THE TECHNIQUE OF PSYCHOTHERAPY

SUPERVISION OF THE PSYCHOTHERAPEUTIC PROCESS

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Supervision of the Psychotherapeutic Process

Supervision of the work of the beginning therapist is an essential requirement in the learning process (Greben, 1985). Without supervision it will be difficult or impossible for the therapist to translate theoretic knowledge into effective practice, to work through blocks in understanding, and to develop skills to a point where the therapist can help patients achieve the most extensive goals. Supervision, then, in psychotherapy is essentially a teaching procedure in which an experienced psychotherapist helps a less experienced individual acquire a body of knowledge aimed at a more dexterous handling of the therapeutic situation.

LEARNING PRINCIPLES IN SUPERVISION

Adequate learning necessitates, first, an appropriate presentation of data in terms meaningful to students, second, the incorporation of this data by the students, and third, the ability of the latter to organize experiences cognitively and to generalize from them to related aspects of their work.

The first requirement presupposes an ability on the part of the teacher to develop an empathic understanding with the students and to discern what aspects of the available material are pertinent to their immediate needs and to the teaching task. The second essential assumes the existence of motivation, an adequate intellectual capacity to integrate the information, and the relative absence of anxiety. The third requisite entails the presence of a synthesizing function of the ego that enables students to examine themselves critically, to give up old modes of conceptualizing, and to apply themselves to new creative tasks. Helpful is alertness and ability of the teacher to keep the relationships on a level where transference resistances' do not interfere with this process. Helpful also is detection of the students' specific learning problems and the evolvement of techniques designed especially to deal with these problems.

Unfortunately, there are many interferences with the expeditious learning of psychotherapy, not the least of which is the ambiguity of the concepts that constitute the marrow and lifeblood of the psychotherapeutic process. It is difficult to authenticate techniques that are universally applicable. A method that works in one case may not be effective in another; it may produce good results for one therapist and a string of failures for another with a different kind of personality; it may be highly productive at a certain phase of treatment and backfire in the same patient at another phase. What appears to be necessary is more research into the actual procedures of teaching psychotherapy. Christine McGuire (1964) has pointed out that much of the ongoing clinical teaching is conducted in a manner that runs counter to basic principles about learning long known to educators and psychologists. A professional coach who sends his or her players out to complete a number of practice games with instructions on what to do and who asks them to provide at intervals a verbal description of how they had played and what they intend to do next would probably last no more than one season. Yet this is the way much of the teaching in psychotherapy is done. What is lacking is a systematic critique of actual performances as observed by peers or supervisors. This is not to say that an account, highly screened as it may be, of what a therapist says he or she has done with a patient may not lend itself to a dynamic learning relationship. The account, however, is most valuable when it is compared to what the supervisor has actually observed in a live session between the student and patient through a one-way mirror or in viewing a videotape of the session.

A sensitive question relates to the validity of using data in teaching psychotherapy drawn from the teaching of related disciplines. Can the information, for example, derived from such areas as social work supervision, the psychology of learning, communication theory, and programmed instruction be applied to psychotherapy? On the surface the reply would be “yes.” Yet there are special problems in the teaching of psychotherapy that force a qualification to this answer.

An individual who masters a complex skill proceeds through a number of learning phases, namely (1) the acquisition and retention of certain factual information, (2) the development of ways of using this

information in a practical way, and (3) the evolvement of a capacity of altering this information when new situations arise that call for different approaches. In psychotherapy modern methods of acquiring information embrace exposure to didactic materials through fact-finding learning (lectures, reading, and observation of therapy performed by expert therapists through a one-way mirror, videotapes, and sound movies) and problem-solving learning (programmed instruction and role playing with immediate feedback). Practical applications of what has been learned are inherent in observing the consequences of treatment techniques by actually *doing* psychotherapy under supervision, by listening to audiotapes and watching videotapes of one's own performances, by observing others performing in psychotherapy through a one-way mirror, or viewing videotapes of their actions, and by clinical conferences and case seminars. The creative employment of psychotherapy with the development of methods designed for the special problems of each patient are consequences of continued supervision and prolonged experience. Through such a program of scholarship, searching inquiry, observation, and experiment, a body of organized knowledge is eventually developed in the matrix of sophisticated theory.

Research into teaching method indicates that the effectiveness of teaching is increased "when the teacher accepts a teacher's responsibility for directing learning, providing every opportunity and inducement for the student to accept a larger responsibility for his own education, and holding out always his and their goal the maximum achievement of which they are both capable" (Hatch and Bennet, 1960). Fundamental is a spirit of inquiry that provides the motivational fuel for the powering of proper learning (Matarazzo, 1971). This is the most sustained when the content of teaching is related to the needs and educational level of the students.

Once teaching goals have been explicated in operational terms and the most effective methods have been designed to help the students achieve these goals, the effectiveness of learning experiences must be tested through the students' demonstrating how much they have mastered. Reliable methods of recording and measuring performance are needed here. This should be more than a matter of clinical impressions,

for, as McGuire (1964) has pointed out, these "are no more acceptable in a scientific study of the educational efficacy of a training program than they are in a scientific appraisal of the therapeutic efficacy of a new drug." The crucial obstruction is, of course, the current relatively undeveloped methods of evaluation. In psychotherapy, where the clinical data may be interpreted in endless ways and where criteria of competence are so vague, evaluation techniques are still more pedantic than precise. Yet it must be agreed that, however tenuous they may seem, measures of competence must be constructed to require students to demonstrate that they can perform in a desired way. Both the continuous case conference and supervision offer means of approaching the thorny problem of evaluation. Important leads may perhaps be taken from the study of the evaluation of the teaching of psychiatry at the undergraduate level in the film test series developed at the University of Rochester, the University of Nebraska, and the University of Pittsburgh. At the postgraduate level a number of interview films have been developed—for instance, those at Temple University Medical School, which may be used to test clinical judgment and problem-solving skills and which can be adapted to the evaluation of different training programs.

PSYCHOANALYTIC CONTRIBUTIONS

Some outstanding work on supervision has been done in the field of social work (Towle, 1954). But the area that has commanded greatest interest for many psychotherapists has been psychoanalytic supervision (Balint, 1948; Benedek 1954, 1972; Blitzstein & Fleming 1953; Bruner, 1957; Dewald, 1969; Ekstein, 1953; Gitelson, 1948; Kubie 1958(a); Sloane, 1957). The early publications of Ekstein and Wallerstein (1958), Fleming (1963), and Fleming and Benedek (1964) are still considered valuable. The latter authors, using electrically recorded sessions of students with patients and their supervisors, developed a project to investigate "the processes of interaction between communicating systems in the teaching-learning relationship" that involved the triadic dimensions of supervisor, student-analyst, and patient. Assessment of students brought into play a complicated network of motivations in the supervisor, for instance, the preconceived expectations of students, the supervisor's own investment in teaching, and

the defensive reactions to students' resistances. "Our experience demonstrated again and again the necessity for a supervisor to listen to and evaluate himself in interaction with his student; and it is our opinion that the more aware a supervisor is of the various aspects of his educational role, the more effective he will be as an object for identificatory learning and as a developer of students in general."

These and later data from studies of supervision of the psychoanalytic process (Chessick, 1985; Buckley et al. 1982; Gauthier, 1984; Glass, 1986) require a reconciliation with treatment situations of greater activity and more limited goals, as in the less intensive dynamic, reeducative, and supportive therapies (Sandell, 1985; Winokur, 1982).

It is almost inevitable that psychotherapists will be influenced by unconscious processes in their patients. Patients who have incorporated parental messages and repudiated their presence may through projective identification accuse the therapist of the very impulses that they deny within themselves. More insidiously the projections may not be direct, but the therapist will become aware of them through countertransference, perhaps reflected in dreams or fantasies (Langs, 1979). Failure to understand what is happening may provoke defensiveness and hostility. Moreover, the therapist may with some patients develop transference, which can lead to antitherapeutic acting out manifested by smothering overprotectiveness, aggressiveness, or sexual misbehavior. One of the supervisor's prime duties is to be alert to such transferential and projective identification interferences and, when they occur, help the supervisees recognize them. This is a tricky task because the supervisor will in so doing be playing the role that should be assumed by the supervisor's therapist, if there is one. What may result is that the supervisees will begin developing more irrational transferences toward the supervisor and, if the supervisor does not watch it, the supervisory teaching process may become converted into a prolonged therapeutic venture with the focus away from the learning of psychotherapy and the welfare of the supervisees' patients.

FUNCTIONS OF SUPERVISION

All participants in the supervisory process bring to it a separate agenda. The supervisees are interested in learning how to do good psychotherapy, and perhaps in achieving certification or earning a degree. The supervisor seeks to demonstrate competence as a senior clinician while teaching the students a skill and contributing to their growth. The institution that sponsors the treatment desires that standards imposed by licensing and regulatory bodies be meticulously followed. The paying agencies insist that records and documentation be carefully maintained and available for auditing. The central members of the conglomerate, the patients, seek the most effective help to reduce their problems and want to be assured that their therapy is going well. Such aims may be contradictory, and the supervisor will deftly have to weave through the tangle of these self-oriented objectives and bureaucratic rules. There may be difficulty in deciding where loyalties should be placed. Good supervisors are able to fuse the disparate elements into a serviceable amalgam. Skills can be taught while considering the welfare of the patient, the needs of the student, and the rules of the institution. Coordinately the supervisor will have to deal with personal frustrations and countertransference, with the students' transferences and resistances to learning, with the intransigence and arbitrariness of the school or agency, and, by remote control, with the anxieties of the patient.

The traditional type of supervision, unfortunately, has become so contaminated with overseeing, directorial, and inspective functions that it has frequently been diverted from its teaching objective. This has particularly been the case in agency work, where the supervisor, as part of the administrative body, is responsible for the quality of service rendered to clients. Many difficulties arise here because the supervisor serves in a dual role—as an overseer and a teacher.

As overseer, the supervisor may be so concerned with maintaining the standards of the agency that he or she may not be able to exercise the kind of tolerance and patience required in a teacher. For instance, under press of responsibility, the supervisor is likely to "jump in" and interfere with the treatment plan set

up by the supervisees, the execution of which, while perhaps less expert than a plan devised by the supervisor, would prove of greatest learning value to the supervisees. Because the students' status is dependent on evaluations by the supervisor, the process of supervision in agencies is apt to become extremely trying. A parallel situation develops when the supervisees are in training at a psychotherapeutic or psychoanalytic school and their careers are dependent on the evaluation by the supervisor. Similarly, if the supervisees are staff members of a clinic, the supervisor as part of the administration may subordinate the teaching role to overconcern with the total case load. This shift in emphasis cannot help but influence adversely the quality of training received; this is inevitable whenever the training is oriented around circumscribed goals set up in relation to specific kinds of service for which the clinic is responsible. Much less complicated is the supervision of psychotherapists in private practice, who choose a supervisor principally to expand technical skills, not being dependent on the supervisor for an evaluation that may destroy their careers or eliminate their means of livelihood.

In schools or clinics, the supervisor will usually operate as a teacher, an evaluator, an administrator, and a policymaker.

Teaching

The first responsibility of the supervisor is observation of the total functioning of therapists to help in the supervisees' educational growth. Toward this end, it may be essential to bring the supervisees to an awareness of how they have failed to live up to therapeutic potentialities, either because of insufficient knowledge or because of neurotic character problems that inject themselves into the psychotherapeutic relationship. It is incumbent on the supervisor, among other things, to help the supervisees (1) to gain knowledge that is lacking, (2) to achieve an awareness of their own character problems that may interfere with the establishment and maintenance of a therapeutic relationship, and (3) to overcome resistances to learning.

Evaluating

A second responsibility of the supervisor is an evaluation of the capacities and progress of the supervisees for the purposes of determining professional development and current skills as a therapist. Evaluation involves a number of areas, including theoretic understanding, therapeutic aptitudes, and the kinds of relationships that are established with patients and the supervisor.

Administration and Policy Making

The third responsibility of the supervisor lies in the helping of administration and policy making of the school or clinic under whose aegis the program is being conducted. The supervisor recommends modifications of the therapeutic and teaching programs that may influence adversely the training and the work of the therapists as well as the patients' responses to treatment.

To summarize, supervision in psychotherapy is fundamentally a teaching process in which a more experienced participant, the supervisor, observes the work of less experienced participants, the supervisees, with the aim of helping the supervisees acquire certain essential therapeutic skills through better understanding of the interventions involved in mental illness and through resolution of personality factors that block performance of effective psychotherapy. Supervision embraces a sharing of experiences; not only those gathered in the relations between therapist and patient, but also those occurring in the relationship between the supervisor and supervisees.

Qualifications of a good supervisor are the following:

1. Ability to function expertly as a psychotherapist.
2. Ability to function effectively as a teacher.
3. Ability to accept the supervisees unconditionally, without contempt, hostility, possessiveness, and other unwarranted attitudes and feelings.

Supervisory problems may roughly be divided into five categories of problems: orientation, recording, technical performance, learning and termination of supervision.

PROBLEMS IN ORIENTATION

Differences in Theoretic Orientation

Important and often irreconcilable differences occur in the theoretic background and orientation of the supervisor and the supervisees, a product usually of varying kinds of preclinical training. Illustrative of such differences are the following:

1. The relative weight to be placed on constitutional as compared with experiential factors in the genesis of neurosis.
2. The importance of biologic as contrasted with sociologic factors.
3. The respective emphasis on past childhood experiences and on current environmental hardships.
4. The degree of stress placed on unconscious conflict as the focus of neurotic and behavioral difficulties.
5. The extent of acceptance of the Oedipus complex, castration fears, and penis envy as universal phenomena.
6. The primacy of sexual over other drives and behavioral disorders.
7. The significance of character structure in creating and sustaining emotional disturbance.
8. The relative emphasis of conditioning theory in accounting for anxiety.
9. The value of short-term as compared to long-term approaches and of psychoanalytic versus behavioral and cognitive therapy.

The most effective supervisor is one who respects the right of therapists to their own ideas and opinions, yet who realizes that some of these may interfere with good psychotherapy.

Differences in Communication

Since communication is the basis of the supervisory relationship, it is important that verbalizations and concepts be understood by both supervisor and supervisees. Assuming that there are no important language differences, problems in communication are frequently related to differences in terminology.

A poignant objection to psychology by scientists in other fields is that it is partial to neologisms. Tendencies to use unconventional and complex terms have been one of the strongest barriers in a rapprochement with other sciences. Both supervisor and supervisees may be victimized by dedication to an esoteric terminology. Translation of complex terms into concepts with which supervisor and supervisees are conversant is vital to a mutual understanding and to the establishment of a common frame of reference.

Difference in Method

Another problem in supervision relates to differences in method—that practiced by the supervisor and that accepted or practiced by the supervisees. Such differences may involve various matters, such as the most desirable number of treatment sessions per week, whether or not to employ routine history taking and psychological workups, the use of free association, the emphasis on dream material and the manner of its employment, the use of the couch, the degree of activity in the interview, the extent to which a transference neurosis is permitted to develop, and the adjuncts to be used during therapy. Resolution of serious differences in method is to be expected in the course of good supervision.

Considerable flexibility will be required in methodologic approaches, particularly when the therapists are expected to handle, in the practice for which they are being trained, a wide assortment of clinical problems. Supportive of the principle of technical eclecticism is the fact that no single approach is applicable to all types of emotional difficulties. Some problems seem to respond better to certain kinds of therapeutic intervention than to others.

Differences in Goals

Problems may arise between supervisee and supervisor on the basis of varying concepts of what makes for success in psychotherapy. Is success in therapy the achievement of complete resolution of all blocks in personality maturation with effective functioning in all areas of living? Or is success to be graded in terms of optimal development within the practical limitations imposed on individuals by their existing motivations, ego strength, and environmental pressures from which they cannot reasonably escape?

Reasonableness dictates that though a responsibility exists in bringing patients to the most extensive personality reconstruction possible, there are circumstances that block this. A modest treatment objective may be the only possible alternative. Supervisees trained in the tradition that therapeutic change falling short of complete reconstruction is spurious, however, may look askance at the supervisor who considers goals in terms of optimal functioning within realistic limitations. Or conversely, the supervisor may be unwilling to accept goal modification and may downgrade changes that fall short of absolute psychosocial maturity and then blame the supervisees for not being able to do the impossible.

PROBLEMS IN RECORDING AND REPORTING

Careful listening to the supervisees' accounts, to the manner of reporting, to evasions and points of emphasis, to slips of speech, and to casual off-the-record references to feelings about patients help the supervisor to evaluate the therapeutic work of the supervisees.

In making this appraisal, the supervisor must take into account that the role being played by the supervisees with the supervisor, and the attitudes harbored, are not a reliable index of what the supervisees actually do with patients. With patients, supervisees are operating in an entirely different setting than with the supervisor, with whom they are in a more subordinate status, more vulnerable, and more capable of being challenged or criticized. They may respond to the supervisor with fear, detachment, resentment, and other character patterns related to feelings about authority. Therefore, it may not be possible for

supervisees to communicate to the supervisor their true capacities to be spontaneous, empathic, and responsive such as may occur with patients in the relatively secure atmosphere of one's office.

For instance, a therapist presented material to her supervisor in a cocky, superior manner, reflecting a somewhat contemptuous attitude toward the patient about whom she talked. It soon became obvious to the supervisor, however, in listening to tape recordings of actual treatment sessions, that hostile feelings were not manifest in the therapist's responses nor in her manner with the patient. Hostility, marshaled by transference feelings toward the supervisor, was seeping into the supervisory session and was influencing the nature of the reporting.

Neurotic feelings toward the supervisor may thus distort therapists' presentation of material. Pertinent data may be deleted, irrelevant items may be introduced, and secondary elaboration may destroy the value of the presentation. Fear of exposing deficiencies, of appearing ridiculous, and of incurring the displeasure and contempt of the supervisor are among the more common causes of poor reporting.

Anxiety to please the supervisor, to hold back differences of opinion, and to suppress transferential displays so as not to antagonize the supervisor may interfere with factual reporting. The supervisees may fear revealing what is happening in treatment so as not to appear incompetent.

Some of the difficulties in reporting may be obviated by insisting on process recording in which there is a verbatim account of both patients' and therapists' verbalizations. Process recording has the advantage of presenting a reasonably cogent picture of what is going on, since the tendency toward distortion or deletion will be minimized. There are certain objections to this method, however, in that the supervisees may be unable to record simultaneously while doing good therapy or because patients protest not being able to make good contact with someone immersed in writing. Furthermore, no matter how careful an attempt to record, the students will be unable to include everything that is said. There will then be a tendency to curtail the material, consciously or unconsciously eliminating elements that cause them to feel

that they are revealing themselves unfavorably. In intensive supervision, in which one case is being presented over a long period of time, the supervisor may, nevertheless, have to insist on process recording until convinced of the therapist's ability to report correctly in a more abbreviated way. (See Appendix K for a case outline.)

Perhaps the most effective type of recording is done with a video machine. These machines are now sufficiently improved and modest in price to become an almost indispensable item of equipment for supervision. This use is described and illustrated by Maguire et al. (1984) and Morgan (1984). Videotaping is valuable not only to the supervisor but also for playback to patients, who observe and listen to themselves communicating (Geocaris, 1960; Gutheil et al. 1981). Video recording is also helpful for playback to the supervisees, who may learn as much by self-observation as from the supervisor (Moore et al, 1965; Beiser, 1966). Moreover, the supervisor may profit from self-observance in supervisory operation. Audio recordings on tape are cheaper but less effective. For purposes of record keeping and for later transcription, however, audiotapes are sufficient. Few patients object to the use of machine recorders, and once the fears about revealing themselves have been overcome, the supervisees can function freely.

The value of video recording cannot be overestimated. It gives a most factual picture of what has actually gone on in the session, not only in content, but also in revealing bodily movements, intonations, and subvocal utterances that cannot be communicated in written types of recording. The method enables the supervisor to observe aspects of the interviewing process that are handled well or poorly. It helps to understand how the different kinds of content are dealt with, whether the supervisees exaggerate, minimize, or negate the importance of certain types of material. It permits observation of how the therapist responds to unreasonable demands of patients, to hostilities and other transference manifestations that are developing in the relationship. It enables the supervisor to study how techniques are being implemented. The difference between the written or verbal account and what actually went on, which is revealed in

observing and listening to a playback, is often so astonishing as to leave little question about the value of this kind of recording (Gutheil et al., 1981; Maguire, 1984; Morgan, 1984).

For instance, one supervisee's verbal account made no mention of hostile feelings in the patient, to which the therapist was responding by shifting the topic of discussion and by complacent, reassuring utterances whenever the patient introduced a slightly antagonistic remark. The supervisee was totally unaware of his diversionary responses, but in the playback he could not escape what had happened. Another supervisee reported a progressively deepening depression in a borderline patient. The process recording related that the patient talked incessantly about how she had been neglected, particularly by a mother preoccupied with outside activities, and a detached father. The supervisee, in her recorded responses, appeared to be saying the right things. A session of the supervisee working with the patient, which was recorded on videotape, however, demonstrated that the therapist had placed her chair so that she was not facing the patient; she was in effect detaching herself from her and repeating the patient's childish trauma. Correction of this position, with the closer interaction that the face-to-face placement encouraged, rapidly brought the patient out of the depression and accelerated progress.

The advantage of watching students performing with patients behind a one-way mirror and of recording the session on videotape so that it may be played back for the students is incalculable, since immediate feedback is possible. Parenthetically, a session in which the supervisor treats a patient, observed by students through a one-way mirror or by watching a video recording, is helpful in pointing out techniques that are difficult to describe verbally. Understandably, it will be impossible to use recordings at every supervisory session due to lack of time. Several recorded sessions presented during each six months of supervision will usually suffice to measure the therapist's progress, and in themselves will justify the use of the video machine. A unique device described by Boylston and Tuma (1972) is "bug in the ear," a receiver placed in the therapist's ear through which a supervisor gives instructions via a transmitter from behind a one-way mirror.

From the standpoint of research, recordings, videotapes, or sound film recordings of interviews permit the researcher to approach the problems of both process and outcome evaluation with greater objectivity (Davidman, 1964; Kubie, 1950b; Strupp, 1960).

Although the students' written notes and observations about therapeutic work are valuable (Beckett, 1969; Bush, 1969; Moulton, 1969), they are rendered more significant by studying the inclusions, omissions, and exaggerations in video recordings of the same sessions. As Schlessinger (1966) points out, different kinds of data are dealt with in both types of recording, each of which has a different potential for teaching but which is by no means mutually exclusive.

Recently, computer programs have been made available that have been found useful by some therapists, for example, Harless's Computer-assisted Simulation of the Clinical Encounter (Harless, 1971, 1972), which deals with diagnostic problem solving. Elaborations of this computer-assisted instruction involving typical psychotherapeutic situations will probably have a significant impact on some students since, as Hubbard and Templeton (1973) have pointed out, they can expose students to a wide variety of clinical problems, provide modes of practice and diagnostic skills in a simulated therapy setting, and permit early feedback by a consensus of experts in the field. The authors predict, because of such technological instruction, that a different role for teachers is possible. Heifer and Hess (1970) and Lomax (1972) have published interesting material on related new trends in teaching.

PROBLEMS IN TECHNICAL PERFORMANCE

The supervisees will experience trouble in various areas in the process of psychotherapy. These difficulties are the consequence either of lack of understanding, experience and skill, or of negative countertransference. They will have to be handled by the supervisor in relation to their origin and function. Most common are the following problems:

1. Difficulties in the conduct of the initial interview.

2. Inability to deal with poor motivation.
3. Inability to clarify for the patients misconceptions about psychotherapy.
4. Inability to extend warmth and support to the patients or to establish a good initial contact with them.
5. Inability to define for the patients goals in therapy.
6. Inability to structure the therapeutic situation adequately for the patients.
7. Inability to recognize and to handle manifestations of transference in the therapeutic relationship—specifically, dependence, sexual feelings, detachment, hostility, and aggression.
8. Lack of knowledge about how to explore and to bring to awareness conflicts that mobilize anxiety in the patients (in insight therapy).
9. Lack of sensitivity and perceptiveness to what is going on in therapy.
10. Lack of technical skill in the implementation of free association, dream interpretation, and analysis of the transference (in insight therapy).
11. Inability to deal with resistances in the patients toward verbal exploration of their problems.
12. Tendencies to avoid problems of the patients that inspire anxiety in the therapist.
13. Tendency to probe too deeply and too rapidly at the start.
14. Impatience with resistances toward the acquisition of insight (in insight therapy).
15. Faulty techniques of presenting interpretations.
16. Frustration and discouragement at the patients' refusal to use insight in the direction of change.
17. Tendency to push the patients too hard or too rapidly toward normal objectives.
18. Fear of being too directive, with resultant excessive passivity.
19. Lack of understanding of how to create incentives for change.
20. Lack of understanding in dealing with forces that block action.

21. Lack of understanding about how to help the patients master anxieties surrounding normal life goals.
22. Inability to scale down therapeutic goals when modification of objectives is mandatory.
23. Lack of understanding about how to implement the translation of insight and understanding into action.
24. Inability to deal with resistance toward abandoning primary and secondary neurotic aims.
25. Inability to deal with resistance toward normality.
26. Inability to deal with resistance in the patients toward activity through their own resources.
27. Tendencies to overprotect or to domineer the patient.
28. Inability to assume a non-directive therapeutic role.
29. Lack of understanding about how to deal with the refusal on the part of the patients to yield their dependency.
30. Lack of understanding of how to handle the patients' fear of assertiveness.
31. Lack of understanding about how to analyze dependency elements in the therapist-patient relationship.
32. Lack of understanding about how to terminate therapy.

Good supervisors exercise tolerance for the specific style of activity of the supervisees. They realize that irrespective of intensive training and exposure to specific schools of psychological thought, basic personality patterns of the supervisees will infiltrate the treatment situation. These cannot help but influence the techniques that have been learned. Some modification of learned techniques will always occur, particularly those that are not compatible with the therapists' style or personality structure. The supervisees will probably never be able to duplicate the exact style of the supervisor, nor vice versa, since they are individuals and relate to patients in their own unique ways. Yet certain basic principles in psychotherapy must not be violated, no matter what kinds of relationships are established and what types

of techniques are employed. By defining the broad bounds of psychotherapy, and by elucidating on the fundamental principles to which every therapist must adhere, the supervisor may help the supervisees perfect skills yet maintain spontaneity, which is a most cherished characteristic in the psychotherapist.

PROBLEMS IN LEARNING

A number of propositions are involved in the learning of psychotherapy that may be expressed as follows:

1. All learning necessitates a substitution of new patterns for old. This requires a working through of blocks that constantly impede the acquisition of new patterns. Sometimes the struggle is minimal; sometimes it is intense.

2. The manner in which learning proceeds is unique for individuals both in relationship to the rate of learning and the methods by which material is absorbed and integrated. Some people learn by leaps and bounds, others by cautious, precarious crawling. Many variants expedite or interfere with learning in different people. What is taught to individuals has to be accepted by them in their own terms.

3. Learning involves both an understanding of theory as well as its integration and translation into effective action. The instruction leading toward an understanding of theory is vested in the instructors and teachers with whom the supervisees have had preliminary training. The instruction for execution of theory into practice is vested in the clinical supervisors.

4. Little learning is possible without a motivation to learn. This motivation must be sufficiently intense to overcome the difficulties that are inherent in all learning. It is assumed that the supervisees have sufficient motivation—in terms of desire to be psychotherapists—to expose themselves to the ordeals of the learning process.

5. Anxiety is present in all learning. Its sources are related to fear of change and the desire to cling to familiar patterns as well as to resistance in altering basic accepted attitudes and behavior tendencies.

6. Some resistances to learning are present in all people in response to anxiety. The kind and the degree of resistance will vary with each individual. Most common are lack of attention, lack of retention, amnesia, and simulated stupidity. In addition, resistance may take the form of dependency, submissiveness, self-depreciation, ingratiation, arrogance, grandiosity, resentment, aggression, and detachment. These are products of specific neurotic character problems but there also may be a universality of expression of such trends in certain cultures, reflecting accepted attitudes toward education and toward the authorities that are responsible for education.

7. Resistances to learning must be overcome before learning can proceed. The attitudes of the supervisor are crucial here. The supervisor's tolerance, flexibility, and capacity to extend warmth, support, and acceptance toward the supervisees, irrespective of the errors that the latter make, promotes the most effective medium for the handling of resistance.

8. Learning is thus facilitated by a warm working relationship between supervisor and supervisees. It is impeded by hostility that develops in this relationship. A primary focus, then, in the supervisory process is the existing relationship between students and teacher, with thorough ventilation of negative feelings before these exert a corrosive influence on the learning process. The supervisees must be encouraged to express disagreements, criticisms, or feelings in relation to the supervisor. The supervisees must also be able to accept criticism, and this will be possible where there is a good rapport with the supervisor.

9. As a general rule, learning blocks are resolved during the first few months of supervision. An inability to master such blocks after several months indicates a severe problem that necessitates incisive investigation.

10. In learning, the supervisees have a backlog of past experiences on which to build. They cannot be expected to progress any faster than would be warranted by the degree of this experience, no matter how hard the supervisor may push; severe demands will be a hindrance.

11. As a rule, in the early stages of learning, the supervisees will feel resentful, unsure, and certain of failure. They will want to be told how to function—indeed, will demand that the supervisor demonstrate exactly what to do. The supervisor must accept the presence of dependency and yet treat the supervisees as equals. The setting of supervision is best permissive, the supervisees being given the feeling that they are free to act, experiment, and make mistakes. Mistakes are to be expected since even expert therapists make them.

12. Learning how to become a therapist is a tedious process enhanced by the active participation in the learner's growth. It is facilitated by selected case studies that serve a specific purpose in filling in gaps in experience, as well as by assigned readings and recommended courses. At all times, critical thinking is to be encouraged.

13. Learning is more an educational than a therapeutic process, and the focus in good supervision is on supervisees' work rather than their personal problems. It is essential that supervisees be treated as adults and not as problem children.

14. Learning is expedited by successes, and it is impaired by failures. Provision should be made for some successes that will reinforce learning. If supervisees encounter repeated failures, damage will be done to their learning capacity. The supervisor should therefore be encouraging and commendatory of any successes that are scored.

PROBLEMS IN TERMINATION OF SUPERVISION

The relationship that supervisees establish with the supervisor will, in general, proceed through various phases, including the establishing of rapport, the understanding of problems that occur in relationship to the supervisor, the translation of this understanding into corrective action, and, finally, the ending phase in which supervisees develop the capacity to carry on, on their own, with working through of the dependence on the supervisor.

If the supervisor has an authoritarian personality structure, it may be difficult to operate on equal terms with the supervisees. The supervisor will want to continue to make decisions, to utter judgments, and to offer interpretations, consciously or unconsciously resenting the supervisees' right to self-determination. Under these circumstances the ending of supervision may impose great hardships on both supervisor and students.

On the other hand, the greater the dependency needs in the supervisees, the more difficult it will be to countenance termination. An inability to resolve dependence on the supervisor indicates severe characterologic problems for which the supervisees may require further therapeutic help.

During the terminal phases of supervision the supervisor, in anticipation of the trauma of separation, may assume a non-directive role, insisting that the supervisees be more active and figure things out entirely alone. One may expect that the supervisees will respond to such non-directiveness with anxiety and hostility and that there will be an attempt to force the supervisor to abandon this passive role. If the supervisor is persistent, however, justifying the passivity displayed on the basis of a respect for the supervisees' growth process, the latter will eventually be convinced of the rationale of the supervisor's behavior.

TECHNICAL DETAILS OF SUPERVISION

Preclinical Training of the Therapist

Before supervision begins, the supervisor will desire information about the preclinical training of the prospective supervisees. Questions that may arise include these: Is the theoretic background of the supervisees adequate for functioning in psychotherapeutic practice? Have the required courses been taken and the essential reading done? Has this theoretic material been integrated satisfactorily? Do the supervisees have the personality qualities that will make for a good therapist? How profound an understanding do the supervisees have of their own emotional and interpersonal processes? Will the supervisees be able to resolve or to control the expression of hostility, detachment, sexual interest, overprotection, rejection, and other strivings on the part of the patient that will be inimical to the psychotherapeutic relationship? Can it be reasonably assumed that the supervisees are sufficiently adjusted to life now, so that they will not use the therapeutic situation and the experiences of the patient to live through vicariously certain frustrated ambitions. dependencies, and hostilities? Do the supervisees have a capacity to empathize with people, to feel warmth toward them and to communicate it? Is there the capacity to be resolute and firm on occasion, capable of insisting on certain essential actions during the therapeutic process? How much experience have the supervisees had in psychotherapy? What kinds of

cases have been treated and with what results? Has there been previous supervision, and if so, with whom and for how long? Do the supervisees believe such supervision has been beneficial?

There is general agreement that the prospective psychotherapist requires an extensive amount of preclinical training. A review of training that is being given in most of the recognized schools reveals a close similarity in prescribed courses and requirements. These include the following:

1. Courses in basic neuropsychiatry, normal psychosocial development, psychopathology, psychodynamics, techniques of interviewing, techniques of psychotherapy, dream interpretation, child psychiatry, group psychotherapy, and behavior modification.
2. Clinical conferences and continuous case seminars that have been attended regularly.
3. Readings in psychiatric literature of sufficient scope to provide the students with a good background in history, theory, and practice.
4. Ideally, enough personal psychotherapy or psychoanalysis to provide the students, first, with an opportunity to achieve self-understanding through self-observation, studying their own emotional conflicts, the genesis and projection of such conflicts into present functioning; and, second, to liberate themselves sufficiently from personal problems and character disturbances that interfere with the establishment and maintenance of a therapeutic interpersonal relationship.

Should the supervisees be lacking in any of these basic requirements, the supervisor must help find ways of making up these deficiencies. (See Appendix L, for a form that supplies the supervisor with essential information.)

The Beginning Stages of Supervision

The first contact of the supervisor with the supervisees is in the nature of an exploratory talk. At this time there may be a discussion of the supervisees' preclinical training, and arrangements may be made as to the hours, frequency of visits, and the method of recording and presentation. The supervisees may be given preliminary orientation as to what will be involved in supervision and how supervisory sessions may

best be used. Arrangements may be made for the handling with the supervisor of any emergency situations that may occur during the course of supervision.

In the early months of supervision, a period of disillusionment is to be anticipated. Supervisees will be brought face to face with practical problems in implementing therapy that may be at variance with what has been learned from books. Student therapists often are upset by the fact that the specific kinds of problems that provoke their patients may be precisely those that are disturbing to themselves. They may be exposed to certain situations that develop in treatment that have a violent impact on them and tax their own capacities for adjustment. It is incumbent upon the supervisor to extend to the supervisees during this period a good deal of warmth and understanding. The primary focus in early supervision is the relationship between supervisor and supervisees, since little progress will be possible until good rapport exists.

Later Phases of Supervision

In supervision the supervisor seeks to ascertain whether or not the supervisees are living up to their potential. If not, the sources of this lack must be diagnosed. For instance, the problem may relate to deficiencies in the kind of preclinical training received, or in the assimilation of educational materials presented in training. It may be due to an absence of perceptiveness or to insensitivity about what is going on in the therapeutic situation. It may be the product of personality problems that prevent the supervisees from establishing a meaningful contact with patients.

The areas in which supervisees need help will soon become apparent. In the main, technical problems break down into difficulties in diagnosis, conduct of the initial interview, use of interviewing techniques, understanding of the operative dynamics, detection and handling of transference, awareness and mastery of countertransference, dealing with resistance, use of interpretations, and termination of therapy.

The task of the supervisor here is not to tell supervisees what to do but rather to teach them how to think through solutions for themselves. Toward this end, it will be essential to ask questions and to structure problems so that the supervisees can come to their own conclusions. Learning problems are to be diagnosed and handled along lines indicated previously. Modes of improving sensitivity are described by Fielding and Mogul (1970).

In the course of supervision, supervisees are bound to show transference manifestations. The supervisor will also have emotional attitudes toward the supervisees. Both positive and negative feelings will have to be subjected to close scrutiny to permit development of empathic yet objective attitudes. Furthermore, the supervisor will have to maintain a certain amount of tension in the supervisory sessions to expedite activity.

The beginning supervisor, particularly, may respond to supervision with untoward feelings. There may be a tendency to be pompous and overbearing and to overwhelm supervisees with material. The supervisor is apt to feel irritable when supervisees do not learn rapidly or defy suggestions and criticisms, even though these are offered in a constructive way. The supervisor may be provoked when there is persistence in errors that are so obvious that they scarcely need identification. Such attitudes on the part of the supervisor will, of course, interfere with learning. An honest self-questioning by the supervisor will often reveal tendencies that stifle the development of supervisees. It must be emphasized again that some countertransference is always present and that it need not be destructive to the teaching objective, provided that the supervisor is capable of understanding his or her feelings and of modifying and correcting them before they get out of control.

Disagreements between the supervisor and supervisees are inevitable, even desirable. All learning inspires resistance. Supervisees will voice protests in changing habitual patterns. They are bound to be critical. Actually, they cannot change unless they are given an opportunity to voice and to work through their criticisms. The supervisor may be offended by such challenging reactions, but will best be able to

respect the supervisees' right to their own opinions, realizing the unavoidable learning struggle that is involved.

Essential for learning is an open mind to new ideas. Some students have already settled their opinions about psychological theory and process and seal themselves off from fresh points of view. What they seek from the supervisor is a confirmation of their frozen ideologies. Similarly, there are supervisors so rigidly wedded to their credos that they insist on their students becoming a mirror image of themselves. Vital for learning in the supervisory process, then, are participants who are willing to collaborate, share experiences, and, if necessary, change. Students must be able to countenance exposure of deficiencies in psychotherapeutic performance. The supervisor must be able constructively to bring students to an awareness of these deficiencies and to provide students with an appropriate means of rectifying them.

Illustrative of some of the problems are the following comments of a supervisor:

> I have a supervisee who is a chatterbox and who is highly defensive about any comment I make—even a casual comment on the dynamics is interpreted as a criticism of her. Her defense is to interrupt, challenge me, justify herself, etc., without permitting me to finish what I have to say. Often, by the end of the session, I find that I have been able to tell her very little. I have been debating with myself whether to take up the problem with her directly, which might merely provoke additional defensiveness, to pull back and tell her virtually nothing until she complains about it to me, or to go on as I have but being very supportive until she feels less threatened.

These are the remarks of a student:

> The trouble with my supervisor is that he is constantly trying to force his point of view on me. I would think that he would know I can't do things exactly how he does them. I would like to have him help me work better with my good points and to help me eliminate my bad points. When I show him what I believe is a gain in my patient, he usually criticizes it as merely defensive, a new resistance.

In both of these illustrations effective learning is being blocked by problems that are influencing the relationship between student and supervisor. The supervisory encounter is far more complex than that of a simple teaching contingency. It embraces unconscious processes that may require mutual exploration. In

any of the social sciences where professionals function as investigative or therapeutic tools, there are bound to be differences in theoretical assumptions and methodological approaches. These differences may interfere with the manner in which individuals communicate themselves to other professionals. Even within the same school, problems in communication may be vast. They are particularly annoying in the psychotherapeutic learning and teaching situation.

The supervisor is constantly involved in a process of self-analysis while relating to supervisees and examining personal reactions, both transferential and reality determined. There is recognition that students will be carrying out therapy with their own personalities and not with the personality of the supervisor. Students may not be able to perform exactly the way the supervisor performs, nor will students be able to deduce from interactions with patients all of the nuances that are apparent to the supervisor. A tremendous amount of tolerance and acceptance will be required from the supervisor that may tax the latter's patience and bring countertransference into play. Although the supervisor serves as a model for the student, it must be a flexible model and not one that demands a clone. These conditions should readily be acceptable to anyone who possesses the sophistication that is a prerequisite for becoming a supervisor, understanding from experience that there is no single accurate way of providing therapy. There are many ways. What can be taught is a broad framework of psychotherapy with a buttressing up of those elements of the students' functioning that permit good therapeutic process, while expurgating interfering elements.

'Intensive' versus 'Technical' Supervision

In practice, two general types of psychotherapeutic supervision may be defined. The first type, "intensive" supervision, consists of the "continuous-case" type of reporting with a single patient, preferably from the initial interview to termination, using video recordings if possible. This enables the supervisor to help supervisees in all phases of treatment by observing operations with one patient over a long-term period. "Intensive" supervision is the most effective kind of teaching for beginning therapists.

The second type of supervision, arbitrarily called “technical” supervision, may be further divided into two subtypes. The first, or “case-load” supervision, which is usually prescribed especially for beginning therapists in a clinic, covers the general progress and specific difficulties being encountered in the entire case load of the supervisees. This might be considered a kind of administrative supervision. The second subtype, which we may, for want of a better name, call “special-problem” supervision, is handled in a manner similar to a clinical conference. Any pressing problem in diagnosis, psychodynamics, or technical management may be presented, and the discussion is centered around the specific difficulty encountered by the supervisees.

The latter kind of supervision is more highly advanced than other types and presupposes more experience on the part of the supervisees. It may also be effectively practiced in a group of no more than three or four therapists, who participate in the discussion with the supervisor. Each therapist may be given the privilege of presenting material on successive sessions. In practice, this proves to be a highly provocative teaching device, provided all the supervisees are on approximately the same level.

The Evaluation of the Supervisee

Evaluation is a means of helping supervisees develop skills through a continuous assay of strengths and weaknesses. As such, it becomes part of the teaching method, pointing to areas in which more development is needed and helping in a positive way to promote such development. Criteria of evaluation may be along the following lines:

1. Method of presentation, and recording ability.
2. Theoretic understanding.
3. Diagnostic ability.
4. Integration of theory into practice.
5. General therapeutic aptitudes, sensitivity, empathy, and capacity for critical thinking.

6. Kinds of relationships that the supervisees establish with patients and the skill in handling these relationships.
7. Type of relationship that the supervisees have with the supervisor and the use made of the sessions.
8. Types of relationships that the supervisees establish with colleagues and personnel of the clinic, if any, with which they are affiliated.
9. Supervisees' good points and special skills.
10. Supervisees' deficiencies.
11. General learning ability and the progress that has been made in learning.
12. Positive recommendations for increasing learning, including recommended readings, prescribed courses, and preferred kinds of cases to be assigned.

Yardsticks of expected progress have never been set. Arbitrarily, a rough gauge such as the following may be useful to indicate minimal levels of achievement:

End of first six months of supervision: Ability to make diagnoses, ability to keep patients in therapy.

End of first year: Ability to understand what promotes, aggravates, and helps emotional illness; capacity to establish good rapport with patients.

End of one and one-half years: Recognition of personal problems in therapeutic functioning.

End of second year: Ability to overcome most personal problems in therapeutic functioning.

End of two and one-half years: Ability to function without serious mistakes.

End of three years: Ability to do good psychotherapy.

Evaluation imposes burdens on both supervisor and supervisees. The supervisor may not want to criticize out of fear of hurting or offending the supervisees. The latter, in turn, may feel humiliated at having weak points exposed. The manner in which evaluation is presented, and the purpose for which it is used, will largely determine the reactions of the supervisees. If understanding is clear that there will be

periodic evaluations, say every six months, to point out the areas in which the greatest or least development has been made, the experience can prove to be an aid to learning.

The evaluation conference may be set up in advance, and supervisees and supervisor may prepare their observations for mutual discussion and consideration. At the conference a common understanding must be reached. If a written evaluation must be sent to the head of a clinic or school, agreement on as many points as possible is best achieved in advance of sending the report.

The point at which the supervisor certifies the student therapists as competent to do psychotherapy will vary with the kind of therapy for which the students are being prepared. Table 61-1 shows an outline for evaluation for certification that has been used at the Postgraduate Center for Mental Health.

Administrative Responsibilities

If the supervisor and supervisees are associated with the same clinic, the supervisor will have further responsibilities. For instance, the supervisor may participate in an analysis of administrative or intake policies, making recommendations toward alteration of old, or the devising of new, policies. The object here is the elimination of influences that are destructive to the patients' therapy or to the therapists' functioning. If supervision is part of a school training program, the supervisor will also probably be engaged in an analysis of administrative and pedagogic procedures in the program. This will include methods of choice of students, modification of curricula, introduction of new courses, and proposed changes in instructors or instructional methods. Routine meetings among the supervisors, or between supervisors and the supervisory head, will cover discussion of such problems in detail, with the introduction of whatever current difficulties the supervisor is having with supervision and routine evaluations of the progress shown by the different supervisees.

SUPERVISION AS AN INTERPERSONAL RELATIONSHIP

The supervisory relationship is one to which supervisees react with mingled attitudes of admiration, jealousy, fear, and hostility. Admiration and jealousy are usually inspired by the supervisor's superior

knowledge, training, and status. Fear of the supervisor is often the product of the therapists' helplessness in the face of an authority, who, they feel, may judge them unfairly and destroy their careers and livelihood in the event they fail to live up to expectations. Hostility issues from many sources. On the one hand, it is the product of dependency on the supervisor, which is especially inevitable at the beginning of supervision. Dependency yearnings that are mobilized are usually accompanied by expectations that these yearnings will be frustrated. Feelings of being victimized by these dependency needs, and the threats imposed by these needs on independence and assertiveness, inspire further resentment. The very acceptance of supervision implies to some supervisees a kind of subordination that imposes burdens on adjustment, particularly when independence has become the keynote in the students' life struggles. The supervisees, in addition, resent demands that they believe the supervisor makes on them. The restrictions imposed on the students, the criticisms directed at their functioning, deliver blows to their narcissism and contribute to further fears of loss of self.

Supervision will thus produce feelings in the supervisees that are related to neurotic attitudes toward authority. Difficulties may come out openly in the form of verbalizations or behavioral acting-out. They may also be concealed behind a barrage of defenses that reflect supervisees' habitual covert patterns in their dealings with authority.

The supervisor, in turn, will respond in supervision with untoward feelings toward the supervisees, many of which are the product of neurotic attitudes toward subordinates. In a flush of omnipotence, a patronizing attitude may be displayed toward the supervisees, with presentation of ideas as if they were irrevocable pronouncements. Contempt may be expressed for the relatively inferior knowledge, skill, or status of the supervisees. Hostility may appear when supervisees challenge the supervisor's opinions or theories. The growth or advance of the supervisees may be resented from a desire to keep them on a

subordinate level, in an effort to preserve superiority. Accordingly, successes of the supervisees may be threatened with chariness of praise, so important in learning. Such attitudes are rarely expressed directly. They may be cloaked in solicitous, ingratiating behavior with overkindliness and overattentiveness. Or they may show up as disinterest, offering the supervisees little help or reassurance. Searles (1955) and Benedek (1972) have written on the use of the supervisor's feelings and "intuition" as a way of gaining understanding into the problems of supervisees.

The supervisory process will thus arouse varied feelings and attitudes in both supervisor and supervisees that are inimical to learning. Sufficient resolution of such deterrents must occur before progress is possible. As a general rule, assuming that the participants are mature people capable of facing their feelings and communicating with one another, differences should be satisfactorily resolved. Problems may persist in some cases, however.

The supervisor may be tentative, indecisive, irritable with the students, overprotective, and patronizing, all of which put a damper on the students' need to express criticism and verbalize doubts. Lack of interest in the students and their growth acts as a damper to learning.

In supervisees, character problems show up in the form of many resistances, some of which persist with an amazing tenacity. Among these are attitudes of conformity and a seeming absorption of every gesture and utterance of the supervisor. This spurious kind of admiration is accompanied by a constant repetition of mistakes, as if all knowledge is shed immediately after leaving the supervisor's office. There may be a continuing fear of losing one's independence by yielding to the supervisor's dictates and demands. Resisting learning then becomes for the supervisees a means of retaining identity.

Another kind of resistance is the need to dominate and to take control by out-supervising the supervisor. In such cases, the supervisees overwhelm the supervisor with material, edit reports—even falsifying material—to impress the supervisor. Belittling and derisive attitudes and feelings may exist

toward the supervisor that are only indirectly expressed and that serve to protect the supervisees from fancied exploitation and injury.

On the other hand, those supervisees with many personal problems may become so terrified about what is happening in the relationship with the supervisor as to seek reassurance, affection, and support in sundry ways. One way is to become helpless and hopeless, assume a defenseless attitude, and seek from the supervisor various panaceas for difficulties. In making such demands, the student-therapist may express lack of confidence in resolving developing problems in an attempt to force the supervisor to shoulder all obligation for decisions. Self-devaluation may follow in the wake of this attitude, much of which is an effort to avoid criticism and to forestall responsibility.

Resistance to learning may also be expressed in the form of hostility. The patterns that hostility takes are legion, depending upon the individuals' habitual modes of dealing with this emotion. When supervisees find it hard to express rage, their response may be depression and discouragement. One individual may seek to terminate supervision on the basis that he is completely incapable of learning. Another may mask her hostility with dependence, with feigned amiability, and with strong gestures to force the relationship with the supervisor into social channels. In instances where the student-therapist is capable of expressing her hostility openly, she may become defiant, challenging, and overcritical. She may develop feelings of being exploited, misunderstood, and humiliated, and she may attempt to find evidence for these feelings by misinterpreting what goes on between herself and the supervisor. She may become suspicious about the supervisor's abilities, training, and personal adjustment. She may enter into active competition with the supervisor, bringing in materials, quotations, and references from authoritative works to challenge the supervisor or to nullify suggestions the latter has made. In some instances, the supervisee may actually become uncooperative, negativistic, and even defiant. In other instances, hostility is masked by apathy and detachment. Here one will get the impression that the

supervisee, while presenting material and listening to the comments of the supervisor, is mentally "off in the clouds."

Supervisees may also try to ward off the supervisor by discursive talk about superficial topics or by self-interpretations that are expressed with great vehemence. This attempt to disarm the supervisor by spurts of productivity has little corrective value for the supervisees, since it is motivated by an effort to belittle the supervisor rather than to learn.

Other resistances take the form of an inability to think clearly and an incapacity to express one's ideas. There may be an insistence by the supervisees that there is great development that is not supported by facts, and though self-confidence and assertiveness may be expressed, these will be found to be without substance. Another defense is an attempt to seduce the supervisor with gifts, lavish praise, and compliments. The overvaluation of the abilities of the supervisor may be boundless, and an unwary supervisor is apt to respond to these devices with omnipotent feelings.

Assuming that the supervisor is capable of controlling or of resolving countertransference, can help be rendered the supervisees to overcome such varied resistances to the supervisory relationship?

One must remember that supervision is a student-teacher, rather than a patient-therapist, relationship. Emotional problems stirred up in supervisees during work with patients cannot entirely be handled by the supervisor in the setting of supervision. Although the outcome of supervision may be therapeutic for supervisees, the goal is toward more adequate functioning in psychotherapy rather than the helping of personal neurotic difficulties. Naturally, the supervisor does point out neurotic problems that express themselves in resistance to learning and in countertransference in the hope of dispelling blocks in functioning. Since some of the problems that supervisees experience with the supervisor may be similar to those being experienced with their patients, working them out with the supervisor is bound to have some salubrious effect on overall therapeutic functioning. It is assumed that most supervisees have had

sufficient personal psychotherapy, or are sufficiently integrated emotionally, to be able to resolve blocks through their own resources in the supervisory setting. The supervisor will have to handle those aspects of feeling and attitude that impede the acquisition of therapeutic skills. This experience, as has been mentioned, may prove itself to be therapeutic for supervisees, but, if this occurs, it is a byproduct of the chief objective—the learning of psychotherapy. Should the supervisor's effort to help supervisees resolve difficulties fail, referral for personal psychotherapy may be advisable, which the supervisor may also benefit from receiving if personal problems in the existing relationship with particular supervisees cannot be worked through. In the event mutual trust and respect do not develop between supervisor and certain supervisees and no progress in learning has occurred after these avenues have been tried, transfer to another supervisor may be necessary.

These difficulties are not uncommon in a school or clinic. They are attenuated, though not entirely obliterated, when a therapist in private practice chooses and pays for a supervisor who does not need to render reports to the school or clinic.

Among the recommended readings on supervision are Alonson (1935), Arlow (1963), Blumenfield (1982), Caligor (1983), Collins (1962), DeBell (1963), Ekstein and Wallerstein (1958), Fleming (1961, 1963, 1967), Fleming and Benedek (1966), Grinberg (1970), Grotjahn (1955), Hess (1980), Kris (1956), Langer et al. (1964), Langs (1979), Schuster (1972), Solnit (1970), Steinhelber (1984), Szasz (1958), Towle (1954), and Windholz (1970).