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Equity in the Agency Experience: A Reflection

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Author's Note: In order to protect confidentiality, names have been changed.

Caroline and I, at the time a wide-eyed 26-year-old, met for our first supervision at my agency on a Friday morning at 10.

It had been a whirlwind over the past few months. Texas, despite its reputation as a business-friendly, cost-efficient place to start adulthood, is actually really challenging to launch a career in anything human services-related. Its state government minimally invests in social infrastructure, so entry-level counseling jobs are often at small non-profits or private practices who hire two or three post-graduate therapists per summer. Folks who do land positions within state agencies are significantly overworked; I had friends who worked at local state-funded agencies who had between 60 and 80 families on their caseload, so while I was frustrated by the lack of responsiveness from jobs that I applied to in 2009 following my graduation, I also refused to completely destroy my energy levels at an agency.

By the end of 2009, it occurred to me that my best chances of continuing my career, after investing two years in a graduate program in marriage and family therapy, lay outside the state of Texas. I applied to therapy jobs throughout the United States and found a few job offers; my ex-wife agreed to seek out adventure in the city that would hire me—Boston, Seattle, St. Louis, and Washington D.C. We decided to accept the offer from the Boston-area company, an agency that promised the opportunity to work with a diversity of clientele and that would, contrary to other jobs, allow me to practice therapy from a diversity of theoretical perspectives while accruing practical hours for my license. Theoretical syncretism has always been a high value of mine. (It also helped that several of our best friends were simultaneously transplanting to Boston.)

In the first week of August, 2010, we packed our belongings into a U-Haul truck and, with the help of my friend Drew, drove two thousand miles from our cozy west Texas town to the big city of Boston. We got into Massachusetts Thursday at midnight, and spent a long weekend unloading said belongings into our apartment in north Quincy; I had wisely flown to Boston a

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month earlier to procure a landing spot.

The first week was actually quite positive. The agency had about fifteen individuals and families waiting for me. Some, such as an early-20s Black man who was attempting to escape the shadow of a physically abusive relationship with his father, met with me in one of the twenty office cubicles. Others, such as a Puerto Rican family that lived on the third floor of a triple decker, required driving to their homes; with the assistance of my handy Tom Tom, I became quite familiar with South Shore geography.

There were some wonderful colleagues that I met my first week, some of whom are still good friends of mine. I was also fortunate to have a firm, yet compassionate boss, Melissa, who advocated for me in significant ways.

On Fridays at nine, the agency required new hires to attend a weekly training hosted by Pam, who brainstormed with us about identifying our favorite types of clients to work with and how we might build collaborative relationships with other support systems in the community to expand our caseload. While my graduate program gave me an outstanding initial framework by which to conceptualize therapy (one of my professors had all of my classmates repeat "Theory drives practice!"), it had failed to provide much insight on the business of therapy.

So Friday morning at 10, I entered my supervision meeting with Caroline excitedly, with my gray box with my client folders in hand, ready to talk about therapy.

Instead, Caroline asked me a series of questions that I was not prepared for.

Are you completing everything in the comprehensive assessment?

How are you doing the CANS (Child and Adolescent Needs) with your families?

What diagnosis are you giving this person?

Over the next year, Caroline, my supervisor, and I met to evaluate the quality of my paperwork. We brainstormed how to write treatment goals that had measurable outcomes. We discussed the nuanced differences in the intensities of anxiety and depression, such as what qualifies as moderate versus severe; Mass Health, at the time, would not reimburse for adjustment disorders. Caroline shared strategies to ensure that therapy lasted within the 12 sessions that Mass Health initially allowed, and when therapy required more than 12 sessions (for those in the contemplative stages of change and after, therapy almost always lasted more than 12 sessions), we determined the appropriate language to convince the insurance reviewers to approve more sessions. There was always time at the end of session for me to "do corrections"—to complete the blank spaces on the paperwork and to rewrite treatment objectives and diagnoses if the insurance company didn't approve of the first draft.

People ask me about the culture shock that I experienced moving from Texas to New England. In a lot of ways, the move was easy for me; the progressive social values of New England and the authenticity, stereotypical drivenness, and independence of New Englanders aligned with my values more effectively than living in Texas.

The space that I experienced the most culture shock was during my Friday supervision meetings with Caroline. Caroline's friendliness and kindness saved me from becoming completely unhinged and leaving. I did confront her around the lack of systemic orientation and the unethical process of giving a diagnosis to someone within five sessions, but I eventually learned that Caroline was doing what the company asked her to do: ensure that the agency didn't subject itself to clawbacks from insurance companies, and that the agency didn't get sued from other sources. (The Child Behavioral Health Initiative, or CBHI, which my agency began to participate in during my second year, developed out of a multi-million dollar lawsuit, and the anxiety that individual agencies could also be sued was palpable during that time.)

Supervision with Caroline introduced me to the fact that managed care has made therapy a game where therapists and other healthcare professionals have to strategize and politically convince employees at insurance companies, masters of bureaucracy yet often lacking knowledge about the process of therapy (or other tips of medicine), to open the purse strings and continue to fund the mental health process of that particular individual and/or family. Fortunately, I grew up in an education system that taught me to take standardized testing against the test, rather than as a reflection of concepts and objective statistics, so I learned well how to write paperwork that would please the gods of the insurance companies.

However, despite the in-service trainings that my agency did (I especially appreciated the training we did on non-directive and filial play therapy), they refused to push back too strongly against the system of managed care; whenever an organization creates this relationship with managed care, therapy can never primarily be a process to provide support, understanding, and healing to communities in need.

In the last few years, agencies in Massachusetts have distinguished between administrative supervision and clinical supervision, so that pre-licensed therapists can achieve the supervision requirements for their license and not use their already small salaries to fund it. However, the systems of supervision within agencies in Massachusetts are significantly woeful.

During my first year in 2010, the supervision that I received was strictly administrative. I received little feedback about the quality of therapy that I provided; the independence that I craved after graduate school was given to me in spades, and I made more than my fair share of mistakes with clients, including getting triangulated into chaotic family systems, overfunctioning for the systems I worked with, despite my best implementation of postmodern principles, and avoiding conflict and hard conversations whenever I could. Clients were suffering and consistently stuck in first-order change; while part of this is on par with being a new clinician, I can't help but wonder how therapy may have been different had I received the supervisory support that I obtained in graduate school.

I did eventually receive clinical supervision; for my second and third years at my agency, three different people provided supervision for me. One was a woman who was incredibly kind, yet I found myself teaching her family therapy concepts, rather than the other way around, as we worked through some of the most complex family systems in our communities. Unsurprisingly, many of the supervisors hired to work with family therapists (LMFT-candidates and otherwise) have minimal experience practicing therapy from a systemic lens. One supervisor provided decent guidance about how to work with couples, but she was asked to leave the agency two months into our working together.

I did find a fantastic supervisor in Kim, who I worked with for over a year. Kim was a former staff therapist for the agency, and provided excellent feedback on building more effective therapist-client relationships, which centered around letting the client direct the session instead of forcing my own agenda. Kim was studying to become an Internal Family Systems (IFS)-certified therapist during our time together, and incorporated systemic principles, through the lens of Dick Schwartz, into our supervision.

As amazing as Kim was, she also had no formalized training in clinical supervision. Neither did my first two supervisors, nor, to my knowledge, many of the other supervisors at my and other agencies in Massachusetts. There is no requirement in Massachusetts for supervisors to have prior education or certification in supervising and training therapists, other than that they have been licensed for three years and, for LMFTs, have supervised a minimum of two other family therapists (LMFT-candidates or otherwise). The Massachusetts Mental Health Counselors Association (MaMHCA) offers a supervisory certification program for LMHCs which provides a basis for administrative and clinical supervisory skills. While this certification is not required, it is encouraged that supervisors obtain formal training. But an encouragement is not a mandate.

Two years after I got licensed, my agency hired me as a contract supervisor to provide individual and group supervision to its employees, a position that, quite frankly, had no business being offered to me. For the next three and a half years, I did the best that I could to help my supervisees conceptualize their clients from a systemic perspective, and did some short-term trainings in family and postmodern theories. The agency and my supervisees both spoke highly of my work, despite receiving minimal professional training and feedback from the agency. I did take AAMFT's approved supervisor training during my second year in my new role, which provided a lot of useful administrative advice and methods for teaching systems theory to new therapists. I was grateful for the support and guidance of the supervision process; I filmed some of my individual and group sessions and watched them with my supervisor, which provided valuable insight. But the approved supervisor training was outside of the purview of the agency.

Supervision is an enormously important part of the growth and development of the therapist, and in graduate school, I received excellent supervision. One group supervisor played a game called "The Hat Game" where we had to randomly select systemic therapy principles from sheets of paper (written on pieces of paper and drawn from a hat) and present how we would address a therapeutic issue from that theoretical perspective. If I drew "narrative therapy" and I began to talk about Bowen's perspective, he would interrupt me and redirect me toward approaching the case from how Michael White would address the case. One of my supervisors exclusively used film during our sessions, and would pause my recording every thirty seconds to ask why I asked that particular question or help me evaluate my nonverbal presentation. Another supervisor explored self-of-therapy questions that I was far too anxious at the time to address. My only complaint with supervision was that I only got four months (one semester) with each supervisor; otherwise, I would argue that the supervision system within my graduate school is a model for what supervising and training new therapists should look like. As marriage and family therapists, we owe the creators and current directors of AAMFT's Approved Supervisor process a gigantic thank you for developing these systems.

There are some positive changes in improving the quality of supervision for postgraduate agency therapists. The Child Behavioral Health Knowledge Center, for instance, recently connected some local agencies with the Yale Program on Supervision and hosts content and

single-session webinars that provide tools to supervisors. The individual skill development plan on their website, for instance, is a useful document to help organize goals and directions. They also describe a field observation process, which enables the supervisor to witness the therapist providing family therapy in the homes of clients. However, there's no statewide formalized process for training supervisors to work with agency clinicians in Massachusetts, not one that's analogous to the Approved Supervisor Training for AAMFT or the American Association for Sexuality Educators, Counselors, and Therapists (AASECT).

The practice of booking our newest clinicians with the most challenging, complex family and social systems, and gauging therapeutic success by the quantity of practicum hours and the quality of their administrative paperwork, without investing in methods to supervise therapists around the complications of their cases and the psychological challenges that arise sets therapists, their clients, and future clients up to fail.

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My ex used to say, "The field of marriage and family therapy doesn't take care of the marriages and families of its therapists." She was right. Entry levels of therapy (which includes social workers, mental health counselors, and psychologists) have elements of indentured servitude to it. To be fair, many sectors of internships are unpaid; the currency collected is the experience and prestige that you can put on your resume with the hope of getting paid handsomely later in life. In graduate school, the internship hours enable you to take the national exam that accompanies your license, and ultimately, with the appropriate number of supervision hours, become a state Board-approved psychotherapist. Graduate school and the agency experience taught me to do whatever it takes, including a full year of work that was a five figure financial net negative, to get that ultimate form of currency: my license in marriage and family therapy.

I settled, because if I wanted to practice my calling ethically, I had no other choice.

Supervision is one of many elements within the contemporary agency system that sets precedents for future therapists to struggle occupationally, financially, and psychologically. Starting in April, 2022, the editorial team of the New England Journal for Relational and Systemic Practice will host "Equity in the Agency Experience: Dream or Reality?" Each month, we will have an hour discussion about how to best support our newest therapists. We hope these conversations will help fill the gaps created by agencies' utilization of the productivity model, which states that success is predicated on the quantity of work, rather than the quality, and the medical model, which limits therapists' ability to engage with the complexities and depths of human experience and the relational processes that create said experience.

We hope that Equity in the Agency Experience will bring two key groups of people together. First, in order to create equity for agency workers, collaboration between therapists and leadership teams at different agencies will be necessary. When agencies exist in their separate silos, therapists lack access to information, training, and support from outside of their agency, limiting the potential for innovation and growth. We hope to provide a space where different companies who are facing similar issues can work together to create fairer, more realistic, and more equitable work standards for our newest clinicians.

Second, there's a significant gap in the experiences of agency workers and private practice

clinicians that we hope this training addresses. In fact, there's a myth that the evolutionary journey of the successful therapist involves leaving agency work when you get licensed and moving into private practice, where there are fewer bureaucratic restrictions to practicing therapy. Licensed clinicians in private practice (especially White clinicians) are less likely to confront the intersection of classism and racism with behavioral health challenges than agency clinicians who commonly interact with consumers of community mental health services. Private practice clinicians, including myself, have the option to opt out of constrictive relationships with insurance companies in ways that agency workers lack. More importantly, agency workers often lack mentoring relationships with more established therapists, relationships that can provide insight for how to comprehensively succeed in a uniquely demanding profession.

Discussion topics will include:

— Challenging the productivity model
— Helping therapists engage with complex family systems, especially when if they didn't learn family therapy skills in graduate school.
— Self-care, and how agency systems create burnout
— Increasing income in the agency model
— The impact of documentation standards on identifying successful therapy
— Creating spaces for self-reflection

The future of our profession depends on our ability to develop systems to provide professional, emotional, and financial support for our post-graduate agency therapists. For more information about how you can join our conversations, visit us online: https://www.neafast.org/equity-in-the-agency-experience.