, both conscious and unconscious. It is a good idea to know how our status markers establish these tendencies of interaction. In the supervisory relationship, it is especially important to examine the weight we give first impressions and "gut feelings." Appearances shape initial encounters. We begin to respond to each other before we know each other well and often enough, before we decide whether we want to respond differently. In the supervision hour, if we wish to correct or change what is problematic, it is a good idea to be open and tolerant in revealing our possibly nasty and problematic thoughts. The unexamined is hard to fix.

In our everyday encounters, and this includes the start of a psychotherapy, what first meets the eye and ear often establishes the initial play. In psychotherapy, the first scene, informed by prejudice and transference, often determines whether there will be more acts to follow.

One role of the psychotherapy supervisor involves the clarification of the features of presentation, which mark the engagement of patient and supervisee. Erving Goffman's dramaturgical analysis of "the presentation of self in everyday life" (1959) bears kinship to what I have in mind. Drama often unfolds as a function of the unspoken conflicts of the players on stage and the actors in a psychotherapy (or supervision) are no exception. The supervisor has a responsibility to help analyze this state of affairs as an empathic participant-observer and critic. The supervisor is not the trainee's therapist, but he or she is a sort of therapist of the therapy, that is, of the trainee-patient interaction (Abroms, 1977). Developing a critical dialogue with the trainee regarding the status dynamics of the trainee-patient dyad is central in good supervision. The supervisor should ask the trainee to consider the following independent of therapeutic technique: "given the relevant observable attributes of both you and your patient, given how you see each other, what can be expected to unfold? Further, is that unfolding what you want in your attempts to be helpful?"

### **POLITICAL CORRECTNESS AS A PROBLEM IN TALKING ABOUT STATUS DYNAMICS**

In ordinary social and business life there are good reasons to be "politically correct" as a respectful stance, especially when situations are ambiguous or when there are significant asymmetries in the power of the participants. We often attempt to be politically correct out of a desire to avoid degrading the other (or revealing our own bias). There are situations,

however, where the politically correct stance is not useful. In a clinical seminar on supervision I conduct, students often produce politically correct descriptions and formulations that, in their polite and socially proper form, get in the way of understanding the actual clinical encounter, the nitty-gritty of what actually happened. I sometimes need to ask about the race, ethnicity, education, social class, religion, dress, smell, and attractiveness of the persons my trainees are sitting with, since they are often reluctant to offer these facts and personal appraisals in their initial presentations. Striving to do good, these students want to be, or at least appear, unbiased and fair minded. At the same time, they are often uncomfortable with what they feel about their patients and what their patients seem to recognize about them. Sometimes I think they *should be* uncomfortable with their feelings. But their reluctance to acknowledge what they are feeling can amount to bad faith in both their work and in the presentation of their work. So, at times, I end up confessing to students about what I think when I practice and what I have learned about how my patients view me. Students usually respond to this with some mixture of mock shock and relief.

I want my students to accept that some of their personal observations, thoughts, and feelings may contrast with what they find useful, appropriate, and tactful to comment on in initial therapeutic dialogue. It troubles me when they demand that all of their thoughts are nice and politically correct and then suffer guilt about what they think, even if their guilt points to personal matters that need to be confronted. Worse, they are sometimes too ashamed to speak to their supervisors or peers about these matters (see also Hahn, 2001). So, I might exhibit a sample of what I think and feel during the treatment and supervisory hour. I remind them that what is safe and appropriate to say varies with the circumstance. I expect that some of what I say to my students will seem, at first, disturbing or inappropriate, but if I do my job well, they may recognize some their own thoughts and attitudes in what I disclose. I have to be careful about how to go about this lesson, and I am sure that I get it wrong often enough, but I think it is necessary for therapist-trainees to acknowledge what they are thinking and feeling in order not to restrict prematurely their understanding under the guise of being nice, safe, and proper. I want them to be proper too, but I think they have a better chance at succeeding if they have the safety and the freedom to examine what is actually happening in the treatment room and in their heads. Whether therapist-trainees describe their interactions in terms that are politically correct or not, their interac-

tions with their patients are likely to be informed by the social factors they are reluctant to acknowledge<sup>1</sup>

### DEGRADATION AND ACCREDITATION AND SELF-DISCLOSURE

A central status dynamic of ordinary life, and a crucial dynamic for psychotherapy and supervision, involves degrading and affirming status assignments. Both psychotherapy and its supervision may involve a rite of passage, with its attendant possibilities of both accreditation and degradation. Rites of passage concern moving from one social role, world, or status, into another. Supervisors have as one of their roles the status and potential obligation to help the supervisee enter the shared professional community of therapists. Rites of passage, as Van Gennepe (1909) clarified, involve the rites of separation, transition, and incorporation. Transitional rites often require an ordeal weathered or a crisis managed as a demonstration of worthiness and emerging competence. For the novice therapist, the crisis may simply come with the territory. Accreditations and degradations involve a common community of shared roles and values, and require a witness to actions that are denounced or accredited by the community. The supervisor is a key player in this drama as both witness and evaluator of actions achieved or failed.

Garfinkel's (1967) conceptualization of degradation ceremonies involved a public ceremony in which a denouncer indicates to a witness that the perpetrator has committed actions that are a true expression of the perpetrator's character and are evidence that he or she is not or cannot be a member in good standing in the community. Both the denouncer and witness act as representations of the community and assert that they are in good standing. These status claims may be accepted or rejected by any (or all) of the participants with varied consequences (Schwartz, 1979). Although Garfinkel portrays a paradigm case of these ceremonies as a public performance, these actions can be, and commonly are, performed silently, unconsciously, ambiguously, or even in a lonely act of self-recognition. To those attuned to the nuance, they can be accomplished by a glance of scorn or disgust. Disgust is a common feature of these fundamental indications

<sup>1</sup>See, for example, Nancy Bridges' (1994). She has written about the problems that occur in treatment when there is a fear to acknowledge sexual attraction during treatment. She states, "For psychotherapy to be effective, it is crucial that both participants have the freedom to experience and explore all and any thoughts or feelings that arise. Behaviors, on the other hand, require more sanctions and regulation. . . ." (p. 495). Bridges sees the supervisor as playing a role in helping the therapist acknowledge, understand and consciously take into account how these feelings may be shaping the psychotherapeutic interaction. I also am reminded here of Sartre' (1969) classic example of the "bad faith" involved in a young woman pretending not to notice that she was being seduced.

of exclusion. Accreditation ceremonies have these same formal features, but these are demonstrations or celebrations of membership in the valued community.

The psychotherapy supervisor has a central role in helping the trainee gain membership in the community of psychotherapists. In the practice of psychotherapy, the patient and therapist do not always have similar memberships and eligibilities in the social worlds they inhabit. In supervision, however, especially in the supervision of trainees, the supervisee is attempting, with the help of the supervisor, to achieve full membership in the professional community of the supervisor. Certain practices may be useful when psychotherapy and supervision are creating conditions where a shared identification is being allowed or fostered. For example, self-disclosure has a basic place in fostering identifications and shared memberships and accordingly has a potentially different role in supervision than in psychotherapy (see also Farber, 2003). Traditionally, and in the service of neutrality, self-disclosure is held as problematic in psychotherapy (see, for example, Gabbard and Wilkinson, 1994). Still, some patients may ask and need to know if their therapist is married, has children, lost a parent, is gay, recovered from addiction, experienced combat, or whatever speaks to whether the therapist is in a position to hear within a shared world. The patient wants to know whether the therapist can "relate". And whether or not these themes lead to therapist disclosures, they are significant questions that have important meaning in the process of the patient knowing how to measure the significance of the therapist's words and deeds. The expectation of empathy, correctly or not, often hinges on these matters.

One role of the supervisor is that of an accreditator, involved in the rite of passage, assigning and confirming on the trainee the status of psychotherapist. The supervisor can do this because he or she is already a member in good standing in the community of psychotherapists. The supervisor, as a judge or observer-critic of the supervisees work, is in a key position to acknowledge that the work being done is authentically psychotherapeutic. Of course, the supervisor can also degrade the trainee and impede or prevent membership in the community.

Just as the psychotherapy setup has to provide a safe place to talk, the supervision has to allow for safe acknowledgment of the issues that the supervisee recognizes (or enacts). It is unsurprising for trainees to feel reluctant to talk about what they actually think. They may worry that what they believe they are actually doing in their treatments may conflict with evidence that they are worthy of initiation and membership in the com-



munity of therapists. This dilemma is inherent when the supervisor is also an evaluator. I find that a reasonable degree of supervisor self-disclosure provides, at least, a possible opening toward greater freedom for the trainee to self-disclose, too. Self-disclosure may be felt by both parties to be an action performed within a shared community and involving values both parties appreciate and accept. Supervisory self-disclosure can go wrong in a variety of ways, from narcissistic spilling to monopolizing the hour, but it can go right as an expression of accrediting the trainees eligibility as an appropriate audience-participant.

### MORAL DISCOURSE

“Moral discourse” is a concept developed by Hannah Arendt (1958) as a method of communication that fosters (and requires) mutual identification and disclosure, and it serves the development of empathy. Patients and therapists create and negotiate shared meanings as they work together, so do therapists and their supervisors. Moral dialogue has a potentially different form in supervision than in psychotherapy. The issue here is self-disclosure. In Arendt’s formulation, we attempt in good faith to reveal accurately our values and position relevant to the matters at hand. In this form of negotiation, we show our hand. Supervisors, I think, can make good use of a disclosure of their own histories as therapists, their own management of being “under the gun.” We may or may not wish to reveal to our patients that we have been there, but it can be good practice to do so with supervisees, especially since we appear to have survived. This is a demonstration that one can successfully navigate from crisis to competence as we, in fact, have, a sort of “once I was lost, but now I am found.” Appropriate self-disclosure as a feature of an “I-Thou” relationship is accrediting in and of itself.

### MEMBERSHIP HAS ITS PRIVILEGES

There is a sort of psychotherapeutic culture that therapists share. We engage in shoptalk with each other, which we rarely offer the uninitiated. The supervisor, as a guide to this territory, may point to special behaviors that are unusual or somewhat exclusive to the community of therapists. Since we are also members of a larger national culture, we sometimes need to help the new therapist appreciate what is specific to our role as therapist and what sets us apart from others. Therapists may ask their patients to examine issues that would not be appropriate to speak of in most other contexts.

Shared culture provides a consensus about where not to look too closely and what not to confront. Trainees often find it particularly difficult to inquire about and explore their patient's finances, sexual expressions, and religious claims. In common with most Americans, trainees often approach these topics as a social taboo. Since these topics are usually considered too personal for conversation within the ordinary American community, it might be the supervisor's job to affirm that psychotherapy involves a special case scenario or an exception to the rules of usual discourse, should an interest in the taboo subject be appropriate. Much like the communities of priests, lawyers, and physicians, the psychotherapist may need to understand that membership in the community of psychotherapists involves license to explore what is otherwise off limits. The supervisor as a representative of the community of therapists is in the position to grant the trainee permission and perhaps obligation to accept this privilege.

### **SUPERVISION AS A RITE OF TRANSITION**

Transitional rites often require an ordeal weathered or a crisis managed as a demonstration of worthiness and emerging competence. For the novice therapist, the crisis may simply come with the territory.

The supervisor as a judge of community standards is in a position to make his or her evaluations and appraisals stick. The supervisor is often the first witness after the event of the novice therapist's difficulties, crises, and ordeals. Paul Russell (1975) talked about "the crunch" as the repeated and key juncture in the psychotherapy of the difficult patient in which the therapist, after messing up, must attempt to manage, accept, and contain the shame, distrust, and broken faith that attend difficult treatments. Reestablishing empathy, and confronting what has gone wrong in treatment, may be the heart of psychodynamic psychotherapy. I suspect it applies to other therapies as well. Here, the lesson is how to recover, reconcile, and accept a second chance. Confronting and accepting failure in what was otherwise a good faith attempt to be helpful is one way to acquire an increased toleration for life. Russell felt that psychotherapy works to the extent that both patient and therapist find passage through the crunch without permanent loss of face (and faith). I think this applies to supervision as well. The supervisor who maintains an authentic and professional stance of appreciation, empathic neutrality, kindness, and openness to negotiation is in a good position to provide guidance and support through the trainee's various ordeals. This flexibly steady attitude is the supervisor's manner of representing a model of professional self-

presentation. The supervisory stance is both an offering and a tool for the trainee in transition.

Recently a supervisee came to me upset about how she handled a very difficult situation. The supervisee is quite young. In her second meeting with a middle aged, acutely suicidal patient, she was ragefully attacked and told, "You are not old enough to help me . . ." My supervisee acknowledged both the narcissistic blow she was suffering and the fact that she thought that her patient was probably correct in his assessment of her age and experience. With an embarrassed tone, my trainee then said that she excused herself, left the consultation, and found a more senior clinician, who she brought back into the treatment room. In supervision, she confessed to her confusions and the complex feeling of having felt both degraded but hopeful that she had done the right thing. My role, I think, was to affirm all of these judgments, except her feeling that she had been properly degraded. We ended up recognizing how she had managed a crisis even while feeling inadequate. All experienced therapists know how feeling temporarily inadequate comes with the territory, and this was a vital fact I wanted to share, along with the lesson that successful work always has a "more-or-less" quality to it.

### STATUS AND SHARED AND NONSHARED COMMUNITY

Common membership may not start with shared community but only with its potential. Generally, supervisees are acutely aware of how their place in the world is different from that of their supervisors, even as they enter the "rites of transition" toward the community that the supervisor represents. Novice therapists are usually also aware of how alike or different they are from their patients, but the novice may need help or permission to talk about these differences. Where I teach and supervise, my trainees are most often middle- or upper-middle class, white women, frequently Jewish, and in their 20's or early 30's. Most often, their patients are not.

For example, recently I began supervision with a 28-year-old trainee, a woman who was clearly and self-consciously attractive, stylish, radiant in her health and with me, open, engaging, and intelligently articulate. All of this was obvious. Our first hours involved her work on three cases. The first two, a young man and a young woman, were both undergraduates from a prestigious university who shared the appearance of a common social background with their therapist. The third patient was a 56-year-old woman with shattered teeth, a history of domestic abuse, unemployment, and public assistance.

My trainee found it easy to talk about the comfort, interest, and excitement she felt working with the first two patients, but only with reluctance and distress could she acknowledge the hopelessness, confusion, pity, and a degree of disgust that she experienced in her meetings with the third. As she told me about the third patient, she had trouble meeting my eyes and unlike her earlier presentations, she mumbled, covering her mouth with her left hand. This hand, I noticed, now had its stunningly large engagement ring turned backward, stone toward her face. Unlike her first two cases, it was difficult for me to follow the chronology of her hour with her third patient.

As she was telling me about these cases, let me also remark that she was speaking to a 50-something-year-old, male psychologist in his role as a supervisor on the faculty of Harvard Medical School. Our meeting was taking place in my, I think, well-appointed but dusty private office on a fashionable street in Boston. To my pleasure, I instantly liked this young woman, and I was happy to be sitting with her, and she could tell. All of these facts are salient. Our mutual appreciation, bounded by the differences in our status, bear a family resemblance to and support Kohut's (1984) insight that talents and ambitions develop in the intersubjective field of admiration and idealization. I suspect that my supervisee idealizes my clinical knowledge and experience, and I hope she has seen the "twinkle in my eye" as I admire her growth. This is a useful relational framework for the development of her "work ego" or "professional self". It also helps secure my identity as a supervisor.

As my supervisee unconsciously covered her mouth, hiding both her engagement ring and her flawless teeth, she betrayed what she wanted to conceal from her patient. This young therapist knew that her display of status and privilege, her considerable potential, might provoke envy and distrust, regardless of the pride, security, and access it also provided her. She knew it from experience. How could she display these features to her damaged patient, to a woman she believed had limited means and potential? How could she help someone she suspected might envy or hate her? What would the words coming out of her mouth mean? How would she contain her disgust? Without reasonable awareness of these "enacted" questions, they posed a crippling barrier to a therapeutic encounter. Without a tolerable awareness, my supervisee found it best to hide. All of this was very different from the first two cases she described.

She was easily engaged in her work with the two university students. Her narration of this work was smooth and competent. In talking about her hour with the young male patient, my supervisee recognized that he

was shy and attracted to her. Awkwardly, he tried to flirt, although she could not be certain he was aware of doing so. The second student, a young woman, spoke to my supervisee in a manner that we both felt to be subtly hostile and competitive. Why, we wondered, was there the difference between my supervisee's narration of these two cases and the third. Here, we found, status markers clearly mattered. Competition, whether friendly or hostile, and flirtation, conscious or not, speak to a common playing field, even if not a level one. With the first two patients, there was an unspoken recognition and acknowledgment of shared eligibility, of a potentially shared and commonly valued social world. These features were lacking in my supervisee's experience of her third client. It was our job to find a common nondegrading social connection to bridge this third relationship.

During the course of supervision we both wondered what she could offer this woman given their vast differences in social eligibility. My supervisee was in no position to convincingly share her patient's pain and sorrow, nor could she offer hope from personal experience toward directions for positive growth. She knew that they both knew that their lives had always been very different. We ended up wondering about the role of appreciation as a stance available to both therapist and patient. Could my supervisee demonstrate an empathic appreciation of her patient's courage in attempting to remedy her situation? Could my supervisee reestablish some degree of appreciation by wondering about the hopes and trials of her patient when this patient herself was 28 years old with her particular world before her? We needed to find some common ground and at times, one can admire and acknowledge what cannot be shared. This serves as the basis for a moral dialogue and negotiation.

### STATUS, EVALUATION, AND DUAL RELATIONSHIPS

Status differences between supervisor and supervisee are especially significant to the extent that the supervisor is also an evaluator who may be responsible for signing off on a trainee's progress. This is a different matter when the supervision is between peers or when the supervisor is a paid consultant. Who the boss is matters. Coercion and the hazards of dual relationships are less potent when the people involved are already peers. Status differences carry with them a coercive potential. People are not usually as free with an evaluator as they are with someone who has no significant power regarding their fate. Still, especially with trainees, there may be a need for the supervisor to exercise some degree of authority, not

only to help correct problematic interventions, but also in recognition of a dual liability should the trainees work go badly wrong.

Authority can be exercised in the requirement of directions to follow or in the correction of an off-course treatment, but it can also force a dilemma that feels neither safe nor comfortable for the trainee to refuse. With this in mind, it is useful to recognize the fuzzy distinction between exercising authority and offering a perspective. At stake is the common observation that coercion elicits either resistance or resigned compliance, neither of which are generally helpful in our work. Psychotherapists need to avoid (or be very careful of) entering dual relationships with their patients. But what of the supervisor's potential dual roles of colleague and status assigner? What are the boundaries and freedoms that attend supervision as a rite of passage toward shared community? At some point or another, I ask my seminar students, "Could you imagine after a good session, having a beer with your patient? And, if after describing this good session with your supervisor, could you imagine going out for a beer with him?"

With their patients, my students are clear. Professional ethics and the average expected status dynamics forge a firm boundary. All are sure they would not drink with a patient. When they explore the question of having a beer with a supervisor, they are less certain. Here, the ethics and status dynamics are less general and more based on the specific status of the people involved. The devil is in the details. Faced with these questions, the seminar ends up grappling with the complexity of the status dynamics of supervision. The rites of transition require that we encounter and tolerate what in our work is exactly uncertain, clearly ambiguous, and fundamentally gray. We try to get it right, but without an appreciation of the places we occupy in each other's social worlds, we are likely to end up lost.

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