The Relationship in Psychotherapy and Supervision

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This book is dedicated to the many therapists who over the years have sought me out for a supervisory experience and in the end have taught me about myself and the nature of our work together.

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Part I. General Considerations Regarding the Supervisory Relationship

Relationship in Psychotherapy and Supervision

Successful psychotherapy and supervision are characterized by a series of relational moments that are experienced by participants as mutually transformational. I say this based not only on the massive research of the recent task force of the Psychotherapy Division of the American Psychological Association,[1] but on the basis of my own experience over a forty year period of doing psychotherapy myself and supervising therapists from many different theoretical and technical persuasions on their most challenging cases.

During my four years of post-doctoral training in psychotherapy beginning in 1969 I set myself up as a consultant to other therapists in Orange County, California where, despite my young age, I quickly became recognized as “senior” in the sense of being able to help therapists with their most difficult psychotherapy dilemmas. Living in the mountains above Orange county, there are two roads down—one to the southwest and the other to the northwest—so I was within easy reach of any number of agencies, clinics, and group practice offices throughout the sprawling county where I found therapists eager to discuss perplexing cases. By 1980 I was consulting with 30 groups of therapists all over the county in their places of work as well as conducting individual and group supervision in my office—along with a full-time private psychotherapy practice of my own. I soon set up monthly reading groups and lectures on topics of concern to therapists. In 1983 I moved my continuing education project, the Newport Center for Psychoanalytic Studies, from Newport Beach to the city of Orange in order to establish a more centralized location for what was to become the Newport

Psychoanalytic Institute. Within five years NPI became securely established so that I was able to assume a back seat position and to continue my own research, writing, and continuing education activities at the renamed Listening Perspectives Study Center in my office. I know of no other individual anywhere who has actively sought out and created as many or as diverse supervisory experiences as I have. Individual and group supervision have been the most important and rewarding activities of my professional career. As a rich learning experience, supervision puts me in indirect touch with clients I might never see in my own practice and exposes me directly to ways of thinking and working with other therapists that would never have occurred to me.

For example, some years ago a young man with extensive Bioenergetic therapy training asked me to be his supervisor for a year at a special education school as he prepared for his state license. He began each hour by describing how one of the children he worked with walked on the playground, or held his shoulders, or threw a ball, or suppressed his voice and averted his eyes. While I have since done considerable training in body psychotherapy myself and have learned how to read a great deal in bodies, at that time this approach was all new and mysterious. But I gradually caught on to how this very skilled therapist perceived tensions in a child's body and how that led him to interact in crucial ways in the child's psychotherapy play. Another man with extensive training in cognitive behavioral therapy would regularly report on the results of homework assignments from a workbook he would give his clients or on what they produced in their written "thought records" between sessions. He had an uncanny sense for which specific details out of many to focus on that would serve to open up the deep emotional life of his clients. From these and many other

therapists I learned new ways of perceiving, new ways of formulating and integrating thoughts and feelings, and new ways of attending to the details of my clients' as well as to my own emotional reactions to each of them. I quickly learned that it wasn't what one did or didn't do in terms of specific theories or techniques that mattered, but rather the total immersion of two people in a relationship search for personal meanings that yielded results. I soon learned several other important supervisory lessons.

I learned to keep my mouth shut and listen carefully when therapists of vastly different theoretical and technical orientations were first presenting their work to me. I realized that how *I* might view the case or how *I* might choose to intervene were irrelevant to understanding this therapist and her view of things and how she had chosen to train herself and to work with this client. We all have our own personalities and our own ways of ordering our understandings of the professional world we work in. It was my first supervisory task to become familiar with the way each therapist had come to grips with the psychotherapy encounter that she or he found themselves immersed in.

The second thing I learned early on was to ask for a detailed rendering of exactly what was going on as the therapy was unfolding. Some therapists chose process notes as their medium of communication, others used tape recordings or detailed case histories, or theoretical discussions about the therapy process, or their countertransference responsiveness—each had her or his own way of thinking about and talking about what was happening. My most frequent questions were, "when your client or you said or did such-and-such, how did you understand it and how did you feel about it?" My second supervisory task then was to elicit the details of the personal

experience of each therapist of what was going on for them and their client—with a minimum of interference or interpretation on my part. At most I might comment on how well things seemed to be going or what a difficult, puzzling, or interesting situation this was—how in the world would we sort this all out?

The third thing that soon became apparent was that from time to time as a therapist would be reporting on her work she would look up at me and thoughtfully say something to the effect of, “what I really think is going on here is….” As these asides would begin I knew I had hit pay dirt! I quickly learned to call for elaboration and speculation—including where that left the therapist in terms of gut reactions or feelings about the client or what was transpiring between them or in the private thoughts and emotions of the therapist. I would then be in a position to ask, “Well, did you tell your client this?” The answer would invariably be “no” or “sort of” or “not yet,” The supervisory process then became one of helping the therapist to further develop her hunches about what was going on with her and with her clients and then to devise ways of communicating with the client about what she knew intuitively but didn’t quite know that she knew or didn’t know how to say. “Your ideas and feelings may not be totally accurate,” I would say, “but you’re a pretty smart and sensitive person, so that whatever you are thinking and feeling can’t be totally wrong either. You just have to find a way of putting it out there tentatively and see what your client does with it. If you throw out your ideas in a hesitating, uncertain, and correctable manner and your timing is bad or you’re way off the mark; don’t worry, you’ll be ignored! But to the extent that your thoughts and feelings are pointing toward something important for your client, he will quickly pick it up and run with it.”

So my basic formula for supervision became, “keep your mouth shut about your own reactions and ideas, ask the therapist for details of what’s going on and how she understands and feels about it, and then challenge the therapist to put her ideas and feelings into the therapy ring for consideration. As the supervisory relationship builds, of course, there will be plenty of room for the supervisor’s personal contributions and for teaching theories that may be of use to the therapist in working with particular clients. But until this happens, the goal is to keep the therapist carefully observing details and reporting what is going on as she sees it and figuring out how to communicate what she sees and feels to the client—regardless of the so-called content of the therapy sessions or whatever techniques the therapist is choosing to use. That is, two people in therapy can be discussing anything that interests them both in any way they can devise. But what becomes decisive in psychotherapy are the relational moments they can jointly create in which they are both emotionally invested in paying attention to what’s happening between them as they carry on together. I find this relational slant to be invaluable even when the therapist’s theoretical orientation explicitly says that proper technique and not the relationship is what’s important. That is, I have found that regardless of theoretical orientation or preferred techniques, when the going gets rough, it is the developing ways that two people collaborate to explore meanings together and their emotional involvements with each other during the process that lead to transformative relational moments. Further, as the supervisory process deepens over time, both therapist and supervisor begin to note tensions in the supervisory relationship itself that become the momentary relational focus that points toward additional dimensions of the therapist’s work with the client. Many times, of course, what’s

happening in supervision reflects what's happening in the therapy so that becomes a focus. More on this later.

I think of relational moments in therapy and supervision as transformational moments—present moments that two or more participants work toward in order to create mutual understanding which they then feel profoundly affected by. At times I think of therapy and supervision in terms of making love—of two seducing each other into mutually stimulating interactions until their horizons of experience meet at a point of union—where each feels recognized, known, experienced by the other—the most rewarding of all intimate human experiences.

The central questions to be addressed in this book are: "What is actually being taught in psychotherapy supervision? And, "what exactly is being learned in psychotherapy supervision and how is it being learned? If we think that definitive knowledge about the human mind is our goal we will surely fail in our supervisory efforts because mind is infinitely complex and elusive. If we think that teaching people to live better lives is our goal then we will surely fail because we have no idea what a better life might look like for any particular person. If we think that teaching therapists theory and technique is our goal we will also surely fail because there are no theories or techniques that can be universally applied to the problems of living that different people encounter. We are left in bewilderment wondering what on earth psychotherapy is all about anyway and how can it possibly be helpful to anyone? Then comes the supervisory question of whatever we may think will be helpful, how can we possibly teach it to others?

If, as is often said, psychotherapy is the impossible profession, then surely the teaching of psychotherapy is doubly impossible! But, fortunately, some of the finest

minds on the planet for more than a century have applied themselves to puzzling out these very questions with some truly astonishing results—so we are by no means totally in the dark. This book is about reviewing and expanding some of the most interesting and useful ideas about the nature and practice of psychotherapeutic and supervisory relational processes.

A Not-so-surprising Relational Moment

The past two decades marking the turn of the millennium have witnessed a sea change in global culture that has profoundly affected how we think about ourselves and how we behave with each other. While there is a certain widespread nostalgia for more leisurely times with seemingly more controllable interpersonal forces, those times now seem lost forever. The TXT generation has no patience for the slow-paced sluggishness and thinly-veiled frauds and hypocrisies of yore. Now moments are relational moments and those who fail to step up to the relational plate are quickly left behind. Older generations decry, as they always have, the deplorable changes in our youth and prophesize gloom and doom to those who fail to understand and respect the old ways of relating. But surely this is wrong. I have a story to illustrate.

One Sunday evening as I was driving home I stopped at a local suburban steak house I had never been to before to get a beer and a bite to eat. The large, high-beamed cavernous dining room was filled with couples and groups of couples from the surrounding neighborhoods gathered for grog and dinner without the kids. The room was full of casual Sunday night laughter accompanied by saxophone, trumpet, and guitar sounds of days gone by. I had arrived at the end of the evening and soon the

cocktail band packed up and couples began saying goodbye to each other and filing out into the chilly damp night air home to bed.

I was about to leave when I began to sense something else happening around me. Instead of things slowing down, the restaurant staff seemed to be multiplying with an influx of young servers and security people arriving. The tables and chairs were being relegated to the wings and sidelines. The lighting changed and I became aware of a prominent DJ booth hanging out over what was rapidly being turned into a large dance-floor. Disco balls and laser lights began whirling and I became aware of a noisy crowd of young people lined up at the door waiting for the signal for the evening to begin. I was the only one of the old crowd left sitting alone at the bar. Curious as to what was about to happen, I ordered another beer. A dozen large video screens up high all around the room jumped into life with visions of young people partying—alive, dancing, laughing, and having fun! A cocktail waitress was distributing instruction sheets on the tables around the room and at the bar. I read, “to register your code name call—and a telephone number. For the DJ call…for screen time call…to give codename of who you want to speak to call….” I sat for a few minutes in bewildered wonderment. Soon the floodgates were lowered and in rushed 150 young people with green plastic bracelets for those who had 21-year-old ID cards and white for the under-aged. Each person had stuck onto her or his back their own code name for the evening—so that anyone could text or call them I quickly realized. And the uproarious party began! The kids all appeared to be from local high schools and colleges and definitely in the habit of escaping the family to gather together here on Sunday nights. Cell phones dangled around necks, wrists, and waists. They had all come in enthusiastic groups and were

there to play with old friends and to meet new friends. As they snapped photos of one another in ridiculous poses the pictures were instantly flashed to the big screen or one of the many other side screens that dominated the room—with everyone laughing, pointing, hugging, kissing, doing hi-fives, and slapping each other on the back (or butt!). Occasionally a bare ass or tit would flash from someone's phone photo file only be quickly censored by the video mistress amidst a roar of laughter. Slide shows from last Saturday night's house party or a recent live rock concert at the Forum filled the room. Amazing clips from YouTube synced to the tune of the hip-hop music filled the air while everybody joined in, dancing, laughing, and doing scandalous "porno Congo lines" with everybody else. This is relationship in a new key—filled with love and laughter and with honesty and the truth of mutual concern and mutual exposure and vulnerability. These young people have been watched by electronic eyes and have been watching everyone else through electronic eyes since the day they were born. They know how to use these expanded electronic means of making contact and have at their fingertips the means to play with each other all day and all night long—enjoying each other in relational modes never before dreamt of that come as a total enigma to their elders.

Not long after my TXT-Videophone evening at the disco, my eyes were filled with tears to watch young Iranians twittering the plight of their revolution to the world—the crushing atrocities of totalitarianism and police brutality can no longer be hidden from the justice-seekers of the world and their pocket electric eyes. And then Tunisia, Egypt, Syria, Libya, and China. This is indeed a new world!

The communication explosion has rapidly overtaken us, creating unheard of relational demands on all people everywhere. For centuries we have lived in a world of

mechanical cause and effect relational realities until the demands of World War Two ushered in new informational relational realities. But mechanical and informational realities are rapidly giving way to global realities of communication and shared relationships.[2] While the new communication-relating realities are taking on breathtaking new forms around the world, we therapists, and supervisors are having a hard time keeping up. This book is a preliminary attempt to assess the newly-formed relational demands of the technological communication era that has at last exposed us for who we are—a relational species, nature's first experiment in emotional intimacy, the cutting edge of Darwinian evolution. It is now clear that relationship is the essence of psychotherapy and supervision.

This book on psychotherapy supervisory and relational processes presupposes that you already have a working knowledge of and competency in the situational requirements and limits of your own psychotherapy, supervisory, and training setting—be they private, academic, agency, or government imposed. But the book is also addressed to all psychotherapists, educators, health professionals, and others who are actively using relationships and communication in their professional world. The book begins with a careful assessment of the impact of the sea-change in the mental health, health, and educational professions over the past two decades attributable to technological advances in neurological and brain studies, infant research, neurocardiology, anthropology, sociology, primatology, post-modernism, constructionism, and relational psychotherapy as well as to a wide range of cultural shifts in the direction of diversity, egalitarianism, and social justice. What is absolutely clear is that we are a relational species, and that our brains and neurological systems

actually form in the context of whatever intimate relational opportunities are available in early development and throughout our life spans. This dawning knowledge clarifying our fundamental relational nature has massive implications for the relational processes involved in doing psychotherapy, teaching, and supervising psychotherapy as well as other clinical and educational disciplines.

As already mentioned, a recent task force of the Psychotherapy Division of the American Psychological Association has reviewed thousands of empirical studies and revealed that the single most consistently important factor determining the overall outcome of all psychotherapies is the relationship between the therapist and client.[3] What clients remember years later is not what their therapist said or did, but the relational moments in which they experienced emotionally intimate recognition from a very real person, their therapist.[4] It follows from this that the single most important factor in the supervisee-supervisor experience is not the imparting of technical or theoretical knowledge, but rather the creation of an interpersonal atmosphere for generating an appreciation of the power of the professional relationship itself. This book explores the psychodynamic and relational processes involved in psychotherapy as well as other clinical and educational training and supervision.

Dream of the Lifeguard Chair

Psychiatrist Jonathan Schindelheim reports a dream he had in supervision that taught him the importance of recognizing and processing the experience of supervision with his supervisor. He describes how as a therapist in training he frequently felt confused, disoriented, and lost either when with his client or with his supervisor. He had struggled to apply his theoretical and technical learning the best he could but still often

ended up feeling inept. One day he attended a supervisory seminar held by Self Psychologist Evelyn Schwaber that changed his entire way of experiencing and thinking about his work. The seminar “suggested a new age of relativity in psychotherapy in which the patient's perceptions have as much inherent validity as those of the therapist.”[5] He notes that the revised therapeutic stance that the new relational relativity ushers in is especially powerful in allowing the therapist to explore the client’s realities in relationship to the therapist.

Subsequently Schindelheim sought out Schwaber for ongoing individual supervision in which he found it an arduous task to relinquish his accustomed place of authority over the therapeutic relationship in favor of a more mutual relational stance with his client. He reports that he felt a new responsibility for his contribution to the patient’s experience and frequent feelings of frustration in repeatedly loosing the shift in perspective he was trying to establish. As he struggled to adopt the new mutual relational stance he felt increasingly insecure but was afraid to express his uncertainties to his supervisor, thereby feeling increasingly alone until he had the following dream.

> The dream occurred during the summer, when my patient was on vacation. He had mentioned that he was going to spend some time at the beach. The dream took place on a beach. It was, however, a desolate, deserted beach in the cold of winter. On the beach was a tall, rickety, old lifeguard chair; its white paint peeling off. I was walking in a huff, ticked off, irritated, away from somewhere on the beach where I knew my patient was, though he was not in view. I was headed toward the chair. I brushed hurriedly past an old policeman; his uniform

> tattered as though to match the condition of the chair. Both seemed from a bygone era. I knew the unshaven policeman no longer had authority over me. He was not going to stop me from getting to the lifeguard chair, if he tried. He did not. I started climbing up the slats of the chair. I could feel it wobbling and was not sure it could support me, shaking as it was. Nevertheless, a defensive feeling about something I did not want to acknowledge drove me to continue climbing up the chair despite my realizing that it was very high, very unstable. I was trying to appear confident to my patient, who somehow was watching. I felt I needed to get away and, having started the climb, now could not stop as a matter of pride. I needed a sense of superiority and of being in control. It seemed essential not to stop before getting to the top and also to be seen not stopping. Although my supervisor was not in the dream, as I climbed the chair, near the top, I heard her voice. She asked rhetorically, “Isn't this exactly what your patient most fears?”[6]

When Schindelheim awoke he knew immediately that the dream was an accurate depiction of his position with his client, his former authoritarian stance, and his supervisor. He hesitantly recounted the dream to Schwaber who immediately asked if her voice in the dream had sounded critical. He was surprised to note that it was not, that it was rather understanding and empathic: “Isn't this exactly what your patient most fears?” Schindelheim came to realize that in his supervision with her he frequently felt awkward when describing his interactions with his client, especially when the client complained about being hurt by his interventions. Even as his supervisor suggested

new and better ways to intervene, Schindelheim *felt* she was in dialogue with his client rather than with him. He was hesitant to discuss his feelings of abandonment and loneliness with her until he realized that the statement in his dream acknowledged both his abandonment of his client when he attempts to retreat to old authoritarian modes of operating and his experience of abandonment by his supervisor when he experiences her as addressing the client's needs rather than attending to his own learning needs. Her nondefensively hearing his sense of abandonment and addressing his learner insecurities in subsequent sessions led him to report with pride how good it felt when she could see his efforts as strong and worthwhile.

The lesson of self psychologist Kohut—that we all continuously need selfobject affirmations throughout life—as well as Schwaber's lesson of empathically addressing learner needs with a sense of mutual respect and selfobject affirmation were well taken in by Schindelheim as he reports how he has generalized his learning experiences into his own role as supervisor of psychiatric residents.

> [In the dream]…she had focused on my patient's experience ("Isn't this exactly what your patient most fears"), [thereby] bypassing my supervisory reality. Without my knowing that she knew and accepted [my reality], I could not feel the supervisory validity needed to bring that part of my experience into supervision. Unaccepted, those perceptions became the focal point of an educative reality, a [block] 'protected' from change, immune to learning.[7]

In subsequent discussions Schindelheim and Schwaber explored his surprise that her voice had not sounded critical—so that he came to understand that *his expectations*

had been based on his own inner self-criticisms and the sense of loneliness that arose from his not feeling able to discuss his insecurities with her. The discussions with his supervisor served to demonstrate the relational lesson she had been attempting to teach him and, at the same time, addressed an impediment to the learning process he was experiencing in supervision. He thus came to see how his *internal experience of learning* was a vital part of the learning process. "When I no longer felt alone in learning, I was increasingly able to hold onto the lesson beyond the cognitive realm. It proved to be an essential ingredient in the development of psychotherapeutic growth."[8]

The lesson: That by following what he had usually found effective in supervision—i.e., going over his process notes with his supervisor—Schindelheim had come to hear her comments as a dialogue with his client and an implicit abandonment of *his* learning needs. Further, as he heard her comments on his interaction with his client he felt preempted in his developing identity as a therapist by what he experienced as *her* superior therapeutic stance—leaving him feeling further inadequate. His story amply illustrates the importance in relationally oriented psychotherapy for the supervisory process to be likewise relationally sensitive.

Case Study: Slavin: Influence and Vulnerability in the Supervisory Triad[9]

A supervisee begins his supervisory relationship by telling the supervisor how touched he had been by something the supervisor had said in case conference. The presenting therapist had talked about the client being very much like a child who needs to know that something she has made and given to the therapist has genuinely impressed the therapist. He then spoke of a recent session with a client.

> The supervisee said he had turned off the fan in the room and the patient commented that he was so sensitive to her. She had just looked at the fan, and he turned it off. The supervisee said that he turned it off because he wanted to hear her better. But the supervisor told him that [his client] was very impressed with the whole moment. It seemed to her that the patient felt that her therapist really understood what she needed, as though she had a wordless influence on him.... At that point the supervisee seemed very touched. He said, “You know, you cradle me, and that makes me stronger, and then I can do it with my patients, cradle them, hold them and give them what they need.” [10]

Slavin comments that there are many meanings here to be explored, but what interests him is that “all parties in this triad—the patient, the therapist, and the supervisor—were open to being influenced and touched. It required their readiness to be vulnerable to the impact of the other, and it required them to feel a sense of affirmation and growth, and for all of them to have a rightful influence.”[11] In the same way that it is important for the parent to be vulnerable and influenced by the child and for the therapist to be vulnerable and influenced by the client, it is important for the supervisor to be able to be vulnerable and influenceable by the supervisee. Relationship in supervision is a triadic experience of mutual vulnerability and influence.

This book addresses the dynamic and relational processes inherent in all types of clinical and supervisory settings. Because I am a psychotherapist and because supervision has perhaps been most carefully studied in the therapeutic and counseling traditions, I will be primarily focusing the development of my supervisory ideas on the

psychotherapeutic situation and ask the reader to generalize to her or his specialty. History is one of those areas.

1. Brief History and Background Considerations

In the beginning Freud created psychotherapy and psychotherapy supervision. As the sole practitioner of the art of psychodynamic psychotherapy at the time, Freud was obligated both to analyze as well as to supervise his early trainees. The tradition of the same therapist both treating and teaching therapists was begun and maintained for many years by Freud in Vienna and subsequently carried to groups of practitioners in Budapest by Sandor Ferenczi and to Zurich by Carl Jung. The group of practitioners that formed around Karl Abraham and Max Eitington in Berlin, however, very early on began to separate the treat-teach dichotomy into the separate persons of personal therapist and training supervisor. All of these early societies of psychotherapy practitioners—the progenitors of modern psychotherapies—began study and training groups reading books and papers together and sharing their casework with each other. The three-pronged training program consisting of personal therapy, individual supervision, and supervisory study groups soon became institutionalized. The belief eventually held almost everywhere was that personal therapy needed to be absolutely private and therefore isolated from other training functions. The confidentiality required for personal therapy ultimately dictated that the personal therapist have no voice in determining the qualifications of trainees to practice.

But even with this tripartite division of training functions, the thorny treat-teach controversy has continued to this day to pose issues for individual and group supervisory processes. Personal and personality issues of the therapist-in-training are

crucial to becoming an effective psychotherapist, so how far can or should a supervisor or supervisory group go into personal issues without interfering with the privacy of the trainee's own therapy? In Freud's earliest references to personal problems of the therapist arising in the countertransference (the therapist's emotional reactions to the client), he advised that personality issues be referred to one's personal therapy.[12] It was not until the 1950s in London that the potential value of countertransference to the therapy process itself became fully recognized.[13]

During the Nazi era psychotherapists from all over Europe were forced to flee to London and the Americas, thus decimating the early societies of psychotherapists and their training practices. Psychotherapy and psychotherapy supervision were forced to adapt to new soils and new conditions. Further, the psychological conditions created by World War II necessitated expanded psychiatry services in both military and civilian sectors.[14] The newly created and greatly expanded wartime demands for psychological services required new kinds of practitioners and new theories of therapy and supervision. In the post-war era, these newly created conditions and new soils demanded widely accessible mental health services. There was little patience for the slow-paced and painstaking processes of therapy and training that had emerged during more leisurely times in Europe. Old-guard psychoanalytic practitioners were shunted off into a corner to make room for the greater time- and cost-efficient practices offered by general psychiatry, clinical psychology, social work, and counseling. Professional training and supervision requirements that only rarely included personal therapy gradually became institutionalized in universities and professional schools and ultimately licensed by governing agencies.

Paralleling these many shifts in the formal aspects of professional training was a proliferation of ideas about what was therapeutic about therapy and how best to practice therapy and to train other practitioners. Universities and professional schools inherited this diversity of theories and practices along with a host of problems related to how to accredit and license qualified practitioners. All of this diversity created by the widespread demand for access to mental health services has left in question exactly what is the essence of the art of psychotherapy and the art of supervision that Freud originally created?

While I could not possibly address all of the complexities in the changing status of psychotherapy and psychotherapy training, it is my goal in this book to outline many of the most important influences that have come to bear not only on the practice of psychotherapy but on the psychodynamic and relational processes involved in psychotherapy supervision and consultation.

The Plan of This Book

Some books best proceed like a detective story, slowly developing suspense with added clues until at last Sherlock masterfully puts it all together in the last chapter. Due to the incredible complexities to be presented in this book I must adopt a different way of approaching psychotherapy and psychotherapy supervision. There are layers and layers of consideration so that at each juncture of new perspective all that has gone before must be re-integrated and the burgeoning complexity painstakingly re-acknowledged. For this reason, I need at this point to tell you where we are going and what demands will be placed on your integrating, synthesizing, and creative capacities. I offer two caveats.

1. **Governance:** I will not be dealing with any of the detailed mechanics of governance involved in psychotherapy work—state, institutional, or professional—other than to acknowledge that the governance of each psychotherapeutic setting provides a constant and crucial backdrop, the effects of which necessarily must be taken into consideration at all times.

2. **Terminology:** I will be surveying supervision from many theoretical vantage points that have evolved from any number of schools of psychotherapy—all of which use differing concepts and vocabularies. Therefore, for the sake of creating a readable text I have reduced complex or specialized terminology to basic terms that do not always do complete justice to the points of view under consideration. For example, you have already noticed that I condensed talk of the entire early history of the psychoanalytic movement to the beginning of psychotherapy, psychoanalysts to psychotherapists, and psychoanalytic institutes to training programs—just as I will shortly condense patients to clients. Further, in the service of creating a smooth text with a uniform vocabulary, I will condense all emotional reactions of the client to her therapist to the term transference and those of the therapist to the client as countertransference. I will avoid all of the terms such as student, intern, trainee, or candidate in favor of keeping clear who is in the role of therapist. The person listening to, teaching, training, or consulting I will simply call supervisor. Whenever groups are involved (peer, case conference, supervision, research, etc.) I will simply refer to them as supervisory groups. I will also speak of the transference of the therapist to the supervisor and the countertransference of the supervisor to the therapist and spell out the supervisor's transference to the client when it is being considered. Resistance and

counter-resistance refer to the conscious or unconscious reluctance processes involved in not remembering or not representing in some manner the transference or countertransference feelings and experiences in the psychotherapy and supervisory relationships. Occasionally this condensation of terms may do injustice to the concepts under consideration. Sorry, it's the best plan I could come up with to maintain a consistent vocabulary under the diverse circumstances involved.

The Seven Voices of Supervision

The work of psychotherapy—especially when it is supervised in any way—can be thought of as a cacophony of voices, if not a comedy of errors, or a masque of clowns! I find it helpful to think of seven distinct sources of variance or seven voices that are forever speaking to all parties involved.

1. The first voice is the voice of the client, whether actually speaking or providing some other form of para- or non-verbal representation or communication.
2. The second voice consists of the speaking or nonspeaking communications of the therapist.
3. The third voice consists of communications generated by the psychotherapy relationship dance itself. Psychoanalyst Thomas Ogden calls this the "third subject" of the therapy, meaning that at some point the relationship takes on a life of its own and, as such, "speaks" to one or the other or both participants—consciously or unconsciously.[15] Therapists and clients are accustomed to hearing from the third in moments of reverie when otherwise unaccountable thoughts, fantasies, and images arrive

unbidden. Reveries often at first seem irrelevant only later to prove deeply meaningful.

4. The fourth voice is the contribution, conscious and unconscious, spoken and unspoken, of the supervisor.
5. The fifth voice or the “fifth subject” manifests in the complex emotional interactions of the client-therapist-supervisor triad—much as the third arises unbidden from the interaction of client and therapist. The fifth voice may have many manifestations and speak in various ways to each member of the triad.
6. The sixth voice consists of the complex relational potentials—whether realized or not—of culture, diversity, and categories of personal or familial relatedness development. Cultural attitudes toward race, ethnicity, sexuality, sexual orientation, age, able-bodiedness, class, work, and other personal identity features are at all times operating in the conscious and unconscious processes of therapy and supervision and affect all members of the triad.
7. The seventh voice is the backdrop of governance—state, institutional, and professional—always at work somewhere in the background.

Therapy and Supervision as Forms of Loving Relationship

I want to consider supervision as a form of lovemaking just as I consider psychotherapy as a form of lovemaking. By that I mean both supervision and therapy are human situations in which two people carefully attend to each other with interest,

curiosity, passion, and ambivalence. There is an intimate and ineffable loving quality to both which we seek to define. There are other human situations devoted to transacting business, to accomplishing common goals, to teaching and learning things, to experiencing things together. But supervision and therapy are tied to ineffable processes of attention, curiosity, wonder, surprise, devotion, compassion, competition, struggle, surrender—all features of intimate, loving relationships.

Psychotherapy and Supervision as Alchemical Processes

I will later address different theoretical approaches to supervision, which will include the thinking of psychoanalyst Carl Jung. But at this point I want to call attention to an archetype of loving intimate relationship—which Jung certainly believed psychotherapy to be—that he found artistically depicted in a set of 16th century alchemical woodcuts from the *Rosarium Philosophorum* entitled, *The Coniunctio*.[16] Jungian therapist and supervisor Claire Allphin in a paper entitled "Supervision as an Alchemical Process" applies *The Coniunctio* to the supervisory process.[17] She points out that Jung employed the images and concepts of the *Rosarium* to illustrate the relational processes inherent in psychotherapy and supervision. As processes, they are not sequential but overlapping and recurring throughout any loving and intimate relationship.

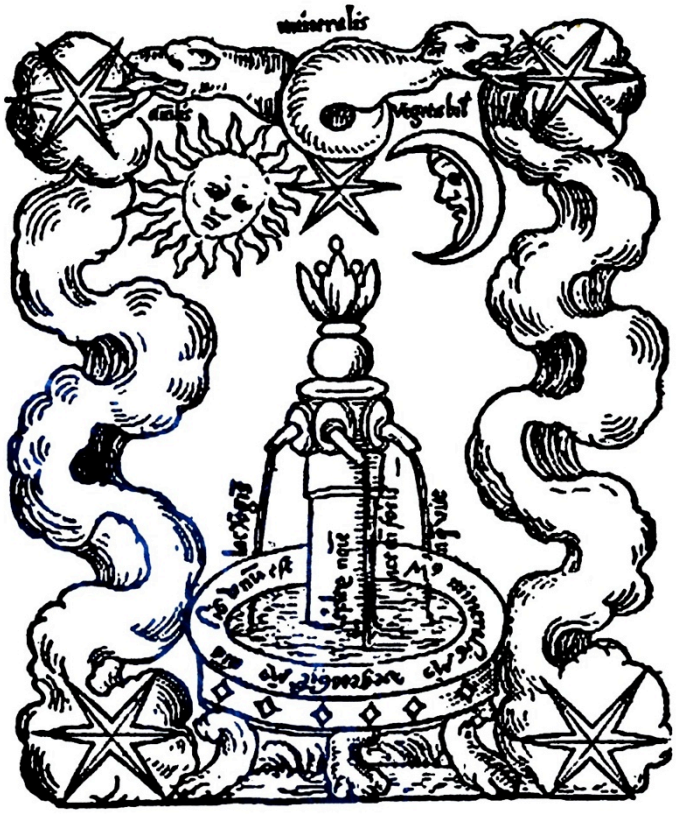


Figure 1 The Fountain

The Fountain contains all of the elements of intimate relating—the four stars of the universe, the three spouts of balance, the two snakes of pairing and the one fountain of wholeness.

> …In the initial meeting between supervisee and supervisor, the experience contains many elements, but the two are differentiated from one another and each may wonder if the match will be a good one. How will this process work between them? Will the supervisee be able to learn from this particular supervisor? Will the supervisor be able to teach this particular supervisee?…The different ways in which supervisee and supervisor react to each other will be noted,

consciously and unconsciously, by one another….This is a time of beginnings and each may want to please the other and/or to be an object of satisfaction to the other.[18]

Figure 2 King and Queen

The King and Queen represent how supervisee and supervisor begin their relationship—clothed, not showing themselves to each other. Jung points out that their left hands are joined representing the unconscious connection that is quickly formed.

Figure 3 The Naked Truth

In The Naked Truth the naked king and queen are becoming more open with each other.

> The supervisee may reveal concerns about the work, worries about competence and fears about making mistakes. The supervisor may experience feelings of not knowing enough to help the supervisee, or may become concerned about the competence of the supervisee, perhaps feeling judgmental about the supervisee's talents and level of self-awareness.[19]

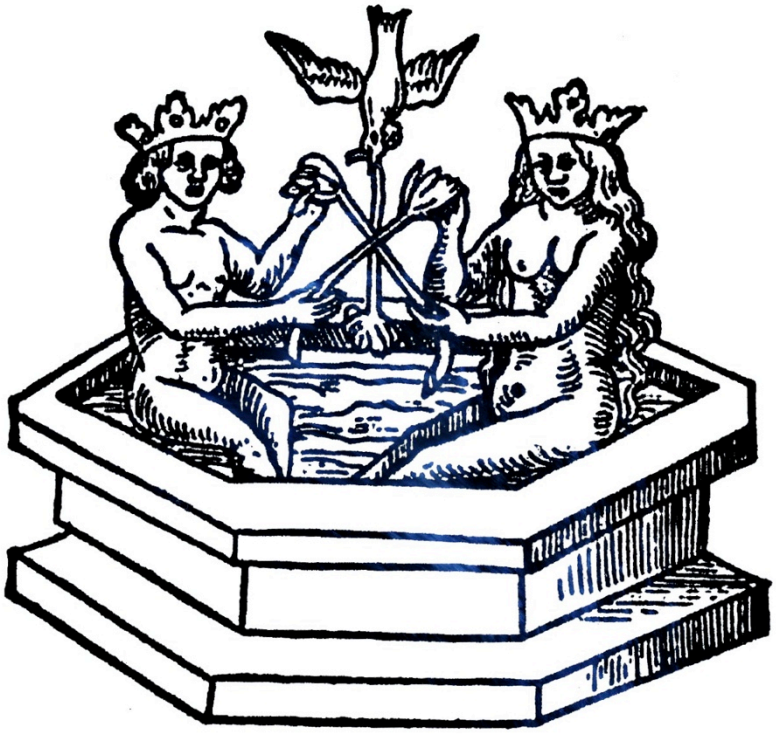


Figure 4 Immersion in the Bath

Immersion in the Bath portrays the king and queen immersed in the beginning of unconscious relating. Confusing and exciting and/or disturbing feelings may be emerging because there is more trust in the relationship. This immersion in the unconscious extends not only to the supervisor-therapist dyad but to the therapist-client dyad as well.

> Since much that is occurring is unconscious, the supervisee may not be able to articulate the problems with the client, and so they are enacted in the supervisory relationship through a parallel process in the way the supervisee unconsciously asks for help or relates the client's material.[20]

Figure 5 The Coniunctio

The *Coniunctio* or The Conjunction portrays the joining of the pair with more consciousness and good feeling as the two give themselves over to each other and to a process of giving and taking from each other. The therapist has opened herself to taking in what the supervisor has to offer and the supervisor has opened himself to learning from the supervisee.

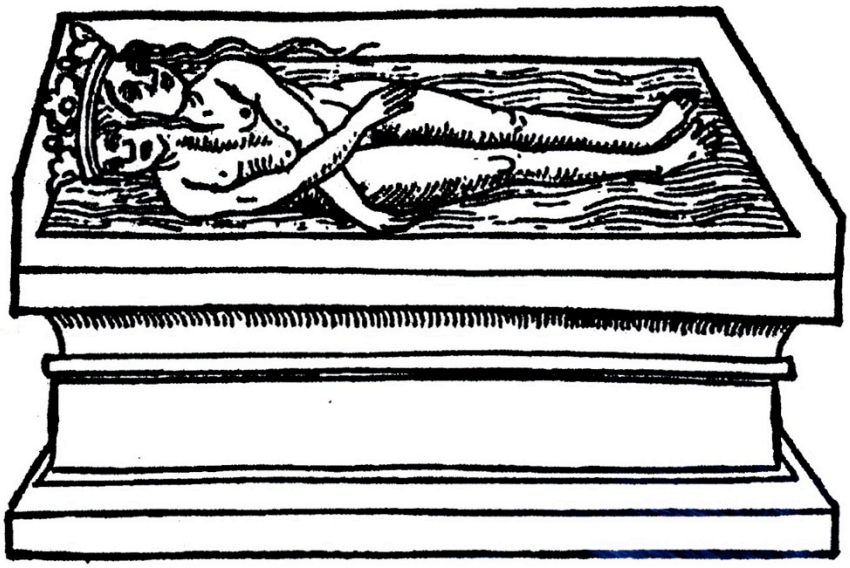


Figure 6 Death

This portrayal of Death suggests the experience of separation and loss after having joined passionately together in the *Coniunctio.* Personal growth necessarily involves merging in order to gain from each other followed by separating in order to consolidate oneself.

> The two bodies, in the image, are one, with two heads, and they are in a sarcophagus. When a supervisee or supervisor has the experience of being different, of not understanding the other, of feeling critical of the other and so on, this can be experienced as hopelessness and/or ineffectualness on the part of either the supervisee or the supervisor.[21]

Figure 7 Ascent of the Soul

The Ascent of the Soul depicts the experience of leaving the established link between the two in order to attain clarity and consolidation on one's own, apart from the *Coniunctio*. Knowing that the separation process, marked as it may be with frustration, disillusionment, and despair, represents the possibility of growth and change can help the supervisory dyad as well as the therapeutic dyad weather difficult times together.

> It may help to realize that this state is one in which there is potential for change, that this death and soulless condition portends development for the supervisee and hopefully for the supervisor as well.[22]

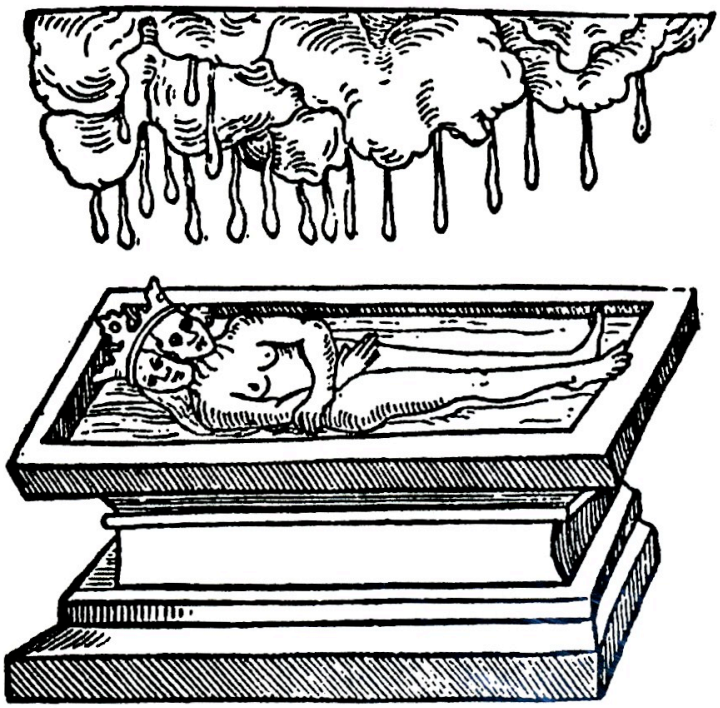


Figure 8 Purification

In Purification, falling dew purifies the body for the return of the soul—suggesting a time in which both dyadic relationships are more hopeful. Just as the supervisor is coming to appreciate the developing strengths of the therapist, the therapist may be attaining a more realistic view of the supervisor and what he or she has to offer.

> If the supervisor feels a loss of the good feeling that comes from being an admired supervisor, it may be offset by a sense that the supervisee has developed a sense of their own professional self as a result of the relationship with the supervisor and the supervisor's ability to teach and enable learning.[23]

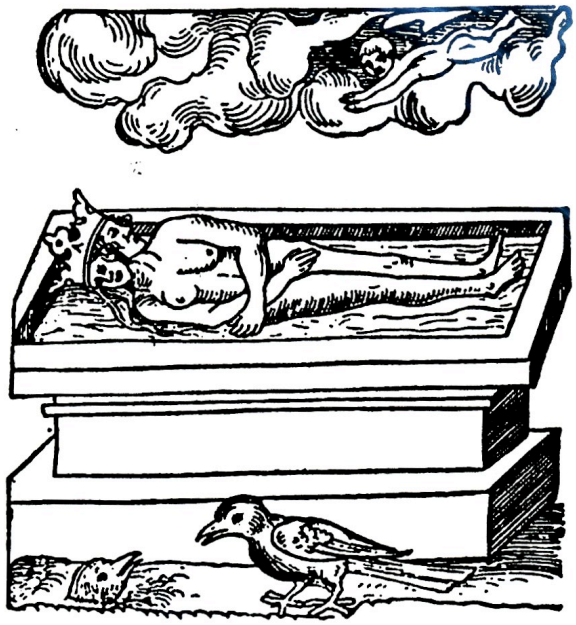


Figure 9 The Return of the Soul

The Return of the Soul heralds the return of vitality and conscious recognition of the unconscious relational processes that have been at work in the therapeutic and supervisory dyads. Each participant may have over-idealized and/or devalued the other in the course of relating, but at this time two attain a realistic admiration for each other and for the process of learning that has been involved.

Figure 10 The New Birth

The New Birth shows a hermaphrodite—representing how the two have become like one in their relationship with each other. The figure represents each member of the pair and how they have taken in and integrated aspects of the other into their professional roles and personal development.

> There is now a collegial relationship, a mutuality in which each respects the other's knowledge..... Each has become a hermaphrodite, has taken in parts of the other to become more competent and developed as clinicians.[24]

Having the images from the *Rosarium Philosophorum* in mind when the going gets rough either in supervision or in therapy may help remind us that we are involved in a collaborative relational process that necessarily has its ups and downs. Jung's and

Allphin's interpretations of the *Rosarium* aid in understanding the expectable over-idealizations and critical devaluations as well as the necessary mergers and separations that are to be experienced in the course of any loving and intimate relationship—which good therapy and supervision certainly are.

My First Group Supervision

In the first week of July 1969, eight of us gathered at the Reiss-Davis Child Study Center in Beverly Hills to begin what was for me a four year post-doctoral training program in child psychotherapy and psychoanalysis sponsored by fellowships from the National Institute of Mental Health. Dressed spiffily for the first day of school with new spiral notebooks and freshly purchased designer pens we waited with baited breath as the fabled Dr. Rudolf Ekstein entered the room and took his seat at the head of the group supervision conference table. Rudy, as we were later to call him, looked around the table directly into each of our eyes and slowly said, "Today we will talk about endings."

Stunned, but willing to comply, we began free-associating about loss, sadness, grief, and mourning. We spoke of helplessness, of tears, of disorienting fragmentations, of darkness, of death. One woman burst into tears as she told us of the death of her beloved grandmother only the week before. One man spoke of how heart wrenching it was last month to leave his midwestern graduate school as he and his wife of six years had agreed to part ways. Our first-day-of-school cheery mood quickly sunk into a bottomless pit of despair as we each re-experienced a lifetime of painful endings and losses.

Finally Rudy said, “This week you will each begin psychotherapy relationships with new children. The depth to which your therapy will go with each child will be limited by your personal capacity to grieve, by your own ability to finally, when it’s time, let go of the child you will connect with this week. We can only enter relationships as deeply as we know we can tolerate the pain of loss. This is why we need our own therapy—to learn to relate freely and deeply and then to develop the capacity finally to experience bottomless sadness, to let go, to grieve, and to replace our lost loved ones with new relationships. We lost the womb. We lost the safety of our family homes when we ventured into school. But our first lesson in mature grief came in adolescence as we turned loose of the internal love objects of early childhood and replaced them with new loves in the world of adolescent social relations. All of adolescence is filled with turbulence, pain, rage, and grief wherein we learn to sustain hope and to tolerate dread. Your experience here will be one of learning to relate freely and deeply to the children you work with, to your colleagues in the clinic, and to your supervisors—and then to experience sadness and grief as you move off into the world on your own. The mettle of a psychotherapist is tested by his capacity to endure grief and to mourn loss.” I was later to realize that Rudy was also speaking about himself and the team of mentors we would be working with over the next four years. Psychotherapy supervision is another relationship in which two people’s mettle is tested by their capacities to relate to each other freely, deeply, and intimately and then to turn loose, to let go, to grieve, to mourn, and to move on.

"Showing Up" for Supervision

How do two people manage to arrive at a supervisory hour ready for an experience that will be growth-producing for both? Both participants arrive with a lifetime of fears and inhibitions around intimate relating. Both arrive with their heads filled with texts on diagnosis, pathology, treatment techniques, and countless guidelines for professional conduct. Yet the central feature of whatever is to be most valuable to both and to the therapeutic dyad they are meeting to consider is relational. How do any two people "show up" for any intimate relationship? The background metaphor or model of mutual and reciprocal relating is making love—of two people coming together with the intention of surrendering themselves *to a process of mutually creating a wonderfully rewarding and mind-expanding experience with each other*. Also ever-present is a threatening background metaphor—the non-egalitarian dominance-submission gender-tagged complementarity model so rife in our culture and in our professional work and training until recent years. How do therapist and supervisor come together and create a mutually enlivening process that benefits both of them while also serving as a learning experience for the therapist in working with her or his psychotherapy client? How can a supervisory relationship be jointly constructed, that is symmetrically mutual and reciprocal while at the same time asymmetrically mentoring?

This supervisory mentoring and learning process has been studied for more than a hundred years with fascinating results that point in very definite directions with implications for all kinds of therapeutic endeavors. Further, the accumulated wisdom about supervisory processes in general has been augmented by recent advances in neurology and brain functioning, infant research, cross-cultural studies, postmodern

constructionism, and perspectivalism—all of which have enriched our understanding of supervision. The overall conclusions seem clear:

- Psychotherapy of whatever persuasion as well as professional work in other clinical and educational settings relies on *relational skills* of both mentor and mentee for its transformative moments.
- *Theories and techniques* of different approaches to professional work differ widely and can be taught and learned through didactic processes.
- The *relational skills* essential to good psychotherapy as well as to other clinical and educational disciplines cannot be taught—but they can be learned.
- While supervisors and supervisory processes differ widely in orientation and style, the central task of the supervisor is to create an interpersonal environment in which the essential relational skills required for effective professional work have an opportunity to develop.
- Supervision requires an entirely different set of didactic and relational skills than psychotherapy or other clinical and educational endeavors.
- The supervisory dialogue is conducted at an entirely different level of abstraction than the clinical and educational dialogue.
- Relational fears are universal but are brought forward and attended to differently by client, therapist, and supervisor in their respective relational processes.
- A frame is required for safe therapy as well as for safe supervision—as it is for all forms of safe intimate relating.

- "Regressive" experiences in client, therapist, and supervisor are an expectable part of therapeutic and supervisory processes.

We cannot know in advance how any particular therapeutic or supervisory process will unfold since beneficial relationships always rely on the momentary capacity and willingness of all participants to bring their fullest possible imaginative and creative skills to the relational encounter—to "show up" in the present moment as it were and to meet at their horizons of personal experience. The questions this book seeks to address are: "what exactly is involved in 'showing up' as teachers, supervisors, and human beings?" and, "what does it mean for two people to have an authentic conversation at the horizon of their experiences?"

Learning about Baseball

One of my training cases was supervised by Mardi Horowitz. The termination with Tony took place shortly after he turned 13. He had first been brought to the clinic when he was 6 for disruptive behavior. Immediately following the intake appointments his mother was diagnosed with terminal brain cancer so therapy had to be postponed for four years through a prolonged and gruesome dying process during which—in addition to other traumatic events—Mother in her loss of judgment had on several occasions shouted, "your bad behavior is killing me." Tony was from an Italian family and a baseball enthusiast. As he began to get good at the game he had much to tell me about the baseball world. Unfortunately, baseball had never been of interest to me though I knew the basics. It was Mardi who came through like a champ coaching me in the ethos of baseball. I had to learn the "personality types" that played each position, the various styles of batting, pitching, catching, and the strategies of the game as well as relating to

the team, the coach, the school public, parents, peers, and girls—all through the metaphors of baseball. I'm afraid I would have been a dismal therapist for Tony without Mardi's walking me through the sports world in general and baseball in particular. During our time together Tony's grades, deportment, and family relations significantly improved and he was chomping at the bit to stop therapy because he had much more interesting things to do than to come to the clinic three afternoons a week to see me. We set termination to coincide with the end of the baseball season but he postponed it until summer because his father and father's new girlfriend were taking the family to Hawaii and he thought he might have some difficulties. We again set termination to coincide with the end of the next baseball season, but it was again postponed because his father was now getting married and the family was taking a honeymoon together. It was clear, and discussed, that letting go is tough and that it reminded him of losing his mother. He remembered with revulsion having to brush his Mom's teeth and bathe her and brush her hair toward the end. My encouragement for him to talk about his Mom was generally resisted until I assured him that our goal in talking about Mom was to remember her in all the wonderful ways he could, not to forget her as his family seemed to imply by not talking about her—especially since the arrival of father's new girlfriend into the household. Finally, we got to the last ten-session countdown and were able to experience and talk about how good our experience had been together and how much we would miss each other, even though we both knew that Tony's afternoon times would improve considerably now! In the fourth session from the end Tony suddenly froze staring upwards into the corner of the room in transfixed silence. I waited for a very long time experiencing the extreme strangeness of the moment—suddenly

recalling this exact behavior had been noted in a psychiatric diagnostic interview four years earlier. The psychiatrist wondered if there were some sort of dissociation or psychotic process, but no answer was evident. This time when Tony broke the silence he looked straight at me with a big grin. “What?” I mused. “Spaghetti!” “Yes…?” “My Mom made the best spaghetti in the whole world!” We both laughed and laughed until tears formed in our eyes. By fixing his eyes away from me he had hoped to avoid crying. It was a moment of deep knowing for both of us and we finished out the three remaining sessions like champs planning for a great future on our separate roads. Thanks Mardi.

On Relating

Professional work in any clinical setting demands personal relationship—whether the individual practitioner acknowledges the force of relationship or not. My mentor, Rudy Ekstein, once said, “our chosen theories about our work are statements of what we intend to do and how we intend to relate.”[25] That is, for a lifetime each of us has developed a variety of ways to relate that are inextricably woven into the tapestry of our personalities. Our professional choices manifest our personal ways of relating in how we think about and perform our work. Some of us relate more comfortably by sticking closely to established traditions—to rules and rituals of the trade. At the other end of the spectrum are those of us who are always striking out on our own—maverick and “wild” therapists who have a hard time appreciating personal and professional boundaries. But most of us find ourselves somewhere in the middle in our chosen professional practices—with theories and ways of working that fit our personalities. As a result, many therapists choose not to notice or to work with the many relationship variables

necessarily involved in professional life. The “therapeutic alliance” is simply taken for granted.[26] Other therapists choose to focus heavily on what’s going on in the relational exchange. But whether a person chooses to by-pass or to actively direct attention to the relational exchanges involved, it has been my experience that all highly-skilled, seasoned professionals are acutely aware of what’s going on in the relationship at all times and are carefully aiming their work into each relational matrix as it unfolds—no matter what theory or school of therapy they hail.

I think of family therapist Virginia Satir whom I once watched conducting a family therapy session in front of a large audience directly telling a sullen teenager that her feelings were hurt because he thought she was ganging up against him with his parents when she was working so hard to find a way to let him at last speak what he needed to say to them. I remember behaviorist Joseph Wolpe telling a group of us about a little girl who had been to numerous therapists for compulsively cutting out paper dolls. After a few attempts to get her attention away from the dolls she was cutting, in exasperation Wolpe angrily yells at her at the top of his lungs, “Stop cutting out paper dolls!” And she did. I once watched Alexander Lowen, father of bioenergetics body psychotherapy aggressively provoke a large burly man who had in fact bare handedly killed several people in the course of his law-enforcement career to the point that everyone in the room was terrified Lowen was going to get slugged—until we witnessed the man crumple on the floor in deep sobbing crying out to his father to stop beating him. All three examples from these gifted therapists—each working in their own way—demonstrates perfect relational empathy under the circumstances. Even one of the founders of Cognitive-Behavioral Therapy, Aaron Beck, after reviewing the

neuropsychological research describes the crucial importance of relational context and asserts,

> "The therapeutic relationship is a key ingredient of all psychotherapies, including cognitive therapy…. Many of the basic interpersonal variables common to other psychotherapy (i.e., warmth, accurate empathy, unconditional positive regard) serve as an important foundation for cognitive and symptomatic change"[27]

So since relational variables are an essential and unavoidable part of professional work it behooves us to fine-tune ourselves to the question, "what's going on here anyway?"

A Relational Thought Experiment

I frequently lecture to large groups of professionals from the health and mental health disciplines at in-service training sessions for various county health agencies and health maintenance organizations—usually on some variation of the theme, "treating the difficult client." Typically, I find myself in a room filled with people engaged in all sorts of professional work and I have before me the task of focusing generically on clients who pose difficult relational problems in clinics and agencies that are operating with limited resources. The question of the day is, "What on earth does a professional dude who engages in private long-term therapeutic work have to say to us in our setting that is so vastly different from his?" I bring this question immediately into the open with the metaphor of a slow-motion camera being available to people like myself who engage in long-term, intensive relational work—a camera that can shed light on interactions that happen in an instant in short-term, behavior management, or diagnostic sessions. I

acknowledge the county or HMO “machine” they work under that demands quick interventions and that extracts reams of paperwork from professionals until they are exhausted and nearing burn-out. There is uneasy laughter. I then ask people to recall their very personal reasons for entering their chosen field in the first place. I invite them to travel back there with me today so that we can bring their original curiosity, enthusiasm, and optimism back to life to invigorate daily work as they now know it. There is rapt attention—“We’ve gone so far from where we originally thought we would be. Work has become such drudgery—we’ve lost hope of ever being able to enjoy it. We’ve become discouraged and jaded in the hope of ever being able to help the people we see on a daily basis. What can we do? The burden is great. There are so many to serve. We get so little support. The people we work with are so seemingly impossible—they have so many needs and we can give so little. It’s overwhelming.”

My attitude? “Not so. Let’s go to work. Let’s put our minds to the most important part of our work, no matter where or how we work—*the relational moment*. There are moments in any human interaction where one human being risks reaching out to another and for an instant the two connect and know they have connected in goodwill and hope.” My audience is still skeptical but spell-bound because this is what we all yearn for—human connection that satisfies *our birthright of intimate relational hope*—the most satisfying experience on the planet and one that every human is capable of—despite whatever intrusive traumas they may have experienced. But how do we get there—to that moment of hope in difficult clinical situations? I ask people to close their eyes for an exercise of imagination. As the room settles into silence I offer this meditation. Slow down and try it yourself as you read along.

Imagine yourself approaching someone with whom you are in the process of developing or expanding an emotionally significant relationship. Your relational companion likewise approaches. It could be your spouse, your child, one of your parents, a sibling or a friend, or even someone special with whom you work or play. Perhaps it is one of your clients if you are a therapist. Perhaps it's your therapist if you are a client.

You feel alive and happy to be seeing your special person and excited by all that is mutual in the approach. There is a smile on both faces and warm greetings in both voices. Both sets of eyes gleam with eager anticipation. Two hearts pick up their pace as the relating dance begins. You two have been in this space many times before, co-creating experiences of joy, laughter, sadness, grief, anger, inspiration, mutual regard, and love.

Actually try right now to conjure up in your mind such a relational situation. Use your imagination for a moment, close your eyes, look at your relating partner with your mind's eye, feel the approach and the anticipation, and feel something wonderful starting to happen between you. As the relating dance begins, each makes her or his own move, and each mutually responds, reciprocating with an expanding resonance leading to the creation of intense harmonies and cacophonies of sound, sight, shadow, color, texture, stillness, excitement, life, and movement as you two relate. Put the book down and imagine the possibility of such a relational moment arriving.

But then, almost before you realize it, just when things are starting to get good, the intensity of the game somehow starts to diminish. You begin feeling something happening in your body, in your mind, in your soul. Your sixth sense has a hold on you

and is slowing you down somehow, pulling you back, inexplicably dampening the intensity of the momentarily achieved and longed-for connection. Perhaps you are thinking of how many things you have to do today. Or some part of you is drifting off toward unrelated thoughts and pictures. In your reverie you might find yourself feeling drowsy, moody, tired, or cautious for no reason you can really think of.

You make a quick, valiant attempt as the relating dance continues to figure out what's going on with you, or what's going on with your partner in the interaction. You wonder what's happening in your bodies and in the relationship at the moment that's causing this slowing, this distancing, this breach in the intimate contact.

As therapists we have some skill at the relating game so we may attempt processing in ourselves or with our relating partner the physical and mental impingements that have just cropped up. Why am I so uncomfortable or distracted or feeling this way at this particular moment? Perhaps you feel edgy, nervous, hypersensitive, distracted or constricted. Perhaps you find yourself losing interest, slumping, or rapidly dropping in energy level. An invisible wall has gone up. Emotional distance is threatening. What's happening around here, anyways? This is the child I love so deeply. These moments are fleeting and precious, why am I feeling bored? This is my spouse, my partner, my love with whom I would rather spend time with than anyone else on earth, so why am I mentally fleeing the scene? This is my friend, my trusted colleague, my valued client or my therapist with whom I truly treasure my time, so what's happening to spoil my enjoyment, to wreck these few precious moments of intimacy, to limit my opportunity for enrichment and transformation?

You attempt a quick recovery. Maybe you are able to take a deep breath and dive back into the rapid-paced fray of the relating dance and be okay. Maybe not. Perhaps the processing has helped momentarily. Maybe you suspect that the particular trend towards disconnection that you are experiencing at this moment haunts the bigger picture of your relationships, your intimacy, your love, your life. This has happened to all of us in various subtle or perhaps not so subtle ways for a lifetime.

"How does what I am experiencing now fit with the bigger picture of my life?" "What are my hopes and desire here?" "What are my dreads and fears?" You may even go so far as to ask yourself, "What's the matter with me?" "What's my problem?" "Why do I do this so much–stray, lose interest, close down?" "Why and in what ways does this loss of connectedness frequently happen with me when it doesn't have to?"

Or, instead of the guilt route, you may go for accusation, silently blaming the other for being so shallow, so boring, so demanding, so distracted, so unrelated, and so forth. Or you may blame yourself or the situation itself or the relationship for not offering enough. But we know too well that guilt and accusation get in the way of unraveling complex here-and-now interactions. Guilt and blame serve to disconnect us further from intimate, hopeful relating. *What kind of relatedness modes or patterns can be operating in the here-and-now of this relationship?*

Considering the Thought Experiment

Involuntarily disconnecting this way happens to all of us in various ways all the time in relationships–but we seldom consciously focus on the process. At certain moments of building excitement, of increasing intimate connecting, we find ourselves feeling cautious, silently backpedaling, inexorably withdrawing, or allowing ourselves to wilt, to

cringe, or to fall into disconnected reverie. We find ourselves withdrawing, jumping from thought to thought or blanking out entirely. And thereby–often much to our chagrin–inadvertently rupturing the developing links to whatever is occurring and to whatever might occur.

Using this thought experiment, I have set the tone for a group of professionals to re-consider what is relationally important to each of them and what factors frequently interfere. I've made clear that we each have our own reasons for dreading and avoiding reaching out to others. Many people seen in clinical settings are especially fearful because they have been subjected to so much relational deprivation, pain, disillusionment, trauma, and abuse that they have traded in their basic human hope for hopelessness, resentment, entitlement, helplessness, anger, and despair. They do everything they can to flee emotional connections because connections have proven painful, traumatic, hurtful, and destructive in the past. I then give the group examples of the fundamental human relational plea disguised in externalized complaints about spouses, children, jobs, and health issues—seemingly hopeless complaints well known to every practicing professional. We have been taught, "hope springs eternal in the human breast."[28] But the question is, "how do we call forth the hope in ourselves and in others in such a way that it can make even a small difference in our days and in our lives? How do we fulfill our callings as health care and educational professionals in highly challenging settings? And how can we as supervisors create learning settings that allow our supervisees to come alive to hope in their clients, in themselves, and in their relationships with us? "We cannot not relate," says Edgar Levenson.[29] But how can

we bring life, creativity, enthusiasm, and hope into that relating in our roles as therapists, educators, and supervisors?

Background Considerations

I will briefly review some recent findings from neuroscience, infant research, and cross-cultural studies which bear on supervisory processes. Later we will review some issues in gender, diversity, and other psychological dimensions that have rich implications for the therapeutic and supervisory processes.

2. Neuroscience and Brain-heart Functioning

It may seem strange to consider brain and heart functioning at the beginning of a text on relational psychotherapy and supervision. But the technologically-generated information now available from many branches of neuroscience make clear that we are a relational species—that our brains and nervous systems *actually become structured early in life and throughout our lifespan* by the relational opportunities and challenges available to each of us.[30] Becoming a health, mental health, or educational professional and relating with a supervisor certainly poses major relational challenges.

We begin with the contemporary realization that there is no such thing as an isolated human mind or brain. Human beings have evolved and continue to function physically and mentally in an infinitely complex human brain field that surrounds us in all directions—past, present, and future. How modern scientists have come to understand brain functioning is a fascinating story now being told by many neurologists and neuropsychologists.[31] Six distinctly different ways of viewing brain and neurological functioning have emerged over time that demonstrate just how complex our emotionally

significant relationships really are and how our brains depend on intimate contact in order to stay healthy and develop.

We have all studied the early “split brain” theory that notes that certain functions are localized on either side of the brain. We also know Paul MacLean’s triune theory of the brain which pictures our reptilian, our mammalian, and our primate brains as having evolved different increasingly complex functions over evolutionary time. But contemporary theories expand our understanding of the importance of brain functioning in our achievement of emotionally significant relationships—of which therapy and supervision are certainly prime examples.

Gerald Edelman won the Nobel Prize for his studies in human consciousness. Using stunning new technologies it was his genius to discover that more important to consciousness than any single part of the brain—are the ever-changing patterns of cell activity integrated throughout the entire brain by way of “reentrant reactions.” He demonstrated that every part of the brain is at all times connected and re-connected to every other part of the brain by a nearly infinite set of different kinds of feedback loops. This means that each part of the brain simultaneously affects all other parts of the brain and the neuron pathways running throughout the entire body because they are constantly inter-connected. He speaks of consciousness as a “dynamic core…a process, not a thing or a place, [which is] defined in terms of *neural interactions*, rather than in terms of specific neural location, connectivity, or activity.”[32] An interesting consequence for human relationships is that “the exact composition of the core related to particular conscious states is expected to vary significantly from person to person”—a fact borne out experimentally by brain-imaging studies.[33] This means that the very ways

each person organizes experiences of self, of others, and of relationships is highly idiosyncratic and ever shifting in different relationship situations over our life span. The re-entry view of the brain means that prior ideas about our split brain and triune brain are grossly over-simplified. All parts of our brains are now known to be coordinated at all times with our ongoing relationships and are governed by our core sense of self in intimate relation to other selves. Few activities are more active in engaging our core sense of self than psychotherapy and psychotherapy supervision. What ineffable processes are necessarily involved no one knows. But there are three additional approaches to brain and neuron functioning that have compelling implications for our therapy and supervisory relationships.

Ever since neuron cells—those long message-carrying brain cells running throughout our bodies—were discovered in the late nineteenth century it has been known that they have many ways of communicating with each other. The simplified telephone switchboard metaphor is of tiny tendrils reaching out from each neuron cell toward other neuron cells and exchanging chemicals called neurotransmitters where the tendrils meet. As our knowledge of neurotransmitters has grown, we have discovered that there are many neurotransmitting chemicals produced throughout our bodies. Neurotransmitters travel instantaneously from place to place in our brains and bodies creating our incredibly complex human nervous system. The metaphor now is more like a cosmic soup filled with billions of space ships (neurons) simultaneously sending out and receiving multi-billions of messages (neurotransmitters) through carefully selected channels and ports. Each message type is intended for only a certain set of doors in certain parts of the body that will let it in. What neurotransmitters are produced and how

they flow around our bodies is determined by different social situations and by what goes on in our emotionally significant relationships.

Thus, whatever we mean by “my mind” or “my self” resides in the incredibly complex system of neuron cell connections and neurotransmitter flows throughout our bodies that are caused by the way we experience our interpersonal relationships. The basic hardware of the neuron system can be thought of as genetically-determined. But the software is installed by our individual relationship learning experiences early in life and undergoes constant changes as a result of our expanding relational experiences throughout our lives. That is, the people we are in intimate emotional contact with participate in our actual brain functioning so that we can no longer claim our brains as simply and uniquely our own. We are relational beings inextricably tied to one another by the necessities of our neuron cells and neurotransmitter flows that are mutually stimulated in our relationships—including the therapeutic and supervisory relationships. In this way we actually come to share reciprocal neurotransmitter flows with those in long-term intimate relationships with us. Joseph LeDoux says, we are constantly interacting with our “synaptic selves and with the synaptic selves of others.”[34] Our partner walks into the room overjoyed and we immediately feel the effects of that joy. Or our client has just experienced something devastating and we resonate deeply at the neurotransmitter level with the angst that he or she feels. But there are yet many other complexities that tie us inextricably to those we are emotionally related to.

Perhaps the most complex of the many ways scientists have come to think about our brains has been outlined by M.-Marsel Mesulam in terms of a brain made up of “clusters of functions.”[35] Rather than consider our brains as simply divided into parts that can be

visibly seen and studied—such as right-left, triune, re-entry, or synaptic—the cluster approach considers how many complex functions we have evolved in various fields of influence around us over millions of years of evolution. Each species evolves based on whatever genetic hardware it inherits in combination with the impact of whatever environmental niche it can find to live in. That is, the telling features of our brains are not what can easily be seen and studied, but clusters of functions that are connected throughout our bodies to various fields of external influence—in the human species primarily our intimate interpersonal interactions. As a species we had to develop family and group life in order to survive in a hostile world so that crucial survival functions have evolved that use the overall emotional connective capacities of our entire brain and nervous systems in coordination with our intimate relationship contexts and possibilities.

The cluster view makes clear that there are many complex factors not only operating within our bodies and the bodies of those with whom we have emotionally important relationships, but also in unseen fields of interpersonal and environmental influence—past, present, and future. For example, a couple may be struggling with sexual issues that are tied to sexual traumas passed down the generations. Or our clients may be suffering with shame or expectations of abuse that have been transmitted transgenerationally by survivors of slavery, colonization, or holocaust. Or our clients may have been traumatized by threats or actualities of military invasion. *Having an openness to the infinite possibilities of our relationships and establishing an ongoing collaborative project with our intimate friends, our professional colleagues, and our psychotherapy clients, and supervisors to continue defining and processing what*

emerges from within and around us at all times can allow us to live fully within the incredible possibilities of our human potential. But there is yet more.

Joseph Chilton Pearce has spent a lifetime studying the mysterious and miraculous in human life throughout the ages such as how the fakirs can walk through beds of coals without being burned. It is his achievement to put together an amazing story now emerging from brain research in two truly remarkable books, *The Biology of Transcendence: A Blueprint of the Human Spirit* and *The Death of Religion and the Rebirth of the Human Spirit: A Return to the Intelligence of the Heart*.[36] Earlier Paul MacLean had recognized that there was indeed a fourth brain but since the research technology of his time could not demonstrate that the prefrontal cortex "did" anything, he simply called it the "angel lobes," noting that these prefrontal lobes had something to do with human higher functions, relationships, and morality. We now know that MacLean was on the right trail of what Pearce calls "transcendence" or "human spirit" in brain functioning.

Immediately behind the ridge of our brow lies the prefrontal cortex—long known as the third eye—the largest and most recent of brain additions. Behind the prefrontal lobes lies the rest of our neocortex. Neuropsychologist Allan Schore describes how the orbito-frontal linkage between the prefrontal cortex and the neocortex parts of our brain is entwined with the care a toddler receives and how this, in turn, determines the lifelong shape and character of that child's worldview, mind-set, sense of self, affect regulation, impulse control, and ability to relate to others.[37]

The neurons of the prefrontal cortex interact with and govern many functions throughout the brain and the entire body having to do with emotionally important

relationships. Pearce reports that the first growth spurt of the neocortex is during the months immediately following birth when the establishment of relational patterns in the family is rapidly expanding. A second growth spurt occurs in adolescence when social relationships in the peer culture are taking center stage. Our prefrontal cortex thus makes us unique among the species in our capacity *to actually organize our brains around our intimate social relationships*—both the primary ones of infancy and the secondary ones established in adolescence. In fact, it turns out that we actually continue to reorganize and expand our brains as well as our neurological, and neurotransmitter systems around our emotionally significant relationships for a lifetime.

But there is more to the story of the neocortex—*the heart-brain connection.* Electromagnetism is a term covering the entire gamut of most energy known today, from power waves that may give rise to atomic-molecular action to radio waves, microwaves, and X rays. Pearce first points out that a heart cell is unique in its capacity for pulsation, which is important for our study of emotional intimacy. Further, heart cells are connected by glial cells that both receive and transmit electromagnetic energy. Recall your biology lab experiment when the class dissected live frogs and removed the hearts that then kept beating outside the body for a while. The mysterious thing was that when one frog heart stopped beating another beating heart could be placed near it and it would begin beating again. We now have defibrillators in airports to help people with heart difficulties re-establish normal heart beats that have been disturbed by airport anxiety. In emergency rooms infants in cardiac distress are immediately placed heart to heart with nurses so that regulation can be rapidly restored. Tinker Bell, E.T., and Elliot the Dragon are repeatedly cheered back to life by the excited passionate shouting of

children in movie theaters! Hearts in intimate emotional relationships not only share pulsations but transmit and receive electromagnetic signals.

Pearce reports that up to 70% of the actual cells in the human heart are actually neuron cells, the same kind of neurons found in our brains. These heart neurons are surrounded by electromagnetically sensitive glial cells and have direct neural connections with the prefrontal cortex of the brain. Pearce summarizes the recently discovered astounding heart-brain-body connections: “The heart's electromagnetic field is holographic and draws selectively on the frequencies of the world, our solar system, and whatever is beyond. Through glial action our neural system selectively draws the materials needed for world-structuring from the electromagnetic fields as coordinated by and through the heart….The dialogue between our heart and brain is an interactive dynamic where each pole of our experience, heart and brain, gives rise to and shapes the other to an indeterminable extent.”[38] Through emotional-cognitive connections the brain has direct, unmediated neural connections with the heart in our moment-by-moment intimate relationship experiences—including those we have in psychotherapy and psychotherapy supervision.

Says Pearce, “Nature's economical habit of building new evolutionary structures on the foundations of older ones has led to our current magnificent potential….We have within us this…three-way connection among our emotional-cognitive brain, our prefrontal lobes, and our heart-brain….Here in this set of connections lies our hope and transcendence….Whatever language or rationale it might take, our task is to discover—or rediscover—these three potentials and align them so that we come into transcendent

dominion over our life."[39] In context, I take "transcendent dominion over our life" to mean expanding our capacities for rich, rewarding, and mind-expanding intimate relationships.

Pearce is only one among many current thinkers to note that *human nature* is not simply biological but psychological, sociological, cultural, and spiritual. We can no longer imagine ourselves as merely inhabiting a solitary body or brain because human nature and human emotional life considerably transcends our bodies. As we struggle to make our relationships work better for us these cutting-edge understandings of our brains and our nervous systems make clear that two people can best relate to each other by acknowledging their inevitable intertwining with each other's nervous system and then by learning to be aware of and to work with their dynamic reciprocal impact on each other. Media sitcoms lead us to believe that we are like independent billiard balls bouncing off of one another in stimulus-response fashion—but nothing could be farther from the truth. We are in continuous dynamic emotional connection with all of our intimates—including our therapists, our clients, our supervisors, and our supervisees—and the ineffability of these connections increases exponentially in long-term relationships. *Learning to work together with our magnificent potentials is our relationship challenge today—our best brain functioning requires it.*

These six views of brain functioning that have evolved over the last century reveal a gradually growing awareness of how our total brain and neuronal functioning expands out of our bodies and into all of our emotionally significant relationships. And conversely, that our best brain functioning is derived from our intimate emotional exchanges with others.

In addition to brain functioning having much to say about the relating of psychotherapy and supervision, studies in infant interactions provide foundational understandings of the processes that underlie adult relationships.

3. Infant Research

During the past two decades we have witnessed the accumulation of a large body of compelling evidence from infant research that has radically changed our conceptualizations of the way human beings develop and relate to each other.[40] For example, we note that in real time a mother and an infant look at each other, smile and laugh, and both are perfectly, happy. But if the baby sees a videotape or a time-delay of his mother's face instead of the real-time display, he quickly becomes distraught. Restore her via live TV monitor in real-time and his contentment returns. We may once have thought that it was her beautiful face he was responsive to but we now know it is her real-time emotional life and her intentionality—*her intention to relate* that hooks him.

Infant research now indicates that babies during their first year of life:

(a) show an innate tendency to express their emotion states automatically;

(b) are sensitive to back and forth, face-to-face mutually contingent emotional communication;

(c) can discriminate discrete facial patterns of emotional expression;

(d) are dependent on their parent's emotional regulation for emotional self-regulation; and

(e) are strongly influenced by their parents' *emotional* communications.[41]

In considering the relationships of psychotherapy and supervision, we are interested in knowing how infant researchers define foundational emotional interaction patterns that lay the groundwork for later emotionally intimate exchanges. According to infant researchers Beatrice Beebe and Frank Lachman who report on thousands of hours in controlled environments watching babies and mothers interact,[42] the first patterns of experience are organized in infancy as "expectancies of sequences of reciprocal exchanges." That is, the first memory systems of babies have to do with how they expect to interact emotionally with their caregivers in order to learn how to regulate themselves and then how to prompt their caregivers emotionally for what they need when they need it. Neuropsychologist Allan Schore after studying thousands of mother-child interaction situations describes how the mutual emotional regulation patterns of infant and mother give rise to similar patterns of mutual emotional regulation in intimate relationships later in life.[43]

These so-called "expectancies of sequences of reciprocal exchanges" are primary memory templates or stored representations of experience that precede our later capacity to remember in images and symbols. These early presymbolic representations or memories derived from an infant's experiences with mother are defined by infant researcher Daniel Stern as "the expectancy of a temporal-spatial schema." In an effort to study the nature of these presymbolic representations or memory patterns first observed in infants, Stern did a frame-by-frame analysis of a boxing match between Mohammed Ali and Al Mindenberger. He found that 53% of Ali's jabs and 36% of Mindenberger's jabs were faster than humanly possible visual reaction time. Stern concluded that a punch is not the stimulus to which the response is a dodge or a block

but is a carefully conditioned hypothesis-generating or hypothesis-probing attempt by each person to understand and predict the other person's behavioral sequences in time and space.[44] We know that as the psychotherapeutic relationship and the supervisory relationship get underway these knee-jerk patterns of relating of both participants become activated so that two become what Donnel Stern has called "partners in thought."[45] Later we will review the intersubjective and relational psychotherapy literature on how mutual enactments characterize the therapeutic as well as the supervisory relationship. Enactments arise from portions of the personality of both participants that have never been formulated, from these presymbolic representations of relationships as well as presymbolic dissociations of dreaded relationship configurations.

All athletes will tell you that when they are functioning in top condition something in them takes over and they go "into the zone" where their reactions are no longer willful in the usual sense but derive from this magnificent capacity to read the situation and live "ahead of the game." Those who study music and dance report the same kind of "in the zone" experience. In more usual social situations we too form temporal-spatial and emotional-arousal schemas of each other's behavioral flow in relation to our own but we seldom notice what we are doing. With our intimate relating partners we find ourselves taking the words out of each other's mouths and in bed our reactions are there before we hear our partner's call. Learning to anticipate the responses of the other in therapy and supervision entails such subtle, ineffable, nevertheless highly impactful processes.

These brief glimpses into the expanding field of infant research make clear that even the earliest of interactions of baby with caregivers are emotionally determined and

regulated into enduring patterns that set the stage for emotional relatedness in later intimate relationships. Infants are busy organizing an emotional-interactive world in the first half of the first year of life, prior to the emergence of symbolic capacity. Though we may not be aware of it, moment-by-moment emotional-interactive regulation in intimate relationships continues for a lifetime. When we struggle to understand our part in a relationship gone awry, we may find that one or the other or both of us are over-anticipating the other's reactions with knee-jerk rapidity and for any of a variety of reasons throwing the interaction off. The most common of these reasons is our transferring one of these knee-jerk emotional patterns or relational fears from the past into the present relationship and mucking up things. An Olympic athlete may have trained endlessly to overcome a faulty reaction pattern established in childhood but deemed inefficient in the current competition. But in a moment of insecurity or anxiety the old knee-jerk returns and the swim meet is blown. How often have we blown a relationship moment in the same way—by thoughtlessly dragging in some inappropriate reaction from the past? The emotional intimacy patterns we learn early in life can continue to haunt our relationships for a lifetime—especially our therapeutic and supervisory ones. But we can work together in later intimate emotional relationships to modify and improve our emotional responsiveness and to overcome our faulty knee-jerk relational patterns.

Infant researcher Ed Tronick has suggested that, in the process of mutual regulation, each partner (mother and infant, or therapist and client, or therapist and supervisor) affects the other's "state of consciousness" (state of brain organization).[46] As each affects the other's self-regulation, each partner's inner organization is expanded into a

more coherent, as well as a more complex, state. In this process, each partner's state of consciousness expands to incorporate elements of consciousness of the other in new and more coherent forms. While these processes of mimicry and affect mirroring have been defined and studied in infancy in a variety of ways, they have also been demonstrated to be lifelong processes characteristic of intimate intersubjective relating. In considering the implications of infant research for understanding the establishment of relational processes in adult relationships, psychoanalyst Jessica Benjamin says, “These internalized schemas lead to expectations of closeness vs. distance in relating, of matched and met vs. violated and impinged upon experiences, and of an erotic dance [each schema being] fundamental to mutual attunement and pleasure in adult sexuality as well as to movements and mutual empathy in the [therapeutic and supervisory] relationship”. [47] Benjamin views these early sensual experiences of mutual attunement as becoming internalized as interactional or intersubjective schemas. When they reappear in later intimate relationships, including the therapeutic and supervisory relationships, she refers to them as erotics of transference.

Drawing heavily on infant research, Benjamin writes extensively on the importance of mutual recognition in intimate relationships, special emotionally-charged moments when mutual attunement between separate minds and bodies is achieved. “In erotic union this attunement can be so intense that the separation between self and other feels momentarily suspended [and] a choreography emerges that is not reducible to the idea of reacting to the outside. In erotic union the point is to contact and be contacted by the other—apprehended as such”[48] I would extend her relational formulation to include the client-therapist-supervisory dyads and triad.

By way of summary, infant research now demonstrates not only that all humans are capable of emotional intimacy from before birth, but furthermore, that all humans are born desiring and seeking out loving intimacy. Psychotherapy research demonstrates that when we encounter blocked loving feelings in our later lives, it is because we fear rekindling the dangers of various kinds of emotional closeness that we once experienced as frightening, hurtful, or destructive in childhood. But psychotherapy research also demonstrates that it is possible through the therapeutic relationship to unblock those closed channels to emotional intimacy and to resume our growth as loving human beings. There is now ample evidence that long-term intimate emotional relationships profoundly impact and actually change the ways our central nervous system operates!

Research from many fields now reveals that the guiding mechanism of Darwinian evolution is our capacity for emotional intimacy. Darwin spoke of emotions as having evolved through natural selection to a special peak in humans. And that our full spectrum of emotions is critically important as adaptation to our human social environment.[49] In each intimate contact from infancy on, we are striving toward emotional understanding of the personal inner life of someone else—even as we attempt to share our own inner emotional life with them.

Infant and child research further emphasize how humans from each cultural group are “specially taught” to view the world of others in highly specific ways and suggest how difficult it is for us to relate across cultural divides.

4. Cross-cultural and Diversity Sensitivity

Living in the multi-cultural climate that we do today, it is increasingly important for therapists and especially for supervisors to be continuously upgrading their cross-cultural sensitivity through reading and ongoing continuing education activities. In my book on the topic addressed to therapists, *Cross-cultural Encounters: Bridging Worlds of Difference*, I put forth ten different perspectives for considering dimensions of differences across the ethnic, cultural, language, socio-economic, and immigrant status lines that we necessarily encounter in one form or another almost daily in our work.[50] Considering such diversity, I conclude that indeed each of us is raised in a unique familial/cultural setting and that routine inquiry into how our differences impact the therapeutic relationship is essential. Kimberly Leary, an African-American therapist working in New York makes the case the clearest:

> When I open the door to the waiting room to greet a new client, that I am obviously a person of color constitutes an implicit and important self-disclosure. At the present moment in time, racial similarity or difference in the consulting room immediately implicates us into a cultural conversation and one about which it is difficult to talk openly….With most clients, if racial similarity or, more typically, racial difference is not mentioned at some point during an evaluation or during the first month of a treatment, I typically comment on the fact that the client hasn't mentioned it directly. I might, for example, acknowledge the social climate surrounding open talk about race in this country…In this way, I am offering the client an opportunity to

> consider the expanded possibilities for communication offered in treatment.[51]

In a supervisory situation three such cultural orientations are immediately at play—client, therapist, supervisor—and it is important for therapist and supervisor to be ever-mindful of and explicit in discussing the differences among them.

Case Study: Roland: "Now that we are Working Together"[52]

One moving example from psychologist Alan Roland that I encountered in my cross-cultural research demonstrates how vital cultural sensitivity can be in the supervisory process. He presents the following story to illustrate how our Western concepts regarding the self in therapy simply do not apply to other cultures. The incident involves an experienced Japanese psychotherapist who had come to the United States for advanced training at the National Psychological Association for Psychoanalysis in New York City.

> Early in his training program in a class on therapeutic technique, he presented an initial session with a Japanese client, a young woman in her early twenties. He related to the class that the young woman was rather hesitant and cautious in telling him of her problems with an American boyfriend. For his own part, he had been mostly silently empathic with her, hardly asking any questions. At the end of the session, he said to her, "Now that we are working together, we shall continue in future sessions".

The instructor was astonished at the way he ended the session since he had said very little during the session. She wanted to know why he closed with, 'now that we are working together we shall continue in future sessions.' The Japanese therapist reports becoming upset because he was not being understood as a Japanese speaking with another Japanese. Roland asks what different assumptions about the nature of self did the Japanese therapist and his instructor make? He points out that Westerners generally assume that there are two independent individuals participating in the therapeutic exchange, each with an “I-self” with ego boundaries engaged in an “I” and “you” contractual arrangement. While the mentoring aspect of therapy is asymmetrical, American egalitarianism promotes the notion that as people they are equal.

> The Japanese therapist assumed a very different kind of self in his client and himself, as well as very different ways of communicating and relating. He based his way of working on the "we-self” of the Japanese, a self that is primarily experienced in relation to others and is particularly integral to Japanese-style hierarchical relationships, in which subordinate and superior form a "we" relationship…. In vivid contrast to the American experiential sense of an I-self, for Japanese, a sense of I-ness, or even of I want or I wish, rarely exists. Rather, Japanese depend on each other to sense what the other wants. The therapist knew from Japanese-style hierarchical relationships, and from years of psychotherapy experience in Japan, that in order for any therapy to take place he had to foster the development of a close "we" relationship between superior-therapist and subordinate-client. In

> Japan…the superior is expected to be empathically nurturing and responsible to the subordinate. He further knew that in their society that so stresses the correct presentation of self (*omote*) in a rigorously observed social etiquette, particularly in the formal hierarchical relationships, Japanese keep a highly private, secretive self (*ura*) in which all kinds of feelings, fantasies, and thoughts are present….Only after considerable time, when a trusting relationship has been formed and the therapy relationship has been gradually transformed from an outsider one (*solo*) to an insider one (*uchi*) will a Japanese begin to share important aspects of his or her inner life. Thus, this Japanese therapist was silently empathic with his client, a not unusual way of communicating in Japan, where both client and therapist, as in other hierarchical relationships, expect the other to empathically sense what each is feeling and thinking, often with a minimum of overt communication. There is after all a saying in Japan, "Nothing important is ever to be communicated verbally."

Case Study: Tummala-Narra: Dynamics of Race and Culture in Supervision[53]

Psychologist Tummala-Narra who identifies as an Asian Indian woman recalls an experience she had early in her training with a White European Man supervisor. In talking with her supervisor about her 21-year-old Indian American client's intent to marry a man via arranged marriage in India, her supervisor gasped expressing his disdain for arranged marriages. Feeling somewhat defensive, she gave her supervisor an idealized version of the Indian arranged marriage system. In so doing the two were deflected from

considering the client's own conflicts about being in an intimate relationship. Tummala-Narra emphasized the advantages of arranged marriages, particularly the strengthening of familial connections, partly because her supervisor's reaction reminded her of many other similar reactions she had encountered in the course of growing up but particularly because her Indian-American friends often emphasized that the Western practice of romantic dating neglected the importance of family unity.

> I reacted to my discomfort with my supervisor's comments and my desire to maintain my Indian cultural identifications in the mental health field, which was dominated by a European American perspective of understanding human relationships, by defending only a part of how I really felt about arranged marriages. I chose not to share some of my apprehension about arranged marriages, which was influenced in some ways by my more Western identifications and in other ways by my own images of the limited role of romantic love in arranged marriages. I worried that my supervisor and I would collude to devalue an Indian sense of collectivism that I valued and instead only idealize Euro American values of individual autonomy and personal achievement. (p.305)

Only later did she realize that her client was not so much distressed about the arranged marriage system as she was about envisioning herself as able to sustain a loving intimate marital relationship at all.

Tummala-Narra came to understand that the interaction with her supervisor allowed her to resist dealing with her own ambivalence about arranged marriages. This

interaction highlighted the sharp contrast of worldviews held by supervisor and supervisee and avoided an in-depth discussion of her client's dilemma. She further reports that her experience of conflicting views toward not only arranged marriages but toward being an Indian American paralleled her client's experience so that the supervisory encounter curtailed the hope of developing a more intimate understanding of her client's conflict. The faulty supervisory encounter paralleled a faulty therapeutic encounter that served to further limit her client's willingness to take necessary risks in forming intimate relationships.

> …we all reveal our personal feelings about race and culture in various ways to our clients and supervisees. As a supervisor myself I was recently working with a White European American female supervisee who was treating a young Indian American man. The client had discussed with my supervisee his reluctance to get married, because of apparent pressure from his parents to marry someone of the same ethnic and religious background via the arranged marriage system. The supervisee conveyed her feelings of sympathy for the client as he struggled to make his decision.[54]

In the supervisory discussion the therapist said that she felt like she had to do something to rescue her client from the 'plight' of an arranged marriage. Tummala-Narra inquired as to the supervisee's understanding of the arranged marriage system and whether "she felt that the client may actually be ambivalent about being involved in an arranged marriage, instead of only despising the notion of it." Her supervisee indicated that she couldn't imagine that anyone brought up in the United States could like

anything about arranged marriages. She confessed that her views neglected a part of her client's worldview. Tummala-Narra further inquired about her experience of having an Indian American supervisor. It came out that she had tried to ignore that her supervisor was a “person of color” in the same way that she had ignored her client’s views on marriage in order

> to manage her anxiety and feelings of inadequacy about working with ethnic minorities whose cultural realms felt unfamiliar to her. These interactions allowed for a more genuine discussion about issues of culture and race, as well as an opportunity to address the experience of shame in supervision. Such junctures are particularly salient in understanding the interplay between dynamic and cultural factors in psychotherapy and supervision.[55]

While this is not the place to discuss the many variables involved in raising our multicultural awareness, I would like, almost as an aside, to briefly discuss one often-neglected topic—transgenerational ghosts. I take this detour because by the time there are three individual cultures interacting there are certainly many ghosts that inhabit the therapy/supervisory processes.

5. Psychodynamic Ghosts in Therapy and Supervision

With seven voices inhabiting the client-therapist-supervisor triangle many unique cultural variables and many transgenerational ghosts are necessarily haunting the process. How can their presence be detected and brought to bear on the therapeutic and supervisory relationship.

The great psychological controversy of the nineteenth century concerned which was more important in human development, nature or nurture? Sigmund Freud believed that his most significant discovery was that more important than either nature or nurture in human beings was a third force: the progressive elaboration from birth of an "internal world." Each stage of our emotional-relational development is molded not only by the genetic and constitutional load we bring into the world with us, but by how we experience and construct in memory each unfolding interpersonal encounter. We may joke about perceiving the proverbial glass as half-empty or half-full, but at some level we know that our early character formation influences all of our subsequent perceptions and projections. We construct ongoing subjective worlds based on how we have experienced relationships in the past.

The central concept of psychotherapy is "transference"—by whatever name we choose to call it. Transference of internalized emotional patterns of relating operates in all relationships but is particularly noticeable in trust relationships—which therapy and supervision certainly are. Psychotherapy teaches us that we all carry within us transference ghosts from the past that influence how we live our present relationships. That is, the central assumption of psychotherapy is that early conditioning in the context of emotionally significant relationships and dynamically impactful experiences heavily influences the ways we construct our subsequent perceptions and lives. The many different theories and practices of psychotherapy, as well as recent findings of neuroscience[56] support our professional belief that in emotionally significant relationships later in life, people can learn to focus on and to alter their relational patterns and behaviors.

Three kinds of internalized ghosts inhabit our internal worlds:

1. *An individual internalization* would be a way we each organize our perceptions and projections based on emotionally-significant experience from our individual, personal, and familial past—such as abuse, trauma, success, or privilege.

2. *A positional internalization* refers to a way we may psychologically organize our experience based upon some condition of the socio-cultural position we were born into or came to occupy—for example, social class or racial prejudice; gender or sexuality bias; or handicapped, immigrant, or refugee status.[57] Psychotherapist Stephen Hartman has recently added to this list our unconscious relation to *the world of materialism and work* as it surrounds us as children.[58]

3. *A transgenerational internalization* is a psychological organization or orientation based upon experiences our parents or ancestors may have suffered but that persists in haunting our present—for example, the possibility of poor self-esteem carried by an African-American individual based upon generations of maltreatment.

Attitudes of ethnic or racial superiority, supremacy, or privilege are further examples of transgenerational transmission or haunting. Racial hatred, religious intolerance, class prejudice, and white guilt are all sustained through internalization and transgenerational transmission.

Hungarian psychoanalyst Nicolas Abraham in 1975 introduced the concept of the “transgenerational phantom” moving the focus of psychodynamic psychotherapy beyond the individual because it postulates that some people unwittingly inherit the secret “psychic substance” of their ancestors' lives.

> The terms ‘phantom,’ ‘ghosts,’ and 'revenants’ as used by Abraham, derive from folklore giving psychological substance to age-old beliefs…, according to which only certain categories of the dead return to torment the living: those who were denied the rite of burial or died an unnatural, abnormal death, were criminals or outcasts, or suffered injustice in their lifetime….In Abraham’s view, the dead do not return, but their lives' unfinished business is unconsciously handed down to their descendants. Laying the dead to rest and cultivating our ancestors implies uncovering their shameful secrets, understanding their nameless and undisclosed suffering….[U]unsuspected, the dead continue to lead a devastating psychic half-life in us.[59]

Says Abraham, The special difficulty of therapeutic work with transgenerational phantoms lies in the client's horror at violating a parent's or a family's guarded secret, even though the secret's text and content are inscribed within the client's own unconscious. The horror of transgression, in the strict sense of the term, is compounded by the risk of undermining the fictitious yet necessary integrity of the parental figure in question.

Recent attachment research clearly demonstrates the operation of transgenerational phantoms in the mechanisms of biologically based and psychologically mediated human attachment. Says Marrone:

> Parental functions are organized by the parents' representational systems, defenses, and strategies, and their manifestation through family scripts, which in turn were formed under the influence of their own parents' representational systems. There is now ample and robust empirical support for this hypothesis. Identification with negative and or abusive aspects of the parents plays an important role in intergenerational transmission of disturbance.[60]

As a clear example of how transgenerational haunting operates, bell hooks in her book, *Killing Rage: Ending Racism*[61], raises questions about

> negative habits of being that may have emerged as forms of political resistance…in the days of extreme racial apartheid. For example, dissimulation—the practice of taking on any appearance needed to manipulate a situation—is a form of masking that black folks have historically used to survive in white supremacist settings. As a social practice, [dissimulation] promoted duplicity, the wearing of masks, hiding true feelings and intent. While this may have been useful in daily relations with all-powerful white exploiters and oppressors…as a paradigm for social relations it has undermined bonds of love and intimacy…. Only as African-Americans break with the culture of shame

that has demanded that we be silent about our pain will we be able to engage holistic strategies for healing that will break this cycle."[62]

Discussing specific mechanisms of transgenerational transmissions psychoanalyst Vamik Volkan writes:

> There is far more to this transgenerational transmission of massive trauma than children mimicking the behavior of parents or hearing stories of the event told by the older generation. Rather, it is the end result of mostly unconscious psychological processes by which survivors deposit into their progeny's core identities their own injured self-images. In order to gain relief from feelings of shame and humiliation, the inability to be assertive, and the inability to mourn, a Holocaust survivor, for example, deposits his or her image of him or herself as a damaged person into the developing personal identity of his or her child; thus, the parent's self-image 'lives on' in the child. Then the parent unconsciously assigns to the image of him or herself that is now in the child specific tasks of reparation that rightfully belong to the survivor: [such as] to reverse shame and humiliation, to turn passivity into activity, to tame the sense of aggression, and to mourn the losses associated with the trauma. What is passed to the offspring is not the traumatized person's memories of the event, then, for memory can belong only to the survivor of trauma and cannot be transmitted; deposited parental self-images are the only elements by

which the representation of traumatic history can be passed from person to person."[63]

Ghosts in Psychotherapy and Supervision

Cross-cultural research in attachment, neuroscience, and infant intersubjectivity confirms that individual, positional, and transgenerational phantoms inhabit our inner worlds, informing us who we are and how we are to be in our relationships and in the world. People raised in different socio-political, economic, and cultural circumstances experience their ghosts differently. Psychotherapy and supervisory settings provide an opportunity to represent in symbols, language, and enactments the phantoms that inhabit our inner worlds. The task of the facilitating professional cannot possibly be to have a knowledge of all of the types of personal, familial, and cultural haunting that diverse people experience. But rather to co-create with the client or the treating therapist a setting that is maximally conducive to the emergence of internal representations in symbols, words, and actions. After all, phantoms cannot survive exposure to the light of day!

6. The Present Moment and Intersubjectivity

Psychotherapy and psychotherapy supervision are essentially transformational relational processes between two or more people that occur in *present moments* of time. I first began writing about the transformative importance of the present moment in psychotherapy as early as 1983 in my chapter on the "organizing experience" of early infancy.[64] It was clear to me then that early human development arises from present moments when an infant emotionally orients and reaches toward his (m)other and when she is waiting and extends herself emotionally in order to meet his reach in a moment of

mutually stimulating contact. In *Listening Perspectives in Psychotherapy,* I demonstrated how such moments of reaching for mutual contact are crucial for effective psychotherapy at whatever developmental level.

Later infant research has studied these moments of emotional contact intensively and exhaustively—noting that early experiences of affect attunement and misattunement are what fuel lifelong developmental processes. Early dyadic contact and regulatory processes lead to later processes of self and other regulation and cohesion that enable humans to perceive and interact with the world of others in enlivening and enriching ways. But it is difficult to talk about present moments of transformational contact in psychotherapy and supervision without first referencing the psychological concepts of subjectivity and intersubjectivity.

In recent years psychotherapists from divergent schools of thought have begun to formulate various kinds of intersubjective or relational views of human development. These formulations rest on the belief that the human mind emerges from and continuously exists within human interactional processes, rather than being simply constructed or conditioned as a separate or isolated mind-self. Simply stated, I am a subject, an agent of my desires, thoughts, and actions. You are a subject, an agent of your desires, thoughts, and actions. When we come together for an intersubjective engagement over a period of time, something else begins to happen that affects us both. That is, there's you and me and the relationship makes three. Intersubjective theories provide different ways of thinking about how our shared intersubjective experiences develop on a moment-to-moment basis, and how we each become

affected by the third vector, the intersubjective field or the relationship we have mutually created.

Intersubjective theory generally distinguishes two subjects in the process of interacting and recognizing each other from one subject observing or influencing another. The main experience of intersubjectivity in psychotherapy is one of *being with* rather than one of *observing and interpreting*.

The central theoretical construct of intersubjectivity theory is the "intersubjective field," defined as "a system composed of differently organized, interacting subjective worlds."[65] Psychologist-psychoanalyst Robert Stolorow and his colleagues use intersubjective "to refer to any psychological field formed by interacting worlds of experience, at whatever developmental level these worlds may be organized."[66] "The concept of an intersubjective system brings to focus both the individual's world of [personal] experience and its embeddedness with other such worlds in a continual flow of reciprocal mutual influence."[67]

While the topics of subjectivity and intersubjectivity have interested philosophers for several centuries, it has only been during the past few decades that the development of subjectivity and the maintenance of intersubjectivity have been scrutinized in a wide range of multidisciplinary studies, including infant research, neurobiology, and relational psychotherapy. Infant researcher Colin Trevarthen observes in early infancy a phase of "primary intersubjectivity" characterized by mutual sharing of intent as an effective psychological activity.[68] Infant researcher D. N. Stern sees intersubjective relatedness as a crucial step in self development as the infant becomes able to share subjective

experiences, especially affective ones. Further, Stern has come to consider the capacity and drive for intersubjective communication as innate and present from birth.[69]

Psychoanalyst Jessica Benjamin[70] formulates a sequence of theoretical stages for the development of intersubjectivity:

1. *Primary recognition*—is "to affirm, validate, acknowledge, know, accept, understand, empathize, take in, tolerate, appreciate, see, identify with, find familiar…love [the other]"….
2. "*Mutual recognition* includes…emotional attunement, mutual influence, affective mutuality, sharing states of mind….Research reveals infants to be active participants who help shape the responses of their environment, and 'create' their own objects"….
3. *Actual interpersonal interaction* is the development of the self within relatedness and interpersonal interaction. The accent here is on the self that is affected by the other's recognition or lack of such so that the child feels either confirmed or denied in his/her sense of agency and self-esteem….
4. *Intersubjective mutual recognition* occurs when "the individual grows in and through the relationship to other subjects….The other whom the self meets is also [recognized as] a self, a subject in his or her own right…we are able and need to recognize that other subject as different and yet alike, as an other who is capable of sharing similar mental experience."[71]

Mutual recognition, "the necessity of recognizing as well as being recognized by the other, is crucial to the intersubjective view; it implies that we actually have a need to

recognize the other as a separate person who is like us yet distinct;"[72] and that we have a need to be recognized as like but separate, different and distinct. "This conscious pleasure in sharing a feeling introduces a new level of mutuality—a sense that inner experience can be joined, that two minds can cooperate in one intention….Awareness of the separate other enhances the felt connection with him: this other mind can share my feeling."[73] Says Benjamin:

> My premise is that recognition of the other is the decisive aspect of differentiation. In recognition, someone who is different and outside shares a similar feeling; different minds and bodies attune. In erotic union this attunement can be so intense that self and other feel as if momentarily 'inside' each other, as part of a whole. In my view, the simultaneous desire for loss of self and for wholeness (or oneness) with the other often described as the ultimate point of erotic union, is really a form of the desire for recognition. In getting pleasure with the other and taking pleasure in the other, we engage in mutual recognition.[74]

Intersubjective theory and practice thus points to the ways we now try to grasp the subjective meanings of the unconscious communication between ourselves and the other person in the room. Intersubjectivity theory acknowledges:

- the unknowability and uncertainty of the meanings of all interpersonal encounters;
- the sense of the multiple possibilities of interpretation in any given moment;

- the realization of the likelihood that we will communicate our subjectivity (whether we wish to or not); and
- the possibility of speaking from our own responses and doubts within the therapeutic situation.

The goal of psychotherapy in this intersubjective/relational view is for both participants in the context of a mutually-evolving, co-constructed intersubjectivity to come to recognize each other and to know themselves more fully in order to attain more flexibility, creativity, and passion in living and loving. The goal of psychotherapy supervision is to find a way to foster the therapist's capacity to encourage mutual recognition in a process of co-constructed intersubjectivity with her client. But—returning full circle—intersubjective contact isn't simply an abstract concept, intersubjective engagement is a real and enlivening experience between two people that *always occurs in a specific moment in time*.

Infant researcher Daniel Stern, after years of studying hundreds of thousands of micro-moments of infants in various kinds of intentional and emotional involvements of babies with their caregivers, has much to say about the intersubjective processes of change that occur in infancy and throughout life in his momentous book, *The Present Moment in Psychotherapy and Everyday Life.*[75] His book is about subjective experiences that lead to change. Stern asks, "How do experiences [change us]? What are such experiences made of? When do they take place?"[76] His answer, "Change is based on lived experience. In and of itself, verbally understanding, explaining, or narrating something is not sufficient to bring about change. There must also be an actual experience, *a subjectively lived happening*. An event must be lived, with feelings

and actions taking place in real time, in the real world, with real people, in *a moment of presentness*."[77]

Stern's curiosity about transformational moments he had observed in infant development took him into dance studios and jazz clubs to study more about present moments in other domains of human experience. His studies have led him to conclude that the basic unit of human experience lasts 8 to 16 seconds—the time for a phrase in language, music, and dance to occur. His finding is reminiscent of our startling eye camera discovery that we do not see in continuous panoramas but rather in instantaneous eye fixations that are seamlessly filled in by our brain functioning. Likewise, says Stern, our present moments of subjective experience are seamlessly strung together by our integrating brain functions.

In ongoing emotionally significant relationships these 8 to 16 second *present moments* often move toward special *now moments* that threaten the status quo of the relationship and threaten the intersubjective field as it has been mutually constructed and accepted up until then. That is, a relationship can be developing quietly in a series of present moments that lead up to some emotionally significant meeting, or conversely, an affect-filled knocking of heads. These emotionally intense moments Stern calls *now moments* that set the stage for a relationship crisis that needs resolution. Stern formulates that the resolution of the relationship crisis—either emotionally positive or negative—occurs in a different special present moment called *a moment of meeting*. "When successful, the moment of meeting is an authentic and well-fitted response to the crisis created by the now moment. The moment of meeting implicitly reorganizes the intersubjective field so that it becomes more coherent, and the two people sense an

opening up of the relationship, which permits them to explore new areas together implicitly or explicitly. This opens the door for the experience to be verbalized and narrated and to become a landmark reference point in the narrative history of the [relationship]."[78]

After studying the motivational systems operating in infant-caregiver dyads for decades, Stern came to realize the critical importance of present moments in all intimate human interactions throughout life.[79]

> Because of their affective charge and import for the immediate future, the now moment and the moment of meeting, focus the participants on the presentness of the moment they are now living. They are both experiencing the unfolding of a piece of reality. They read in the behavior of the other a reflection of their own experience. This provides a form of re-entry via another's mind so that the experience becomes intersubjectively conscious.[80]

But even though researchers Stern cites agree that the capacity for intersubjectivity is innate we still want to know more about how this capacity evolved in the human species and how it operates in interpersonal relationships. One recent line of research is currently focusing on the "mirror" neurons. The discovery of mirror neurons gives us the first clues toward understanding how we enter into each other's subjective worlds. Says Stern,

> Mirror neurons provide neurobiological mechanisms for understanding: reading other people's states of mind, especially intentions; resonating

> with another's emotion; experiencing what someone else is experiencing; and capturing an observed action so that one can imitate it—in short, empathizing with another and establishing intersubjective contact ….Mirror neurons sit adjacent to motor neurons. They fire in an observer who is doing nothing but watching another person behave (e.g., reaching for a glass)…. the pattern of firing in the observer mimics the exact neuronal pattern that the observer would use if he were reaching for the glass himself…. [Thus, Mirror neurons permit us to]…experience the other as if we were executing the same action, feeling the same emotion, making the same vocalization, or being touched as they are being touched.[81]
>
> Another neurological correlate to intersubjectivity is the discovery of the adaptive oscillator neurons that allow us to synchronize our actions and emotions with others —as exemplified by the perfect synchrony of lovers or of two kitchen companions when washing and drying dishes together. Stern points out that the crucial implication of the oscillator neurons is that when people move synchronously or in temporal coordination, "they are participating in an aspect of the other's experience. They are partially living from the other's center."[82]

Developmental and neurological evidence thus suggests that beginning at birth and extending throughout the lifespan human beings are at all times enmeshed in an intersubjective matrix of emotionally intimate relationships. The desire for intersubjectivity is one of the major motivations that drives psychotherapy forward.

Therapy clients want to be known and to share what it feels like to be them. And therapists want their own subjective experiences and the emotions that accompany them to be conveyed in a helpful way to their clients. Research now makes clear that the desire to know and to be known and the ongoing emotional regulation of the intersubjective space are essential features of any intimate friendship or other intimate relationship.

7. Diversity: Gender, Gender Identity, Sexuality

There is no need to review here the revolution in narratives and practices regarding gender, gender identification, sexuality and sexual preference that has marked the twentieth century and continues. Simone DeBeauvoir as early as 1947 clearly delineated the gender narratives received through the course of history that have guided the behavior of men and women into the present.[83] Further, the successive waves of sexual role definitions, gender identity orientations, and sexual preferences that have continued to evolve since the 1970's need not be reviewed here as they have been well-elucidated in the culture at large and well-amplified in the psychological literature. Suffice it to say that Freud's comment at the dawn of the twentieth century to the effect that, though scientists have studied human sexuality for decades and are at a loss of make sense of it, every man and woman on the street corner knows exactly what sex and sexuality are about, still holds true.[84] Freud's observation highlights the perennial uncertainty we face with regard to our gender, sexuality and sexual orientations as well as the defensive postures of subjective certainty and objective knowing that we tend to assume.

Therapists and supervisors alike are filled with the same kinds of "just so" stories about gender, sex, and sexuality that clients regularly bring to the psychotherapeutic encounter. In my book, *Sex in Psychotherapy: Sexuality, Passion, Love, and Desire in the Therapeutic Encounter*,[85] I highlight how constricted and constricting our personally constructed tales of sex and sexuality are and how limited the therapeutic and supervisory encounters can be if we believe all the culturally-based narratives we have "learned" about human sexuality. In that book I set out to blow sky-high the notion that we can ever understand human sexuality—given its infinitely complex and ever-changing nature. So, I ask you how fundamentally correct and universal are the following supposedly sacred truths?

- Men by nature are forever dominating and women submissive.
- Men fear being engulfed by their mothers of infancy and project this wish-fear onto all women.
- Women fear being competitive with their mothers of infancy and forever project this wish/fear onto other women.
- Men want a sexual relationship with their mother of childhood and wish to dispose of male competitors—a triangular scene pursued in various ways for a lifetime.
- Women want an idealized/sexualized relationship with their fathers of childhood and wish to dispose of their female competitors—a lifetime triangular scene.
- Men choose female therapists hoping to be nurtured by them and then to seduce them.

- Women choose female therapists trying to rework the defeat they experienced with their mothers and/or to triumph in the oedipal competition.
- Men choose male therapists in order to identify with their masculinity and feel more powerful themselves because their own fathers failed them by being too weak or too strong.
- Women choose female therapists hoping to identify with their feminine power because their own mothers failed them by being too nurturing or too seductive.

Had enough? And the stories go on—all possible, all plausible, all held as forms of truth. Occasionally one or the other "fits." What are poor therapists and supervisors to do with the voraciously clung to myriad sexual narratives that daily fill their consulting rooms? Certainly not be taken in by them; certainly not simply enact them in the therapeutic and supervisory relationships.

Let us consider for a moment the nature of subjectively held "truths". In not quite an aside I would like to consider the thoughtful and penetrating essays on the nature of prejudice found in a book edited by Donald Moss, *Hating in the First Person Plural*.[86] In the lead essay Moss puts forward a thesis and then invites twelve experts who have researched various forms of prejudice—racism, homophobia, misogyny, etc.—to apply his developmental thesis on prejudice to their speciality with most illuminating results. His reasoning is basically this: In average, expectable human development infants seek to establish themselves as knowing, acting, effective beings in the context of their given social environments. With good-enough parenting their efforts to perceive, to reach out, to act, to experience competence and effectiveness more or less succeed and a strong sense of self, of personal security and effective agency in the world—a strong "I",

becomes established. But when the growing child's efforts are met with failure, shame, and humiliation a sense of insecurity and ineffectiveness results—a weak "I". As the child grows up with an uncertain, weak, and demoralized sense of self, he seeks a platform from which to perceive and act, which promises a sense of cohesion and power in the world. In order to accomplish this, he identifies with a group who "knows," a "we" that possesses a strength that he does not. "We know women, we know homosexuals, we know blacks. They are not like us but we know how they are and we hate them." The Moss thesis on prejudice is that subjectively perceived or experienced inferiority, weakness, helplessness, or uncertainty is denied and projected by identifying with a an "in-group" position—a "we"—of superiority, strength, power, and certainty.

In the present context I am extending this thesis to a broader set of issues encountered in psychotherapy and supervision—defensive identification with various culturally- and professionally-supported and condoned "we's" who know—we's who are superior, strong, powerful, and certain. How easy it is to hide behind culturally and personally constructed "just so" stories about gender, gender identity, sex, and sexuality rather than to live in perennial uncertainty ourselves or with our supervisees or our clients. How easy it is not to question every nuance of the constructed narratives regularly put before us. How easy it is for us as therapists and supervisors to avoid going to our own dreaded places of perceived inferiority, weakness, helplessness, and uncertainty! It is easier to simply retreat to a bastion of knowledge and power—honorable, gender-tagged and lived by the human species for millennia. I rest my case on sex and our foolishness in thinking that we understand much of anything in this infinitely complex area. Instead, we must be forever questioning the just-so tales told by

ourselves, our clients, and our supervisees—easier said than done, I must admit. Read my *Sex in Psychotherapy* book, you'll be astounded at what has been pulled together there from many sources that form a bewildering complex set of ideas about sex, sexuality, gender, and gender identity.

Case Study: Tummala-Narra: Bisexuality in Cross Cultural Supervision[87]

Asian Indian Psychologist Tummala-Narra reports on her supervisory work with an Indian American woman supervisee who was seeing a 32-year-old Bangladeshi American female client. Her client's depressed mood related to her parents' disapproval of her bisexuality. After only a few sessions the therapist found herself sympathizing with the parents' not being able to imagine their daughter's being bisexual. In the following discussion it came out that the therapist found her client's immigrant experience to be much like her own in that it "involved her wish to carry forth her parents' dreams of a better life for her in the United States and her wish to please them."[88] The therapist had reported a growing feeling of separateness from her client and the client reported feeling reluctant to talk about her growing romantic interest in a female colleague.

> A notable challenge in supervision involved my supervisee's and my ability to address the issue of ethnic similarity and individual difference. I noticed that as my supervisee described her association to a nostalgic and idealized image of her parents, I began to remember my family members in India with what felt like a matched degree of nostalgia and sadness. I was aware of the powerful experience of migration to a new and unfamiliar cultural context, which implicates a

> complicated process of mourning and separation….Simultaneously, I felt more distant from the client and unable to fully hear her experience. I then shared my associations with my supervisee and wondered with her whether we were colluding to avoid the complex and painful nature of the client's relationship with her parents, related to her sexuality and her cultural identifications, by idealizing our preimmigration familial relationships.[89]

What came out was that the supervisee had experienced a reluctance to speak in supervision about her feelings regarding her client's sexual orientation for fear of disappointing her. Further she indicated how insecure she felt about how she would be able to help her client since she knew so little about bisexuality.

> The supervisee as well as the client experienced a type of silencing by and a wish to connect with a perceived figure of authority (i.e., the supervisee and me), who carried an ego-ideal characterized by the expectation of maintaining deference and respect for one's parents and older members of the Indian community. The client, the supervisee, and I, perhaps simultaneously at this point in the treatment, hoped to capture and sustain our shared fantasy of preserving our idealized notion of our respective parents and shared the burden of their immigration and related loss. [Further, it came out that] the supervisee's feelings of vulnerability regarding her client's bisexuality were likely related to her ambivalence about her client's wish to become more emotionally intimate with her in psychotherapy.[90]

Tummala-Narra notes the potential in the supervisory triad for all three to engage in what she calls, a “fellow immigrant transference,” which operates on the assumption of sameness of individuals due to their racial or cultural similarity….” This type of transference, if left unanalyzed, can contribute to a minimizing of the client's uniqueness and the enactment of painful interactions with significant others in the client's life.…[91] This vignette also amply illustrates the importance of cultivating an attitude of openness and open discussion regarding the similarities and differences of value systems and world views—regardless of the cultural/ethnic/racial origins of each member of the triad. But there are other forms of diversity and sensitivity.

Case Study: Stimmel: A Blind Therapist and a Supervisor’s Blind Spot[92]

Barbara Stimmel discusses a case that illustrates the potential for the concept of parallel process “to be used by the supervisor as a resistance to identifying a transference reaction to the supervisee, independent of the particular case being presented”[93] She cites the example of a bright and talented blind woman who was grateful for her early suggestion that they would need to consider together the many meanings her blindness might have for her clients.

Stimmel also referred her to a blind colleague to discuss the special circumstances that arise as a result of her blindness as a therapist. She reports an openness on the part of the therapist to reactions on the part of her clients and to her suggestion that her blindness would no doubt be used as a resistance by both client and therapist in the work to come. Supervision was off to a great start.

In the third year a difficulty was encountered with a patient who was also a therapist. In the beginning the client and therapist addressed the therapist’s blindness but nothing

further was said on either side. The client was described as provocative in her struggle around dependency and autonomy. One example would be that the patient would ask for a third hour in a week only then to reject it. The same would happen with interpretations. She constantly challenged the therapist, leading her to question her competency and to adopt a somewhat subdued style that avoided opportunities for interpretations. The constant provocations and the therapist's retreat suggested that the treatment was in a precarious state. One day the supervisee indicated that she almost cancelled supervision because she was feeling upset and unhelpful to her client. It seems that the client was having difficulties with a psychotherapy client of her own and she frantically sought advice from colleagues but was sure her therapist would not offer advice.

> The supervisee then turned to me with her own concerns about her ability to be of help. She was afraid the patient was turning her into a 'destructive helper', much as the patient's mother had been to her. …I also began to recognise my identification with the supervisee-as-therapist, and I suggested that my confusion paralleled the therapist's own, which in turn reflected the patient's ambivalence about helping her own patient. The therapist was relieved at this description of the parallel process.[94]

In the following therapy hour the client reported a childhood struggle she often had with her mother. It seems that her mother would force layers of extra clothing on her daughter on school days and the daughter would express defiance by coming home "underdressed". The client reported that her very disturbed mother would regularly

become enraged and a fight would ensue. At this point in the supervision hour Stimmel reports two thoughts crossing her mind. The first was a curiosity about the client's current reaction to the therapist's blindness. The second thought was that the client made sure to *show* her mother her defiance rather than to protect herself against her mother's rage. As Stimmel is reminded that her supervisee has never seen her she realizes that it was not enough for the client to protest to her mother, she had to *show* her defiance. Stimmel surmises that the precariousness of the treatment is in large part due to the fact that the therapist cannot *see* her client's defiance—as if some concrete manifestation of the defiance must somehow be *seen* in order to be sure she had made an impact.

> The therapist had been unconsciously identifying with the destructive helper of a mother the patient had. She also identified with the helplessness of the patient in the face of her mother's domineering helpfulness. I, too, had in part identified with the unseen patient as well as with the unseeing therapist. [The parallels were striking.][95]

But the plot thickens as Stimmel steps back and notes how overall pleased she is with the way the work is going with this particular supervisee. The free associations go well, the interpretations are well received and the work is progressing beautifully. She asks, "Can it be possible that things can go so well?" What she noted was an absence of the tension between teacher and learner that ordinarily characterizes the learning situation. She also noted that she had been ignoring the therapist's idealization of her as well as the narcissistic gratification it was providing for her. Once the veil of denial was lifted Stimmel noted that there were frequent opportunities to make interpretations

of her own transference to the supervisee. One possibility was realizing that through using her authority as supervisor she had become somewhat of a domineering mother to the supervisee with the therapist 'obeying' her clinical advice. Stimmel reports that she then realized that if her role had been less gratifying she would have been better able to help the therapist disidentify with her and to develop a more balanced view of her own strengths and weaknesses. She confesses that her increasing knowledge of parallel processes allowed her to defend against stronger much more personal dynamics that were in play with her supervisee. Much of this became clearer when shortly after Stimmel moved her office and in the initial session she encouraged her supervisee to move freely around the room and "see" everything in her new office by touch. The supervisee's pleasure was palpable and Stimmel then realized much more:

> In the absence of a daughter of my own, whom I could teach and to whom I could leave a legacy of my own womanhood, I had created a daughter in the supervisee, which had a variety of transference implications. I had also ignored a major, longstanding identification with the supervisee of the sort that an empathic mother might experience. I, myself, was blind. In this instance, my transference …was truly a blind spot. This transference…included conflicted unconscious wishes that a daughter (with whom I could identify) would gratify [me].[96]

Stimmel comments that when resistance to transference to the supervisee is operative it is comforting for the pair to see the near symmetry of the parallel process—paradoxically, the nexus of the resistance "frequently resides in a moment of success."[97]

The last general backdrop consideration before we consider specific perspectives on supervision is one that I have developed extensively in my book, *Making Love Last: Creating and Maintaining Intimacy in Long-term Relationships*, which, though pitched at couples, and couple's therapists, considers the nature of all forms of human intimacy including that established in psychotherapy and supervision.[98]

8. Personal Growth through Emotional Intimacy

Researchers from many fields have been preoccupied the past few decades with discovering the nature of human consciousness. Many ideas have been forthcoming but none so compelling as that put forward in *The First Idea: How Symbols, Language, and Intelligence Evolved from Our Primate Ancestors to Modern Humans* by child psychiatrist Stanley Greenspan and primate psychologist Stuart Shanker.[99] Their text integrates a world of recent neurological, infant, primate, anthropological, and psychological research.

The authors demonstrate convincingly that while our best attempts to date to understand the development of the human mind have been based on Darwinian determinism, there has been a missing link in our thinking that has flawed our studies until quite recently. They see the leading edge of Darwinian evolution as the human capacity for personal growth through emotional intimacy. The origins of symbolic thinking and speaking depend on social transmission of cultural practices learned anew by each generation. The sufficient condition for the development of human thought involves a series of emotional-interactive learning steps—in which even the tools of learning must be interactively relearned by each generation. Greenspan and Shanker maintain that our highest level mental capacities, such as reflective thinking, only

develop fully when infants and children are engaged in certain types of nurturing learning interactions.

The foundation of emotional engagement that leads to symbolic thought involves a series of early emotional processes that a baby and her caregivers enter into from the get-go—processes that develop over time and that are referred to as self-regulation, other-regulation, and mutual regulation. The critical missing link in our understanding between early mutual emotional regulation processes and the human capacity for reflective thought is *the unique capacity to separate perception from action.* For example, a trout perceiving a fly darts toward it, or perceiving a shadow flees. Mammals instinctively fight, freeze, or flee in instantaneous response to threatening perceptions. Human infants and impulsive individuals likewise are emotionally swept away by unmediated perceptions. Telling examples would be a baby who sees his mother and instantly reacts with loving or aggressive responses. Or consider a barroom reveler who is suddenly angered and strikes out without thinking. Normal human development encourages the attachment of various emotions to a wide range of perceptions. For example, perceptions of mother become imbued with both love and hate, with both hope and dread. Often a complex fabric of interwoven and even contradictory emotions is embedded in human perceptual images that allows pause for consideration of multiple meanings of the perceptions as well as meaningful choices. In this way human images slowly become “freestanding” as it were—multiple perceptions linked together with complex and contradictory emotions that mediate between perception and action. The other species live on the stimulus-response reflex arc and are thus prevented from having ideas, and from developing symbols to capture the essence of complex

emotional perceptions and to make possible thoughtful choices. But the fulcrum for the development of human cognitions is the development of freestanding images that mediate between perception and action thereby giving rise to symbolic thought.

The critical accent of Greenspan and Shanker's sixteen lifespan stages of *Functional Emotional Development* describes and defines emotions not simply as various affective states but rather as the child's *overall emotional abilities*. "The overall emotional abilities are 'functional' in that they enable the child to interact with and comprehend her world. They are 'fundamental emotional organizations' [in that they] guide every aspect of day-to-day functioning, unite the different processing abilities, and…orchestrate the different parts of the mind."[100]

Say Greenspan and Shanker, "Just as the discoveries of the wheel and fire set in motion enormous technological advances, the learned ability to signal with emotions and progress through various stages of emotional transformation enabled the development of symbols, language, and thinking, including reflective reasoning and self-awareness."

It is through a lifetime of intimate emotional relationships that our capacity for growth and consciousness-expansion in committed relationships emerges. People who have been deprived of early relationship learning for whatever reason have a difficult time achieving the intimacy in human relationships required for complex self-development in later in life.

In our personal, psychotherapeutic, and supervisory relationships it is our capacity for symbolizing, for thinking and talking about our emotional engagements with our relating partners, that holds the key to consciousness-expansion and relationship

development. At the heart of consciousness expansion in psychotherapy and supervision lies our unique human capacity for symbolization and reflective thought. Consciousness is, after all, a word derived from ancient Greek for “knowing together.” Greenspan and Shanker’s works parallel and support a recent trend in attachment research into a process called “mentalization.”

Fonagy and Mentalization of Experience[101]

Therapists and supervisors emphasize the critical importance of talking about our intimate relational experiences as truthfully as possible with our relating partners. In struggling to represent our experiences with our relational partners in words, pictures, and gestures we actively move from experiencing only at the level of the body, at the level of the unconscious, at the level of the unthought known to the plane of mental contemplation, excitement, and consciousness expansion. This intersubjective process of mutually expanding our consciousness of ourselves and our relating partner is referred to by psychologists as “mentalization.”

Every time we enter a new relationship or have a new experience in a familiar relationship, that experience has to be integrated within the innumerable pre-existing relational templates. This means that new experiences of everyday life always entail various forms of re-experiencing or re-visiting past relational moments as well as anticipating future relational moments. Dedicating the time with our relating partners to mentalize with each other whatever micro-happenings we can identify and represent in words, pictures, and bodily experiences is committing ourselves to living within the richest of all possible human environments—the “subjective-intersubjective matrix.”

Part II. Supervisory Perspectives

Relational Perspective 1

Parallel Process and Projective Identification

I would like to express at the outset of my discussion of parallel process and projective identification a healthy skepticism regarding both well-worn concepts. That is, while projective identification and parallel process are both widely used and accepted concepts with respectable histories, at this point in time they have become not only over-generalized and therefore somewhat hazy but also have become heavily critiqued so that caution is advised. As we will see, both concepts imply a loose field theory orientation in which reified experiences seem to mysteriously, if not magically, fly back and forth in the triadic relations between client and therapist, therapist and supervisor, and supervisor and client. The challenge is how to retain whatever clinical usefulness the concepts may entail while at the same time tightening up our understanding and formulations of them. Both concepts are rooted in Freud's 1914 observation that whatever cannot be remembered is repeated through enactment. "…We may say that the patient does not remember anything of what he has forgotten and repressed, but acts it out. He reproduces it not as a memory but as an action.[102] In brief then, in *projective identification* the therapist is thought to respond to the client's action in a way that repeats some long-forgotten internal experience of the client—that is, the client unconsciously projects something into the therapist or into the therapeutic process that the therapist unconsciously identifies with. In *parallel process* the unremembered emotional experience impacts the therapist in such a way as to allow the therapist unconsciously to re-enact the experience in the supervisory relationship. Both concepts can be used to account for much of what goes on in therapy and supervision, but over

time they have come to be seen as over-used and imprecise, and as perhaps even hiding other critical enactments.

Gediman and Wolkenfeld introduce us to this perspective on considering supervision:

> Supervisors of…psychotherapy have observed a phenomenon in supervision which, despite its regularity, would appear to startle them anew each time they note it. Therapists manifest major psychic events in supervision, including complex behavior patterns, affects, and conflicts which parallel processes that are prominent in their interactions with their clients in the treatment situation. Furthermore, the therapist does not seem to be aware that he is conveying that impression to the supervisor. The phenomenon of which we speak partakes, in a word, of the "uncanny." A supervisee who so garbles his presentation that his supervisor is rendered helpless to respond intelligently to its content complains bitterly of his client's exasperating inarticulateness. Or a therapist asks how to deal with his client's insistence on reading his dreams from notes taken immediately upon awakening in the morning, rather than reporting them from memory, while the supervisee presses the supervisor to listen to tape-recorded sessions.[103]

In other words, non-conscious emotional configurations that are at play in the therapeutic dyad become uncannily repeated in the supervisory dyad with the therapist doing to the supervisor what he is experiencing being done to him by his client. Harold

Searles as early as 1955 was the first to note this phenomenon while supervising therapists working with schizophrenic inpatients:

> The emotions experienced by a supervisor–including even his private, 'subjective' fantasy experiences and his personal feelings about the supervisee–often provide valuable clarification of processes currently characterizing the relationship between the supervisee and the client….
>
> In my view, the supervisor experiences, over the course of a supervisory relationship, as broad a spectrum of emotional phenomena as does the therapist or even the client himself—although, to be sure, the supervisor's emotions are rarely so intense as those of the therapist, and usually much less intense than those of the client. Moreover, the supervisor can often find that these emotions within himself do not represent foreign bodies…but are highly informative reflections of the relationship between therapist and client….
>
> It appears that the reflection process is initiated when the therapy touches upon an area of the client's personality in which repressed or dissociated feelings are close to awareness, so that he simultaneously manifests anxiety and some defense against this anxiety. The therapist then, being exposed to the client's anxiety, experiences a stirring up of his own anxiety with regard to the comparable area of his own personality. The therapist now, it seems, unconsciously copes with this anxiety in himself by either identifying with the defense-against-anxiety

> which the client is utilizing, or by resorting to a defense which is complementary to that which the client is utilizing. Next, when the therapist comes for supervision about this therapeutic relationship, the supervisor may intuitively realize… that the therapist, in the anxiety and defense-against-anxiety which he is exhibiting, is unconsciously trying to express something about what is going on in the client—something which the therapist's own anxiety prevents him from putting his finger on and consciously describing to the supervisor. It is as if the therapist were unconsciously trying, in this fashion, to tell the supervisor what the therapeutic problem is.[104]

Searles' work was soon expanded by Ekstein and Wallerstein in their 1958 classic text on supervision, *The Teaching and Learning of Psychotherapy.* They speak of shared *parallel learning problems* and *parallel ways of seeking help and of helping* in therapy and supervision. "The sense of professional identity in the beginning therapist is particularly dependent upon his ways of seeking help and helping, especially when he discovers that what he reports of his client's sessions so often parallels problems he, himself, experiences in supervision."[105] Subsequently Doehrman in her supervision research notes a "reverse mirroring" phenomenon and states that it is often not at all clear which way the mirror is facing. In the cases she studied, she claimed that therapists behaved with their clients either the same way or the opposite way that they experienced their supervisors' behaving with them.[106]

> …Doehrman (1976) describes a process which is the converse of that noted by Searles…. Therapists develop quite intense transferences

> toward their supervisors and act out, in their treatment of the client, impulses and affects arising from this source. In summary, the chain of individuals, client-therapist-supervisor, constitutes a single system and significant affective constellations move with ease along it in both directions.[107]

These early beginnings legitimised the idea of a parallel process but subsequent writers have pointed out the risks involved in regularly looking for parallel processes when other processes may be at play. For example, Lesser points out that thinking of parallel process as the source of difficulties in supervision may avoid looking at the sources of conflict within the matrix of the supervisory situation itself.[108] Stimmel adds, “Parallel process… may be used also as a resistance to awareness of transference phenomena within the supervisor in relation to the supervisee.”[109] Further, a number of writers agree with Grey and Fiscalini that the procedural similarities of therapy and supervision may account for what often passes as parallel process. And that there are many chains of processes in human relationships that may appear similar and/or reciprocal that cannot be counted as reflective parallel processes.[110] Perhaps Berman sums it up best, “Parallel processes should be understood as one potential aspect of the complex network of cross-identifications within the supervisor-therapist-client triad…." [111]

Relational psychoanalysts Frawley-O'Dea and Sarnat in their comprehensive 2001 text, *The Supervisory Relationship: A Contemporary Psychodynamic Approach*, discuss parallel process in terms of relationship.

> [A relational model of] parallel process refers to the means by which key relational patterns of one dyad come to influence the relational configuration of the other dyad. Parallel processes are most likely to be set in motion when the transference-countertransference matrix in play in the first dyad involves nonverbal, unsymbolized relational constellations that are central to the relational functioning of that dyad but have not yet been consciously processed and linguistically encoded by the members of that dyad….A parallel process enactment of a similar relational pattern offers members of the first dyad another chance to consciously access the meaning of their relationship by transferring elements of it to the second dyad, whose members may better be able to notice and name them. *Parallel process is best understood, therefore, as an interdyadic transference-countertransference situation based on sequential enactment of identifications, often, projective identifications.* While a parallel process can originate in either the treatment or the supervisory dyad, it is the supervisee who, by her overlapping membership in both dyads, necessarily is the interdyadic conduit of the relational material expressed through a parallel process.[112]

O'Dea and Sarnat contrast *symmetrical* parallel process which is described above with what they call *asymmetrical* parallel process in which primitive, split off, dissociated parts of self are not being enacted in the therapeutic dyad but instead become known by the enactments of the supervisory dyad. These processes stem from disorganized,

dissociated, confused and confusing transference-countertransference patterns. Coming full circle to how Searles first noted parallel processes in the supervision of schizophrenic inpatients, O'Dea and Sarnat note that

> While asymmetrical parallel processes may characterize the work of any pair of supervisory and treatment dyads, they are likely to be particularly prominent when the supervised client's history and character are marked by chaos, disorganization, trauma, or pronounced dissociative barriers between self-states. If there is some analog between the intensity of the analytic relational field and the relational configurations emerging in supervision, asymmetrical parallel processes will be most evident when the supervised treatment involves a more disturbed or dissociated client. Furthermore, the relational complexities of a parallel process may deepen across the triad if supervisee and/or supervisor also have histories, organizations of self, or dissociative tendencies similar to the client's.[113]

In conclusion, O'Dea and Sarnat advocate that supervisor and supervisee develop a lively conversation about their relationship and the process of supervision they are engaged in. In doing so they will have the opportunity to experience with each other (1) what relational patterns are currently in play in the supervisory relationship, (2) what these patterns reveal about the relationship between supervisee and this supervisor and their work together, and (3) what might our relational patterns be pointing to in the transference-countertransference matrix of the therapy relationship?

Case Study: Caligor: Parallel and Reciprocal Processes[114]

The following abbreviated vignette comes from a clinical supervision research project. The client Helen is 35 and never married. She is characterized as overtied to her mother who is described as quite hysterical, sacrificing, and overprotective. Her adoptive father was invalided several years before his death when she was seven so that he was home a great deal and she grew quite close to him. Helen has a recurring dream that she is in her mother's house and involved with a man who has no face. She gets close to him and he has power over her. She wakens frightened. She has had a terrible time separating from mother and keeps her distance from men by avoidance. When there is intimacy she becomes "compliant, clinging, helpless, demanding, easily upset, teary, enraged, and denies and distorts the facts—seeing herself as the victim."[115] She is in a relationship with a married man who is sporadically close and distant.

The therapist Fred comes into the supervisory hour upset feeling that, despite considerable progress, he and Helen are at an impasse over the relationship with her boyfriend, Mel. There are two upsetting issues. First, Helen wants to cut back on the number of session due to money problems. However, since she works free lance Fred feels she could choose to work more to pay for the sessions but he has not confronted her on it. Second, she complains that Mel is not available enough for her and she sees herself as a victim. He used to be more available but that has changed, how can she ever trust a man? But without him she would be lonely and depressed.

Fred reports how frustrated he is when she brings up the issue of Mel because he can perceive no intention to do anything about it, only to complain and feel victimized.

"*She gets pissed off, she gets frightened, she makes noises about it. Should I leave, this is crazy, what should I do, I'm getting older….Why hasn't therapy helped her more…?"* [116] Fred's supervisor reports:

> No matter how Fred attempts to get Helen to look at what transpires with Mel, he gets swirls of words, incoherence, unrelated responses, floods of affect, vacillation, paralysis.
>
> Again and again Fred *tires* (my typing slip—I meant *tries*), but is not heard. As he talks about this, it is apparent to me that he feels quite exasperated, frustrated. As the supervisory session progresses, he depletes, ending up feeling frustrated, impotent, defeated, withdrawing, avoidant; he is overwhelmed by her torrent of words….
>
> With the issue of Helen's determination to cut back on the number of sessions, Fred soon succumbed, did not press the point. He described it all with muffled rage and defeatism.
>
> When on several occasions I tried to get Fred to focus on what he was experiencing as he related the material, he responded with swirls of words, not quite hearing my questions nor responding to the content appropriately. When I would try to point out certain material, he would either interrupt me or say yes … and go back to where he had been.
>
> When I tried to focus on the similarities between the patient's way of relating to Mel and to him, he again could not hear me. It was only toward the end of the session that he began to perceive that he and Mel were somehow in the same boat with the patient.

> When I queried several times what he felt was going on between us, he veered off.…The session ended with a frustrated feeling that some issues had been stated but nothing resolved.[117]

When the peer supervisory group listened to the tape each individually felt the same apathy, loss of focus, impotence, and frustration as the supervisor during the supervision. When they tried to probe and query the supervisor he became defensive and evasive—just as the therapist had been with the supervisor. The group did not press him just as he did not press the therapist and the therapist did not press the client. At the end of the group one colleague shrieked, "My God, how is it possible to do therapy in the first place?" Caligor concludes:

> It is my contention that good supervision cannot take place without awareness of the parallel process, without which pathological processes may win out. Or there may be some pre-conscious collusion between the supervisor and therapist; there may even be an ongoing love affair with minimal or no attendant anxiety or disjunction between them, but also peripheral pseudo-learning and pseudo-growth.[118]

Case Study: Gediman and Wolkenfeld: "Psyching Out" in Parallel Processes[119]

A supervisor enjoyed her sessions with a particularly gifted supervisee. The therapist seemed to have anticipated all issues that crossed the supervisor's mind, had given them serious thought, and had come to similar or identical conclusions as the supervisor with a regularity and congruity which was heartwarming. The supervisor said very little at first, because her supervisee seemed to be doing all the work so well, and

this was a source of deep gratification. Soon, however, she experienced a growing sense of unease that there appeared to be not even a minimal degree of tension between her and the supervisee. It was at this point that she noted there appeared to be no resistance on the part of the patient about whom the supervisee was reporting, and this parallel lack of tension alerted her to a previously overlooked, obvious parallelism: the supervisee had described her patient as rare and gifted. In fact, the patient had established a firm working alliance and had demonstrated optimal capacity for self-exploration and reflective awareness. The supervisee was particularly pleased that her patient independently arrived at the very interpretations and understandings that she did.

Aware now of a parallel process, the supervisor learned from the supervisee that her patient had disguised his rage at a previous therapist by saying exactly the things she wanted to hear, thereby "psyching her out." When the supervisor understood that she might be avoiding competitive feelings by being perfectly "in tune" with her supervisee and that such perfect harmony could serve as a resistance or deteriorate into a derailed supervisory situation, the detection of the parallel "smooth impasses" was no longer delayed. It seemed as though neither therapist nor supervisor wished to risk the working alliance. While the harmony was narcissistically gratifying in both processes, therapy and supervision, it prohibited the optimal interpersonal tensions requisite for their continued unfolding.

Relational Perspective 2

Treatment versus Supervision

At the outset of psychotherapy Freud faced the solitary task of teaching others what he had learned about the treatment of psychological symptoms. Early on, he understood psychotherapy to be a temporal-relational process involving the therapist's capacity to be intellectually and emotionally present as the client was encouraged to talk about whatever came to mind. Freud also understood that the listening task required one to have a theory of the mind to guide one's thoughts. And, from his own self analysis, Freud had learned that therapeutic listening requires one to be relatively free from one's own detracting internal conflicts. He thus instituted the now time-honored three pronged training process—(1) didactic seminar work, (2) one's personal therapy, and (3) the mentoring supervision of cases. At first Freud was required to function as teacher, therapist, and supervisor, but as additional therapists were trained these three training functions soon became divided and performed by different senior therapists. Didactic teaching seminars came to include reading papers and books as well as case conferences or group supervisory processes in which problems common to all therapists could be shared and discussed. Personal therapy to be successful was understood to require absolute privacy and a confidential setting quite separate from the rest of the training. But the supervisory task posed different problems. Was it the supervisor's role simply to teach the application of psychological theory and technique to so-called "control" cases? Or, since personal internal conflicts of the therapist regularly emerged in the supervisory process, was it also the supervisor's task to promote the treatment of these conflicts as they emerged? Freud himself was very clear

on the matter: take these issues to your personal therapy and leave the supervision free to focus on elucidating the issues emerging in the case.[120] In other words, Freud knew that internal conflicts from childhood of the client were transferred into the treatment and must be analyzed, i.e., examined and broken down into their essential elements—following the dominant metaphor of chemical analysis of his day. But he believed that when internal conflicts of the therapist emerged in the so-called "counter-transference", they were best referred to the client's personal and confidential therapy. This view generally prevailed until the 1950's in England when the countertransference—the emotional reactions of the therapist to the client—came to be viewed as a valuable working tool.[121] The importance of countertransference and the ways it can be used as a working tool have continued to expand to this day.

Paralleling the radical shift in expanding the value of countertransference to the therapeutic process, a number of other forces—cultural and professional—have emerged that bear on the so-called "treat-teach" controversy in supervision, forces that will only be briefly enumerated here. First we might note the cultural breakdown of the general authoritarian, hierarchical approach to learning in favor of a more egalitarian relational approach in which teacher and learner tackle problems of learning more interactively. Also, over time Freud's earliest understanding of the nature of unconscious processes gradually expanded from his "repressed unconscious," to the "pre-reflective unconscious", to the "unthought known", and to "dissociated and enacted unformulated experience", thus changing radically our understanding of the central therapeutic task of making the unconscious conscious.[122] But perhaps the most important shift has come with our growing understanding, now supported by research,

that by far and above over any particular theory, technique, or content of psychotherapy, the single most important variable in the therapeutic process is the relationship itself that is established between the therapist and client.[123]

It is interesting to note that in media presentations of psychotherapy in recent years the mutative force that is clearly portrayed is the developing relationship between the client and therapist. Vivid examples are films like *Equus*, *Ordinary People*, *Good Will Hunting*, and the HBO television series *In Treatment*. In each of these high visual dramas therapeutic change comes as a result of moving, emotionally charged relationship moments between therapist and client. So the bottom line question for supervision today becomes: how is therapeutic relationship taught and how is it learned?

Here are some of the controversial points that have come up in the treat-teach controversy over the years:

- The supervisor needs to avoid addressing the therapist's personal issues or the personal countertransference because they are most appropriately addressed in the therapist's own personal therapy. To do so would be to foster unhelpful regressions and to compete with the personal therapeutic process or the treating therapist by offering the possibility of a transference displacement or a good-bad transference split between the personal therapist and the supervisor.
- Personal issues can only be looked at in a safe, confidential, and bounded setting in which there is a surrender to regressive processes that study genetic factors in the life of the therapist in a setting that can be appropriately contained. Because the supervisor is concerned simultaneously with the wellbeing of the

client as well as with the background legal, institutional, and ethical dimensions of governance of the therapeutic process, the supervision is not totally safe, confidential, and contained, so that it is inappropriate to encourage the emergence of genetic material and regressive processes.

- But personal issues are regularly triggered by the therapist's involvement with clients. To simply refer personal issues to personal therapy can be experienced by the therapist as demeaning and/or pathologizing. Furthermore, just because a personal issue is being triggered by engagement in a therapeutic process with a client doesn't mean that the issue is ready to come up in the therapist's own personal therapy at this time. In either case the supervisor's unwillingness to help the therapist with personal issues can seen at the least as shaming and/or abandoning—not to mention whatever transference issues toward the refusing supervisor may become engaged.
- The fine line between treat and teach has to be established within each supervisory dyad. For the supervisor to excessively encourage an examination of personal issues is to foster unnecessary and unhelpful regression. But for the supervisor to refuse to address countertransference issues is to exclude potentially valuable information that has been stirred up by the client from entering the supervisory and therefore the therapeutic processes.
- The supervisor must respect the privacy boundaries of the therapist in any attempt to elucidate countertransference variables. Asking for thoughts, feelings, fantasies, and reveries—either about the therapeutic or the supervisory dyad—in empathic and non-intrusive ways can be enhancing, but to openly request the

elucidation of genetic factors, or to force the investigation of countertransference experience is widely understood as an inappropriate boundary violation on the part of the supervisor. Even in those extremely rare instances where a more intense regressive experience in supervision may be deemed useful, the suggestion is that it needs to occur at the request of the therapist and be contained by the supervisor.

- Supervision needs to operate with an explicitly discussed contract between therapist and supervisor from the outset that spells out the nature and limitations of the learning process and what may be safely expected and involved. One responsibility of the therapist is to limit how far the process moves into his or her personal and private space. One responsibility of the supervisor is to be constantly sensitive and inquisitive with regards to how the therapist is experiencing the supervisory boundaries and be prepared to empathically limit and contain any regressive experiences that may occur by re-directing them to the learning task involved in the client-therapist dyad.
- The transference and countertransference that develops between the therapist and supervisor has been a taboo subject and carefully avoided. The rationalization is that opening up the therapist's transference to the supervisor promotes regressive forces and competes with the personal therapy and the role expectations of the personal therapist. Perhaps a more honest explanation would have to do with the supervisors' needs to maintain an authoritarian teaching position with a defensive posture that prevents the emergence of personal

vulnerabilities, dangerous countertransference regressions, and inadvertent boundary violations on the part of the supervisor.

- What everyone can agree on is that no matter what transpires in the supervisory process, in the treat-teach mix established jointly by each supervisory dyad, it is the supervisor's responsibility to see that *at all times the supervisory process is indentured to the learning process.* While blocks in the learning process may require temporary incursions into the therapist's own internal conflicts, all such incursions must be re-directed toward the teaching and learning of therapeutic issues that come up in the client-therapist dyad.

One of my therapy supervisors, Hampstead-trained Marshall Wheeler, summed it up one day by explaining that yes, personal issues always come up and often need to find space in the supervisory relationship to be somewhat elucidated. But regressive experiences, especially in the presence of a respected teacher, tend to foster self-consciousness that detracts from paying close attention to the therapeutic task at hand. He made the point that the psychotherapeutic task is complicated enough by itself without adding the complications of self-consciousness to weigh the process down. Experts in the field who hold that personal issues and regressions from time to time need to be allowed to enter supervision seem basically in agreement with Marshall that the teaching and learning process needs to stay in the foreground while any mutually agreed upon necessary regressions or feelings of self-consciousness need to be allowed to fade into the background.

Perhaps the most significant historical change in the treat-teach supervisory dilemma has been in the area of what is to be taught and what is to be learned. That is,

to the degree that whatever is mutative in psychotherapy has come to be understood as the product of affectively-laden relational moments, how do we formulate what is significant in relational moments and how can the supervisory process be slanted in order for the teaching and learning of mutative relational moments to occur? True enough, theory and technique can be left to didactic and case conference seminars. Also true, that regression to study genetic factors of internal conflict can be left to the therapist's personal therapy. But, caught between the Scylla of teaching and the Charybdis of treating, the therapist and supervisor must jointly make their way through treacherous waters—never quite being sure the best way to steer the teaching and learning process toward generating relational moments—regardless of theoretical orientation.

Case Study: Frawley-O'Dea and Sarnat: Blurring the Teach-Treat Boundary[124]

Frawley-O'Dea and Sarnat relate the story of therapist Laura presenting Susannah, a 19-year-old college student, to her supervisor Jack. At the beginning of the supervisory relationship Laura choose to tell Jack a little about herself—revealing that she came from a family that did not value education and how hard she had to work to put herself through school. Laura's therapy with Susannah went well with supervision focusing on transference and countertransference themes in both the therapeutic and the supervisory relationships. But at some point Laura's demeanor toward Susannah began to change. It seems that Laura had been attempting to explore the various meanings of Susannah's "occasional shoplifting, abuse of alcohol, and overeating." In supervision sessions Laura began to speak of Susannah in impatient and demeaning tones. Laura related how Susannah had begun cutting classes at the prestigious college

her parents paid for her to attend and was in danger of failing the semester. In one supervisory session, Laura derisively asked, "Can you believe this kid is cutting class just to have sex with her boyfriend because that's when he's available?"[125] Instead of engaging with Susannah to analyze this behavior, Laura was conveying her dismay and disapproval of the class cutting.

Her supervisor, Jack, commented that she seemed angry with Susannah and enquired what might be happening in the transference and countertransference to cause such an intense reaction. Laura's response was dismay at how Susannah could "blow such a great opportunity that's just been handed to her on a silver platter."[126] Attempts to explore her reaction at first fell on deaf ears. Then

> As gently as possible, Jack then asked Laura if her strong reaction to her patient and to this particular form of acting out might stem, at least in part, from personal feelings about Susannah apparently blithely trashing what Laura would have cherished—a college education at a good school, paid for by parents who valued an education. Jack added that if he were Laura, he might want to shake some sense into Susannah. Instead of staying with her to better understand what this acting out was all about and what Susannah might be conveying about her relationship with her parents, her internalized constructions of self and other, and the transference toward Laura then active in the treatment, he might want just to tell her to grow up![127]

Following the supervisory session Laura took Jack's hunch up with her own therapist who remarked that he just might be onto something. In the next session with Jack she

reported that she had been angry with him until she considered the matter further. Laura jokingly remarked that both of them couldn't be totally wrong and she asked Jack's help in the future when he thought her impatience and envy might again be triggered.

> Here, we see a contained and circumscribed example of a blurred teach/treat boundary. Laura's envy toward Susannah, expressed through her derisive remarks and disapproving attitude, interfered with her work as a therapist. Jack's 'treat' intervention focused on Laura's professional work. He and Laura did not go further into her relationship with her parents, nor did they talk about the possible ways in which this dynamic affected Laura's other relationships. However, Jack's interpretation was undeniably in the "treat" area, and it initially aroused defensiveness and resentment in Laura. Yet it apparently stimulated a deeper consideration of this aspect of Laura's psychological functioning in her own therapy, where it likely led to enhanced personal growth. In this vignette, 'treating' in supervision remained indentured to the primary task of teaching while, in the supervisee's own treatment, the goal of personal development took priority.[128]

Case Study: Frawley-O'Dea and Sarnat: Regression in the service of learning[129]

Frawley-O'Dea and Sarnat report on what can happen in even a relatively short period of time when "the supervisee feels free to reveal the full extent of her regression in the service of learning, as well as other regressive reactions."[130] The therapist, Lisa, was an intern in supervision with Gloria in a brief treatment setting. Lisa expressed an

interest in learning to identify and use her countertransference. Early supervisory sessions were didactic but by the sixth week Lisa arrived feeling quite distraught and critical of her work after listening to tapes of her therapy sessions. In her prior placement she had experienced competency in helping clients in crises but she felt a beginner in doing therapy.

> Lisa worried that she had gone "too far" in response to her patient Tina's admission to her that she sometimes pushed people away. Lisa had responded by telling Tina that she herself had found it difficult to connect to Lisa in their first session, and then worried that this disclosure might have hurt Tina, since Tina had canceled the following session.
>
> …In discussing these painful feelings, Lisa mentioned that, in her therapy, she had realized that she was experiencing herself as an omnipotent 2-year-old who can destroy everything….Lisa said she thought she had felt too powerful as a child in her family, and that no one had set appropriate limits for her. Gloria said that Lisa seemed to feel she was capable of being terribly destructive, even though part of her knew that her intervention had been far from catastrophic. Lisa agreed.[131]

Gloria reassured Lisa that what she was going through was a frightening but predictable period of regression in the service of learning and that she herself had gone through something similar, as do most people. Gloria then said that Lisa seemed to believe that she should be able to contain her own and others' anxieties by herself and

that this was a tall order for anyone, especially a learning therapist. When Gloria asked if Lisa had thought of calling her in the midst of her difficulties, Lisa responded that she had but was worried that Gloria would think she was "overreacting." Lisa laughed when Gloria said, "Like your parents might have."

> Gloria was inviting Lisa into a relationship experience that could have significant personal impact upon her. Such poignant moments happen frequently in supervisory relationships that acknowledge the universality of regressive experience. And they happen without particular complication, as long as both supervisor and supervisee engage in a process of mutual regulation as to how far the process will go, and as long as the primacy of the supervisory task is kept clearly in mind by the supervisor.

In the ensuing weeks Lisa had some struggles to support Tina but the two were successful at connecting. When she described the experiences to Gloria “Lisa commented that she thought that her own experience of Gloria's emotional availability when she had been upset had allowed her to be present in a new way for Tina. As Lisa spoke, Gloria reflected silently on the parallels between Lisa's beginning to allow herself to depend more on her supervisor and her newfound ability to allow Tina to experience dependence upon her.”[132]

> Lisa had come to supervision wanting to learn to use her countertransference to further the work of treatment. And having set this as a goal of supervision, a series of countertransference regressions did indeed emerge during the 12-week supervisory

> relationship: her feelings of incompetence as she gave up her old ways of working; her feelings of destructive omnipotence; her submission to a critical parent imago; her feelings of helplessness and despair about containing another's distress; and her defenses against experiencing and expressing her own need for emotional containment. In part, these reactions were triggered by events in her relationship with her patient.…But Lisa also exercised a degree of choice, both consciously and unconsciously, when she allowed these experiences to emerge with clarity and intensity in supervision. And because of Lisa's introduction of these experiences into the supervisory relationship, Gloria was able to help her to work through some of her internal obstacles to engaging therapeutically with Tina.[133]

Case Study: Sarnat: Working Through a Treatment Issue in Supervision[134]

Sarnat relates her work with an experienced graduate student, Janice, who began supervision wanting to broaden her range of relational skills, and especially to work on her assertiveness and constructive use of aggression both as a person and as a therapist. Sarnat notes that Janice's avoidance of confrontation seemed to be a "neurotic problem deserving of supervisory attention."[135]

Having been requested to, Sarnat began pointing out to Janice her avoidance of confrontation and self-assertion with her clients as a technical issue, suggesting different ways the issue might be approached. "With one of her clients, Mary, she avoided talking about the need for a fee increase; with the other, Ann, she was over-solicitous in an effort to avoid the client's anger."[136] When these responses were pointed

out to her she acquiesced, perhaps because of the power differential between supervisor and supervisee.

> [Janice] saw her learning problem, but felt helpless to change it, despite my explicit technical suggestions, and was unable to express her feelings about my focusing so actively upon it. Her block became a source of suffering for her, and of frustration for me. Things began to go wrong in her therapies. Rather than gradually beginning to feel freer to assert herself with her clients, she instead became confronting and strict with them, enraging them, and then becoming depressed, guilty, and angry in response.
>
> With considerable feelings of failure, I realized that my own need to feel competent, interacting with her characteristically passive stance, had led me to become my most dominating self. I wondered if she was perhaps providing me with an object lesson in how destructive dominating figures can be, her dictatorial tone with her clients a byproduct of the pathological interaction with me. I saw that I was contributing to a situation in which she felt the need to acquiesce and submit to me, instead of my helping her to find her own strength and point of view.[137] I also saw that the difficulties that were emerging between us provided an opportunity for direct reworking of the relationship problem that [Janice] wanted and needed to address.

The situation soon came to a head with Janice becoming angry at Sarnat, letting her know that the supervision was making things worse rather than better. This

confrontation occurred shortly after Sarnat had herself begun to examine what was going on so that she was receptive to the confrontation. Sarnat reports that the moment Janice "let her have it" was more characteristic of what one might experience in one's own therapy than in supervision.

> My task as I understood it was to manage my own frustrated and guilty feelings, while trying to hold, contain, and accept her feelings…, offering an empathic response rather than responding by either retaliation or self-reproach….I told her that I understood that she had been feeling enormously self-critical and that it felt like too much to handle on her own. I said that I understood that she was trying to make me feel some of the sense of failure that she had been feeling. I added that part of the responsibility for the recent problems with her patients was indeed mine, as these problems had developed while we were working together. I said that I too had been distressed about the turmoil that had developed in both of her therapies, and that I felt that my own didactic overactivity and implicit claim to "knowing how to fix things" had contributed to it.[138]

Tears came into the eyes of Janice as she took in Sarnat's willingness to share responsibility for what was happening. She chose not to go into what her experience of the moment was and Sarnat respected that choice. "My sense was that she was processing a new relationship experience at that moment: that angry feelings can be allowed within a relationship without a rupture of the empathic connection, or injury to either party."[139] Janice apparently needed this experience with her supervisor to

overcome her inhibitions to confrontation that she could not be taught didactically. Sarnat reports that after that session the relationship became more collaborative and mutual. The dominance-submission "dynamics receded as the supervisee began to express her feelings and perceptions more assertively and comfortably, and I, in response, began to feel less like the all-knowing expert."[140]

Subsequently the two explored what had shifted in the relationship. Janice indicated that after she had confronted her supervisor who was able to acknowledge nondefensively her own involvement in the deteriorating situation, she had been able to internalize a valuable model that she could follow with her own clients.

> [Janice] subsequently reported finding herself feeling more accepting of both her own aggression and her clients'. Soon she had an opportunity to demonstrate to Mary that she was comfortable with her anger. In response, Mary— who had defended against affect, closeness, and dependency for 90 sessions—now began to speak of needing her therapist, and to cry in the sessions.
>
> [Janice] also reported feeling more comfortable with Ann's rageful and rejecting feelings. Ann responded by bringing these feelings more freely into the treatment, simultaneously venting them less on her children, which had been the problem that originally brought her into treatment.[141]

Sarnat wonders what would have been the result if she had attributed Janice's difficulties entirely to internal conflicts that were properly to be taken up in the

supervisee's therapy. Janice might have felt abandoned, humiliated, and endangered—knowing that only part of the problem had been addressed.

> I would argue that it should be left to the therapist …to discover how much of the work he or she wants to do and can do in each setting [supervision or therapy]. Not all supervisees are as open to emotional engagement in supervision as [Janice] was. What is crucial is that the supervisor not use the supervisee's therapy or psychotherapy as an excuse for excluding relationship problems that develop in supervision from being addressed within that setting; and that he or she not view the supervisee's learning problems as only intrapsychic rather than as inevitably involving the supervisor's contribution to some degree.[142]

Sarnat mentions the debate over how much disclosure supervisors should make to supervisees about their "supertransferences" to either the supervisee or to the client. Her position is that,

> no such concerns need complicate our theory of supervision. The direct acknowledgment of supervisor supertransference…is highly compatible with the supervisory frame, in which development of a regressive transference is certainly not an aim and supervisor anonymity is both unnecessary and inappropriate. Indeed, serving as a model for identification is considered by many to be a key component of the good supervisor's participation…,and was important in the supervision described….[143]

Those who have turned their attention toward studying relational moments in therapy all say in one way or another: *the only way to learn relationship* is to be in relationship, so that all three aspects of the teaching and learning of psychotherapy—didactic, therapeutic, and supervisory—must be accomplished in authentic, safe, and bounded relational contexts. Thus the traditional authoritarian or didactic stance of the supervisor must be expanded to include the mutual experience of a real mentoring relationship between vulnerable equals who are sharing in a common teaching and learning relational task—even if the learner and mentor roles are asymmetrical in terms of experience and expertise.

Relational Perspective 3

The Therapeutic Instrument

In attempting to describe what he believed was going on in the therapeutic process, Freud used many metaphors, one of which was "the analyzing [or therapeutic] instrument" conceived of as a telephone receiver aimed at the telephone microphone—an image of the therapist's unconscious organ being attuned to the client's unconscious transmissions.[144] Otto Isakower in the early 1960s refined Freud's image to clarify the two-way nature of the communication and that it was *physical*—based on auditory and visual as well as other nonverbal cues.[145] Theodore Jacobs in his *The Use of the Self* expanded the notion of the analytic instrument to include not only "…a system operating primarily through the verbal-auditory spheres [but] a multichannel system containing components that register not only the verbal and acoustic signals but also movement patterns, autonomic responses and visual stimuli."[146]

At this point in our awareness of relational variables in psychotherapy the mechanical image of a "therapeutic instrument" may seem a bit out of place. But I mention it because I want to recognize the *intent* from Freud through Isakower and Jacobs to register the essentially two-way conscious and unconscious nature of therapeutic communication along with a *third* instrument or system running between the total mental and physical functioning of both participants, We might now refer to this complex system of interpersonal communication, along with Thomas Ogden and others, as the "analytic or therapeutic third" or simply the third of the relationship.[147] That is, in this search for the ineffable fox of the therapeutic and supervisory relationship there has continued to be a search to define some set of processes or some operative

interpersonal sensory system that convey a potential infinity of meanings between any two relating people—but especially the two being studied in therapy and/or supervision. It is interesting to note that Freud mentions this metaphor in teaching and supervising therapists and that it was in studying the supervisory processes that Isakower refined his notion of the therapeutic instrument as an effort to teach therapists how to look for what is important in the therapeutic relationship.

Isakower imagines the end of the session as the client leaves and each participant–who has had his or her full self attuned to the other for the time of the session–is now cut off, abandoned, missing the other half. It is in that moment that each tends to notice the plethora of physical sensations and mental images that have been silently at play in the interchange and are now left floating unconnected, without their other half as it were. While the “therapeutic instrument” has been operating silently in the background throughout the session, in this moment of disconnect and in the moments that follow a slow motion process can sometimes be noticed while one is re-integrating one’s self – a process that is highly informative of what has been silently happening during the interaction of the session. This observation seems particularly important to me in light of the ubiquity of insightful “doorknob” comments and the significant afterthoughts often noticed by both client and therapist—as well as in the widespread supervisory awareness that boundaries are often crossed and even violated in the last five minutes when both participants are feeling the vulnerability of disconnect and loss. To me the potential value of the evolving concept of the therapeutic instrument, despite the mechanical and reified image it offers as it morphs into a multichannel system and today into a nonlinear open system—a therapeutic third subject—is that two minds and

bodies can work toward a mutual attunement to connections and disconnections of the multifaceted interpersonal system in which uncanny aspects of the relationship can often be momentarily grasped for mutual study.

Donnel Stern in *Partners in Thought*[148] formulates that at some point one of the participants may have a "new perception" of the other or of some aspect of unconscious relational process being enacted. This new perception allows for the processes of representation or mentalization (of dissociated, enacted experiences) to occur. The outcome for both, he writes in his forthcoming book, Relational Freedom: Unformulated Experience and the Therapeutic Action, is a new degree of "relational freedom"[149]

Relational Perspective 4

Trial Identification and Internal Supervision

As early as 1942 Robert Fleiss spoke of "trial identification" by which the therapist puts him or herself into the client's shoes in order to empathize with the client's experience.[150] Melanie Klein introduced the concept of projective identification to describe ways that the therapist comes to know the inner experiences of the client.[151] Paula Heiman spoke of how all of the therapist's reactions to the client are potential communicators about the client's experience.[152] Heinrick Racker emphasized the projective and introjective experiences alive in the therapeutic relationship such that they give rise to countertransference in the therapist that may be passive or active (concordant or complementary) reflections of the client's inner relational experiences.[153] Heinz Kohut has spoken of empathy and vicarious empathy as human faculties for knowing the experiences of others.[154] Arnold Model has noted a shift in recent years from a one-person psychology in which the analyst's job was to see and interpret the patient's inner life to a two-person psychology in which both participants are at all times tuned into the experiences of each other.[155] Merton Gill has expanded the notion of transference from simply a relational template projected onto the therapist to transference as a co-created experience where more than a grain of truth is involved as two people perceive and interact affectively with the inner experiences of one another.[156]

Furthering this line of thought, social work psychoanalyst Patrick Casement has commented on trial identification as a personal and supervisory technique:

> [A] technique that I often focus upon in supervision is that of encouraging a student to trial-identify with the patient in a session, most specifically to consider *from the patient's point of view* how the patient might experience what is being said, looking for ways in which the patient's experience might be different from what is intended. This self-monitoring is essential because it is always more difficult to interpret transference meaningfully if the analyst is also affecting the patient through the way in which interpretations are given, their style and manner, and/or the timing of them.[157]

All of these contributions move toward what Owen Renik has called “the analyst’s irreducible subjectivity.”[158] In other words, the therapist can no longer be viewed as a neutral blank screen but is seen as a fully participating member of the therapeutic engagement with not only a subjectivity of her own but also possessing the capacity to “de-center” from her own subjective position in order to empathically grasp the experience of the other—a capacity now widely recognized through neurological and infant studies to be part of the human genetic endowment.[159],[160]

Casement has further elaborated a process he calls “internal supervision” for paying attention to the therapeutic process. He states,

> When a student therapist begins to work with training cases under supervision, the supervisor has a crucially important function in holding the student during this opening phase of clinical work—while he or she is learning to hold the patient analytically. The supervisor provides a form of control, making it safe for the therapist and patient to become

> analytically engaged, and helping a student to understand and to contain what is being presented by the patient.[161]

Teitelbaum summarizes the process of moving from external supervisor to internal supervisor:

> Casement views this process of acquiring an "internalized supervisor" as a precursor to a later stage of professional identity in which the analyst, now capable of functioning in a more autonomous way, carries around her own "internal supervisor." Reliance on one's own well grounded and individualistic way of doing the analytic work is the essence of the "internal supervisor." Hence, Casement envisions this as a developmental process in the growth of the analyst, in which "the shift from an initial dependence upon the external supervisor, via the internalized supervisor, to a more autonomous internal supervision is a slow process."[162]

In a later paper Casement elaborates the internal supervision process:

> The functions of internal supervision evolve from a student's experience of his or her own analysis, from formal supervision and clinical seminars, and from following the clinical sequence of many sessions. It is therefore fundamental that students become able to process for themselves what is taking place with a patient, particularly when under pressure in a session, in order to become aware of different options and the implications of each. Interpretation, and

> sensing when to remain silent, can then more readily become the skill it needs to be, rather than being too much a matter of intuition or (sometimes) paralysis.
>
> For the more immediate processing of internal supervision to become possible, students need to establish a mental “island” within which to reflect upon a session at the time rather than later. Along with this, it is also valuable to develop a benign split between the participating ego and the observing ego in the therapist, similar to that recommended for the patient [by Sterba]. This allows greater freedom for a therapist to be drawn into the dynamics of a session whilst still preserving, in the observing ego, sufficient detachment for monitoring the vicissitudes of a session. This double use of the ego, and the capacity to reflect upon what is happening, can also help toward making sense of a therapist's affective responses to the patient, and sometimes of being flooded by feelings in a session, without being incapacitated by what is experienced.[163]

From an evolutionary angle Carl Jung has called our attention to what he calls *participation mystique* or *unconscious identity*—a state of identity in mutual unconsciousness.

> The further we go back into history, the more we see personality disappearing beneath the wrappings of collectivity. And if we go right back to primitive psychology, we find absolutely no trace of the concept of an individual. Instead of individuality we find only collective

relationship or what Lévy-Bruhl calls *participation mystique*. The collective attitude hinders the recognition and evaluation of a psychology different from the subject's, because the mind that is collectively oriented is quite incapable of thinking and feeling in any other way than by projection.[164]

In his early years the child lives in a state of participation mystique with his parents. Time and again it can be seen how he reacts immediately to any important developments in the parental psyche. Needless to say both the parents and the child are unconscious of what is going on. The infectious nature of the parents' complexes can be seen from the effect their mannerisms have on their children…This is an expression of primitive identity, from which the individual consciousness frees itself only gradually.[165]

Jungian therapist Hugh Gee notes that in Jung's *participation mystique* or *unconscious identity*:

…Jung is keen to show not just the fact of a sharing of an emotional state, but also the importance of the differentiating process. His more positive attitude towards the early stages of relationship can be found in his comments on the 'container' in his clinical amplification of the alchemical *vas*, and in what he says about *Eros*, the God of relatedness. In developing the analogy to alchemy, Jung describes how the analyst and patient are like two ingredients in the container of

> the relationship: as a result of their interaction upon each other changes are brought about in each of them.
>
> I find Jung's conception of the container more appropriate than the way Bion used the same word, in that his Kleinian formulation has the analyst being the container, as opposed to what Jung recognized—that *the relationship* is the container.[166]

Seth Aronson has called our attention to another widely used metaphor to characterize the ineffable of psychotherapy and supervision as “play” and “playground.”

> The creation of the “playground” that Freud first described and Winnicott and Levenson allude to permits both literal and figurative play between supervisee and supervisor and the flexibility necessary for the candidate to “stand in the spaces,” which Bromberg describes. In some ways, this is also reminiscent of the developmental task facing the adolescent on the brink of adulthood. Erik Erikson, Harry Stack Sullivan, and Peter Blos, among others, describe the “trial identifications” through which the adolescent discovers the “me” and “not-me,” which are critical to the development of a secure, cohesive identity. For this to occur, however, it takes a parent with the right blend of permissiveness and restraint to allow the child's identity to develop.[167]

In all of these various descriptions of ways in which information is broadcast from the client’s unconscious to the receiving unconscious of the therapist and on to the

receiving unconscious of the supervisor (i.e., Freud's "therapeutic instrument"), we can understand that the reflecting processes can also be reversed from the supervisor to the therapist and on to the client. At various points in these reflecting processes efforts are made by one or the other to represent the information in consciousness.

All of these concepts—trial identification, empathy, vicarious introspection, subjective decentering, internal supervision, participation mystique, and the playground—serve as helpful metaphors for conceptualizing not only the therapeutic process but the many dimensions of the supervisory process.

Relational Perspective 5

Witnessing in Psychotherapy and Supervision

From the moment we are born we experience ourselves being witnessed, watched—and from being watched and interacted with we experience ourselves as recognized and known. Infant researchers and neuropsychologists now make clear that it is from the earliest experiences of having our nascent expressions witnessed and responded to that our emotional and neurological lives come to be mutually attuned to and regulated with those of our caregivers and the environmental surround. That is, during the earliest months of life the orbito-frontal neural loops connecting our eyes to our prefrontal cortex *actually organize all parts of our brains and neurological systems throughout our bodies* according to the specifics of the emotionally attuned relationships that are available—and not available—to us. The earliest connections that form in response to our actual and anticipated interactions with our caregivers form the neural basis for lifelong implicit and explicit memory as well as the neural scaffolding that determines our subsequent capacities for various kinds of relationships and learning experiences. At all stages of relational development the emotional colorings of experience determine what is to be remembered and how—as seen most clearly in the processes of affective attunement and misattunement in infancy.

Traditional psychological theories have held that we internalize early caregivers as recognizing witnesses and that the ways they see and recognize our emerging selfhoods comes to determine how we subsequently witness and narrate our own lives. Interpersonal/relational psychoanalyst Donnell Stern in his landmark book, *Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment*, says

that although our need to be witnessed by others takes on increasingly complex forms as we grow older:

> We [always] need to feel that we exist in the other's mind, and that our existence has a continuity in that mind; and we need to feel that the other in whose mind we exist is emotionally responsive to us, that he or she cares about what we experience and how we feel about it….Without a witness, even an imaginary witness, events either fail to fall into the meaningful pattern of episode that is narrative, or we merely enact our stories blindly, unable to think about them or know what they feel like. Our witness is our partner in thought.[168]

Robinson Caruso's and Anne Frank's diaries stand out in our imaginations as human attempts under circumstances of extreme stress to create a witness to solitary experiences when no other witness was available. Caruso was stranded alone on an island while Frank was traversing the earliest glimmerings of puberty in a stifling environment that was unable to interact with or witness that nascent part of her starting to blossom. Carol Gilligan has shown us the candor and vulnerability Frank displays in her earliest diary written to herself and in her imagination a close friend and how, once she heard via the radio that war diaries would be kept in a museum in London her narratives changed dramatically to accommodate the new imagined external witnesses.[169]

With regards to creating narratives that we experience as witnessed, the early psychoanalyst Carl Jung was perhaps the first to emphasize that we are a symbol-generating and a story-telling species and that the fundamental truths of human life

invariably become embedded over time in stories handed down from one generation to another. He spoke of archetypal images and narratives common to all humans that have many different amplifications preserved in different languages, cultures, tribes, families, and individuals. Each person can experience the private self being witnessed through reflected archetypal narratives.[170]

A similar point of view is taken by George Lakoff and Mark Johnson in their development of the psychic organizing function of metaphor. Language and thought according to them can ultimately be traced back to physical/emotional experiences of metaphor through which, for example, warm becomes associated with pleasure, affection, and safety and cold becomes associated with pain, rejection, and danger through the witnessing and interactive functions of early caregiving. The elemental metaphors are formed by coincidences of two emotional/physical experiences—psychoanalyst Wilfred Bion calls them beta elements.[171] All later and more complex metaphors are derived from those primal affectively-colored relational experiences—the caregiver's thought and management giving rise to what Bion called the alpha function or rudimentary thought processes of the infant. [172] Psychologist Roy Schafer spoke of the endless stories we create for ourselves and for others as functioning to pull together diverse and often contradictory experiences into seamless coherent, emotionally tinged narratives that serve to make sense of our lives, our points of view, and our actions. The rules of narration—that is, that a story have a past, a present, and a future, that there be a plausible plot with characters whose emotions clash, and that there be a climax and a conclusion—allow us to put otherwise incoherent, inchoate, and inconsistent experiences into an order that hangs together. A witness, usually in the form of a

narrator, is always somehow present—whether simply in our own internal dialogues or in the stories we tell to others.[173] Joseph Campbell has studied the master narrative and its countless amplifications of the human adventure in *The Hero with a Thousand Faces*.[174]

Psychologist Donald Spence held that in therapy we have tended to believe that if we could locate the historical truth of what really happened to us in the primordial past that we could create a story that would make sense of how we function consciously and unconsciously in the present—that is, why we do the things we do and say the things we say. He countered the trend of searching for historical truth with an insistence that psychotherapy is a here-and-now relationship experience and that we generate stories to satisfy the present social context. That is, the truth that emerges in therapy is not historical truth but narrative truth—a set of stories that are jointly created by client and therapist that seamlessly weave together narrative elements that well-describe or "fit" our current experiences of ourselves in our current interpersonal contexts—notably the relational context of psychotherapy.[175] Theorists of narrative note that our stories tend to change with time, circumstance, and interpersonal context. And that even when we think we know our storyline well, we often find ourselves in mid-sentence realizing that what we are now saying to ourselves or to someone else simply isn't true or isn't being remembered at all correctly, or is being sanitized or augmented somehow. Further, memory research amply demonstrates that our stories about ourselves are quite apt to be unreliable and that memory itself—far from being a video camera record of events—not only changes over time but varies according to circumstances of recall and reporting. That is, even memory functions according to what can be narrationally

organized. Experiences that cannot be sensibly placed in coherent life narratives—such as memories of abuse and trauma—may simply not be recallable in ordinary circumstances but often live on to wreak havoc in our relationships.

Why do we need internal witnesses who see, recognize, judge, and know us in certain ways? Donnel Stern in *Partners in Thought* takes hold of the problem of the narrative and the witness in a somewhat novel manner.

> It is as true in the clinical situation as it is anywhere else that, by the time our best stories are spoken, they just seem right, convincing generations of psychoanalysts that it was the *content* of what they said to their patients—that is, clinical interpretation—that was mutative….I am arguing that the appearance of new content or newly organized content, which is generally narrative in form, is not usually the instrument of change at all; it is rather the sign that change has taken place….The important thing about a new understanding…is less its novel content than the new freedom revealed by its appearance in the analytic space, a freedom to feel, relate, see, and say differently than before….What *is* remembered from a successful treatment, as a matter of fact, is much less the analyst's words or ideas than something about the appearance of that freedom, something about what particular important [relational] moments *felt* like, something sensual, perceptual, and affective. The new story is, then, not the engine of change but the mark change leaves behind…. Each new story is simultaneously what change leaves behind and part of what

> brings about the next generation of clinical events….The affective changes that take place in treatment, and are memorialized in the new narratives that fall into place there, are reflected in our ways of remembering the past, creating the present, and imagining the future. (pp. 116-117)

The witnessing that characterizes the therapeutic relationship can be said to allow people more freedom to think, feel, and relate. As elaborated elsewhere in this book, it is the safely-framed relational witnessing of therapy—*regression in the service of progression*, as it were, that allows the re-experiencing of past relational patterns in the present relationship so that they can be witnessed, known, and re-narrated. Similarly, it is the witnessing in a supervisory relationship that is safely-framed to promote *creative learning* that allows psychological regression to previous relational patterns for the purpose of seeing how they operate in the present professional learning experience—*regression in the service of the ego*, as it were.[176] That is, the functions of witnessing and narrative formation serve distinctly different regressive purposes in therapy and in supervision—in order to allow progression in *relational growth* in therapy, and in order to allow relational understanding that facilitates *ego growth* – in learning supervision.

Relational Perspective 6

The Learning Alliance

The early therapeutic relationship was conceptualized by Freud as an almost imaginary one in which the therapist functioned as a blank screen for the client to project his or her inner relational patterns onto. With time, however, it became clear that not only was it impossible for any interacting human being to be a blank screen but moreover it was necessary for therapist and client to form a *real working relationship* that became known as the "therapeutic alliance."[177]

In an early research project into the supervisory process Fleming and Benedek coined the term "learning alliance" to denote the collaborative aspect of supervision.

> Just as in the psychoanalytic situation, in spite of its rigors, the analyst intuitively supports the 'therapeutic alliance', so does the supervisor direct his activities, sometimes deliberately, at other times intuitively, toward maintaining a 'learning alliance'. Just as the therapeutic alliance is a basic factor in the success or failure of therapeutic work, so the equilibrium in the learning alliance may determine success or failure of a supervisory experience.
>
> Our records [of the research project] demonstrated the marked influence of the 'learning alliance' on the teaching-learning process. The supervisor's preconscious and conscious concentration on establishing this alliance was very apparent. Much effort, especially in the early stages of the relationship, was directed toward maintaining equilibrium in the alliance or toward improving it.…Disturbances which

> appeared in the equilibrium of this relationship seemed to originate in the student [therapist's] attitude toward being taught—in other words, his 'problems about learning' to use the phrase of Ekstein and Wallerstein. Diagnosis of the state of this working relationship gave clues to the student's anxiety about exposing himself and being judged, to his capacity for self-examination, to his objectivity about his supervisor, and to his tolerance of criticism.[178]

In addition to forming a learning alliance to facilitate supervision Ekstein and Wallerstein spoke of the need for attention to 'learner difficulties,' modeling their concept on the concept of 'therapeutic resistance'—that is, the human tendency not to allow frightening or disruptive relational patterns from the past to be transferred into conscious relational experiences of the present.[179] Expectably, each learner has a life-long history of favorable and unfavorable learning experiences—many of which entailed pain, shame, and humiliation. In the process of opening up one's therapeutic ear and offering up what has been heard to the supervisory ear, long-established patterns of unconscious inhibition to learning quite naturally arise. This, of course, gives rise to the "treat-teach" dilemma often encountered in supervision. That is, how much of the learner's expectable inhibitory processes can be meaningfully and effectively addressed in a supervisory situation versus what countertransference features are more properly addressed in a personal and private treatment situation.

In considering the problem of how supervisors view not only the learning alliance but the problems in learning necessarily encountered along the way, Teitelbaum has coined the term "supertransference" to point towards the blind spots that the supervisor has in

seeing and responding to the resistances to learning that are universal in the supervisory process. “In their zeal to impart their knowledge…supervisors frequently bypass the important step of establishing a positive supervisory alliance [and] a stalemate may follow. This is among the most commonly observed supertransference phenomena.”[180] In a later contribution Teitelbaum adds:

> Increasing emphasis is being given to the need to cultivate the supervisory alliance as a precondition for meaningful teaching-learning to take place. While this may seem obvious to the trained supervisor of today, it is a dimension that was often erroneously taken for granted in the past. Supervisees need to develop a feeling of trust that the supervisory atmosphere is a benign one, that they can feel safe in exposing themselves in spite of the evaluative component of the supervision, and that the supervisor is earnestly interested in being there for the supervisee in a way that meets her learning needs and professional development. If this dimension is meaningfully attended to via a supportive, encouraging, and validating supervisory atmosphere, then a teaching-learning focus can evolve around issues in theory, technique, the listening process, countertransference, and so on.[181]

Interpersonal psychoanalyst John Fiscalini, using Sullivan’s category of “parataxic thinking” to describe the human tendency toward deeply personal distortions of thought that naturally occur in the transference-countertransference processes of the supervisory relationship advocates the formation of an alliance with a robust conversation about what’s happening within and between members of the dyad:

> …[It is]… informative and corrective for supervisor and supervisee to examine directly any dialogic difficulties in supervision which arise from parataxic complication of differences in viewpoint, style, metapsychology, etc. Open review of their integration by supervisor and supervisee leading to a more candid, even creative, supervisory dialogue can correct or obviate negative triadic effects and enrich both the analytic and the supervisory experience. In other words, *supervision works best when supervisor and supervisee can talk straightforwardly with one another, including talking about each other….* The supervisory dialogue, the exchange of experiences, ideas, and opinions between supervisor and supervisee, is richest when it permits open and candid review of the supervisory as well as the therapeutic relationship.[182] (emphasis added.)

Fiscalini further addresses the processes of modeling and identification that contribute to the learning alliance:

> I would like to turn briefly to the issue of modeling processes in supervision; that is, *how the supervisory relationship itself becomes supervisory information*. The impact of the supervisory relationship upon the supervisee and his or her patient is evidenced in the common observation that supervisees tend to identify with their supervisors. Supervisees frequently begin to work with their patients in ways similar to the ways they have been or imagine themselves as having been related to in the supervisory situation. In other words, identification and

> modeling processes are set in motion that apply to how one is or thinks one is dealt with as supervisee as well as to how one perceives that his or her supervisor works with patients. [183] (emphasis added)

Fiscalini then tells of a former supervisor who “had a lively and deeply respectful curiosity about patients and a similar curiosity and respect about how I went about analytic work with my patient.”[184] Although nothing was ever said about this quality Fiscalini later realizes that he likewise became more interested in or curious about his patients in a deeper and fuller way that was more tuned into gaps in information and informative details, especially in what those events meant to them. “This supervisor's way of being with my patient, and with me, unconsciously became an important part of my own analytic attitude.”[185]

Addressing the supervisory relationship from the standpoint of building the learning alliance, Hunt suggests

> When a therapist comes to supervision, the best place to start is to give him a chance to express his feelings toward the patient and the progress of the treatment. Therapists often arrive carrying a considerable load of unresolved emotion derived from the impact of the patient and they need a chance to express it and have it accepted. No one does their best thinking if they are jammed up with unventilated affects. Starting with the therapist's feelings about the patient usually leads one to the central current problem more directly than would a chronological account.[186]

Searles, who first noted the reflective parallel phenomena in supervision, describes the learning alliance that he strives to cultivate as lateral rather than vertical or hierarchical.

> Very early I endeavour to become clear, in my own mind, how the student himself views his work with the patient, and what he himself is endeavouring to do in the treatment. The indispensable value of the supervisor's attentiveness to this point is comparable with the necessity, in analytic treatment itself, for one to attune oneself, as far as possible, to the patient's own subjective experience. I endeavour to keep to a minimum any interference with the student's own individual style of treatment; comparable again to the treatment situation itself, the other person must be left free to find that road to Rome which is most in keeping with his own capacities and interests. One is often tempted to try to indoctrinate the student with one's own individual style of conducting treatment; but respect for the other person's individuality is, in the long run, the only basis on which supervision, like analysis itself, will succeed....[187]
>
> In achieving his own potential larger self, he will on innumerable occasions need affirmation from the supervisor that the feelings he is having are 'all right' for him to be having, and that his responses to the patient are 'all right', too, or at any rate probably not irremediably destructive. Very often, he is hesitant to report to us his most therapeutically effective responses to the patient, for fear we shall think

> them not sufficiently ‘therapeutic'—not in keeping, that is, with his view of [what he should be doing.]… [188]

Thus, in forming the learning alliance it is generally agreed that both participants have the responsibility (1) to raise questions and doubts about the ways the process of the therapy and supervision are coming to be understood; (2) to consider what underlying assumptions, biases, and feelings may be operating in the mutually created relational experience; (3) to jointly explore and search for alternative ways of experiencing and formulating that are clearer and more cohesive and that can be experienced more authentically by both participants; and (4) to formulate these alternatives together out of the shared supervisory relationship. With these goals in mind Yerushalmi compares the supervisory learning alliance to cross-cultural communication:

> The joint responsibility and synchronization of the activity [of supervisor and supervisee] create a strong basis of shared experiences and enforce a unique ‘internal language.’… When people from different cultures (or speakers of different languages) wish to establish a shared emotional world and an authentic relationship, they establish new and idiosyncratic cultural or linguistic structures. Likewise the supervisor and the supervisee create their own idiosyncratic structures. Though shared, these structures include aspects of each of them, and thus create an intermediary space that constructs and strengthens their relationship. To continue the metaphor, the supervisee can be compared to the immigrant who is trying to establish a work, marriage,

or other relationship with a member of the local culture, and is plagued by feelings of strangeness, alienation, and effacement, alongside his or her idealization of the local culture. The relationship will thrive if an intermediary space is created: a new and shared subculture that includes cultural and linguistic elements that can be sustained and enriched by both of the original cultures. Shared symbols and values, unique linguistic structures—these are what will foster feelings of attachment, reciprocity, shared responsibility, and mutual respect. It is impossible to conceive of a healthy relationship in which one of the pair completely renounces his or her values and constructions of the world in his or her native tongue.

Supervisees, like new immigrants, are neither naive nor lacking in values and constructions of the world when they approach the new therapeutic culture. They should not be renouncing aspects of their world, but rather integrating them with those of the supervisor. This will create and foster a profound and significant relationship between them, while enriching and enhancing their joint constructions. This process may generate strong, rapidly interchanging, and sometimes conflicting feelings of joy, excitement, anxiety, anger, alienation, and deep affinity.[189]

Relational Perspective 7

The Learner's Position: From Pleasure and Pain, through Pride and Shame, to Victory and Defeat

We each have a history of learning that goes as far back as before we were born. Freud spoke of the early "purified pleasure ego" as our first sense of personal agency. That is, anything that we did at the beginning of life that resulted in a sense of pleasure constituted the first "me" and whatever we did that resulted in pain was our first "not-me." In German pleasure and pain are on a continuum of "pleasure-unpleasure" that cannot quite be translated, but that was Freud's formulation of our earliest selves as we learned how to move, how to reach, how to suck, how to pee, evacuate, and so forth. Our earliest learning was based solely on the experiences of pleasure and unpleasure or what Freud called the "pleasure principle".

With development, the learning dimension came to include an expanding awareness of the social milieu we were born into and the "reality principle" took over the learning situation. We then learned to relinquish pleasure in the short run in order to get what we needed in the long run—that is, we learned to seek out what worked to provide positive human emotional connections that would in the long run give us what we needed. And we learned to inhibit or avoid completely activities or situations that served to produce negative or broken human emotional connections. Getting slightly ahead of the picture, we can see that the foundation is hereby laid for the later subjective experiences of the "good-me", the "bad-me", and the "not-me" noted by Harry Stack Sullivan. That is, learning to "avoid completely" realms of potential intersubjective experience that promised traumatic discontinuities in human emotional connectedness provides the basis for potential experience that is dissociated or disowned, whole areas of possible

or potential experience that become cast into the forbidden realm of the never experienced not-me. This will be an important point later as we talk of more recent historical developments in our understanding of unconscious functioning—that is, that there is a realm of potential unconscious experience that has not been repressed but has for a lifetime been completely avoided, and has therefore remained unformulated.[190] Nevertheless avoided potentials can suddenly and shockingly appear in later intersubjective fields. More on this later.

The second and third year of life bring a budding sense of self that takes pride in accomplishments and social approval and feels shame when reprimands and disapproval are forthcoming from the social environment. That is, according to Kohut, the consolidating sense of self requires others for experiences of affirmation, twinning, and idealization (selfothers).[191] By the fourth and fifth years of life triangular relationships between competing selves that are experienced as separate and independent lead to feelings of victory and/or defeat in triadic interpersonal cooperation and competition.[192]

In this increasingly complex sequence of relational processes spanning the first few years of life we each experience a pattern of successes and failures that lay the foundation for how we will experience subsequent learning situations. Psychologists place tendencies toward perfectionism, limitations in frustration tolerance, and strivings for narcissistic supplies as qualities that often mark troublesome learning situations at each of these three phases of learning how to learn from others. Needless to say the positive and negative experiences we have throughout our school years adds more complexity to our capacities and problems in learning. But this is a psychological

analysis of our individual stages and phases of learning how to learn. Of particular interest are some findings from recent neuropsychological research.

Almost as an aside, I think it is essential to fully appreciate what is going on at a neurophysiological level during supervisory learning. The two researchers who have done the most to help us appreciate the *physiological function of shame* in social learning situations are neuropsychologists Alan Schore of UCLA and Stephen Porges of the University of Illinois at Chicago.

Schore begins his discussion of the neurological substrate of shame with a review of Margaret Mahler's[193] developmental theory highlighting the "practicing" subphase of separation-individuation that extends from about 10 to 18 months. Citing extensive infant research, Schore makes a case for the abrupt change that occurs in infant-maternal behavior as the interpersonal focus shifts from the early pleasure principle to the later reality principle.

> In optimal growth-promoting environments, the interactive mechanism for generating positive affect becomes so efficient that by the time the infant begins to toddle he is experiencing very high levels of elation and excitement….At 10 months, 90% of maternal behavior consists of affection, play, and caregiving…. In sharp contrast, the mother of the 13- to-17-month-old toddler expresses a prohibition on the average of every 9 minutes. In the second year the mother's role now changes from a caregiver to a socialization agent, as she must now persuade the child to inhibit unrestricted exploration, tantrums, bladder and bowel function (i.e., activities that he enjoys). …In other words, in order

to socialize the child, she must now engage in affect regulation to reduce the heightened levels of positive affect associated with the pleasure of these activities. How does she do this? In fact there is one very specific inhibitor of accelerating pleasurable emotional states, one negative emotion that is closely associated, both psychologically and neurologically, with positive affects. Shame, a specific inhibitor of the activated ongoing affects of interest-excitement and enjoyment-joy, uniquely reduces self exposure or exploration powered by these positive affects…. The negative affect of shame is thus the infant's immediate physiological-emotional response to an interruption in the flow of an anticipated maternal regulatory function….In other words, shame, which has been called an "attachment emotion"…is the reaction to an important other's unexpected refusal to enter into a dyadic system that can recreate the attachment bond….This intense psychophysiological distress state, phenomenologically experienced as a "spiraling downward," reflects a sudden shift from energy-mobilizing sympathetic-dominant to energy-conserving parasympathetic-dominant autonomic nervous system activity….In such a psychobiological state transition, sympathetically powered elation, heightened arousal, and elevated activity level instantly evaporate. This represents a shift into a low-keyed inhibitory state of parasympathetic conservation-withdrawal…that occurs in helpless and

> hopeless stressful situations in which the individual becomes inhibited and strives to avoid attention in order to become "unseen."[194]

Schore thus calls our attention to a developmentally determined physiological process mediated by maternal attunement and misattunement that occurs during Mahler's practicing subphase so that a toddler alternates between elated states of self-aggrandizement and pride when affirmed and deflated states of shame and helplessness when disconfirmed. In this essentially normal process of "disruption and repair" the good-enough caregiver induces stress and decreased activity through misattunement and reinstates increased activity and positive affect through reattunement. But, of course, this process occasionally goes awry even in optimal child-rearing situations and becomes disastrously shameful in nonoptimal situations. Just how and how much each of us were subjected to physiologically disabling shaming experiences in toddlerhood and in later life profoundly affects how we address later learning situations.

From a somewhat different angle Porges introduces the concept of "Neuroception" as a subconscious system for detecting threats and safety.

> By processing information from the environment through the senses, the nervous system continually evaluates risk. I have coined the term Neuroception to describe how neural circuits distinguish whether situations or people are safe, dangerous, or life threatening. Because of our heritage as a species, neuroception takes place in primitive parts of the brain without our conscious awareness. The detection of a person as safe or dangerous triggers neurobiologically determined

prosocial or defensive behaviors. Even though we may not be aware of danger on a cognitive level, on a neurophysiological level, our body has already started a sequence of neural processes that would facilitate adaptive defense behaviors such as fight, flight, or freeze….A child's (or an adult's) nervous system may detect danger or a threat to life when the child enters a new environment or meets a strange person. Cognitively, there is no reason for them to be frightened. But often, even if they understand this, their body betrays them. Sometimes this betrayal is private; only they are aware that their hearts are beating fast and contracting with such force that they start to sway. For others, the responses are more overt. They may tremble. Their faces may flush, or perspiration may pour from their hands and forehead. Still others may become pale and dizzy, and feel precipitously faint.…To create relationships, humans must subdue these defensive reactions to engage, attach, and form lasting social bonds. Humans have adaptive neurobehavioral systems for both prosocial and defensive behaviors….By processing information from the environment through the senses, the nervous system, continually evaluates risk. As evolution has proceeded, new neural systems have developed. These systems use some of the same brain structures that are involved in defense functions to support forms of social engagement….When our nervous system detects safety, our metabolic demands adjust. Stress responses that are associated with fight and

> flight, such as increases in heart rate and cortisol mediated by the sympathetic nervous system and hypothalamic-pituitary-adrenal axis, are dampened. …In the presence of a safe person, then, the active inhibition of the brain areas that control defense strategies provides an opportunity for social behavior to occur spontaneously….In contrast, when situations appear risky, the brain circuits that regulate defense strategies are activated. Social approaches are met with aggressive behavior or withdrawal….[195]

Porges and his research collaborators speak to evolutionary forces in vertebrate nervous systems that have allowed the expansion of affective and behavioral repertoires and that have molded both human physiology and behaviors. “A product of this phylogenetic process is a nervous system that provides humans with the ability to express emotions, communicate, and regulate bodily and behavioral states.”[196] Porges has been especially interested in various kinds of learning situations and how the polyvegal system of nerves that regulates the prosocial and withdrawal states that a person has developed over a lifetime profoundly affect how that person experiences at a subconscious level the safety or danger of mentoring opportunities.

The point I wish to make in this neurophysiological aside is that research made possible by recently expanding technologies speaks clearly to issues of shame and social withdrawal according to how each of us experiences a given learning/relational situation. Considering shame as a learner variable has implications not only for a therapist in supervision, but also for a supervisor attempting to be relationally involved with and learning from a supervisee.

Countless neuronal pathways become actively blocked or closed off throughout our growing up years in direct response to unsatisfying and frightening relational experiences. Neuropsychologists Schore[197] and Porges[198] report on large scale brain and neuronal research that now demonstrates massive dampening effects on neuronal structures caused by neglect and trauma. What I have come to call "fear reflexes"[199] develop in response to ungratifying, neglectful, and hurtful interpersonal situations thus causing channels of potential emotional connectedness to constrict and close off more or less permanently. It is as if a sign is posted on channels of connection found to be unsatisfying or frightening—"Never reach that way again." All infants, toddlers, and older children experience body-mind fears arising from a series of relationship situations that are universal in childhood. In my clinical research I have identified "Seven Deadly Fears" that have been studied through a century of relational psychoanalysis.[200] I will later summarize my findings on these seven levels of relational fears that we are all subjected to in one degree or another in the process of growing up. By studying fear reflexes together in the context of our developing relationship partners—in and out of therapy and supervision—we can work toward regaining access to those closed off channels of love that were genetically designed for intimate emotional resonance but were closed off due to the traumas that gave rise to various developmental fears.

Relational Perspective 8

Some Psychological, Anthropological, and Sociological Considerations: Regression, Progression, and the Frame

Human psychological growth has been a mystery since the beginning of time. Different cultures in different times and places have addressed growth issues in a variety of ways with different metaphors and procedures. When Freud, a nineteenth century scientist and physician, addressed the mystery of human growth he borrowed the currently prevailing metaphors of science and medicine to establish his practice of psychotherapy—but many innovators since his time have modified and replaced his original metaphors.

Because we are creatures with minds embedded in bodies—with mind-body systems as it were—issues in human growth are necessarily both mental and physical. This means that when growth issues arise in either realm the other is inextricably involved. Throughout time, however, since the physical side of the mystery of human growth has been more observable than the mental, difficulties in human growth have usually been seen as physical ailments of one sort or another—though often understood to be of spiritual or mental origin.

A curious story-song from the South American Cuña Indian tribe, as told by anthropologist Claude Levi-Strauss, well-illustrates this connection. Briefly, the traditional song is one sung by the Shaman when after ordinary efforts of the midwife have failed to deliver the baby he is called on to expand the mother's consciousness of her body. Through the use of incantations, incense, and symbols the Shaman leads an imaginary procession of spirits up the birth canal to reprimand *Muu*, the goddess of

fertility, for overstepping her power and rummages around violently inside the woman's psyche-body against the host of *Muu's* spirits until the child is successfully delivered. The illuminating feature of this set of procedures, according to Levi-Strauss, is to illustrate how the mind "hooks into" the body.[201]

Following Freud, the concept of unconscious mind has been widely used to discuss issues in human growth—both how to enhance growth experiences and how to address blockages to mental expansion. Medical metaphors of "cause, treatment, and cure" have frequently been called upon to address our human growth mysteries.

Over time, two diametrically opposed processes of growth have been noted that for convenience I will call educational and analytical. *An educational process* is essentially progressive and constructive and involves conditioning procedures that expand and enhance existing growth and development. Antithetically, *an analytical process* is essentially regressive and destructive and involves procedures that encourage a breakdown of existing developmental structures that are providing blocks to further growth and development. Said differently, many times we encounter novel learning challenges and we learn progressively through some form of didactic teaching and learning process how to expand our repertoire of knowledge or skills. At other times we struggle with some, usually relational, challenge and in the face of frustration and defeat we have to "go back to the drawing board," to regress as it were, to discover what has gone wrong and to devise ways of correcting or overcoming our learning or relating block. The two opposing processes—progression and regression, constructive and destructive—are, of course, usually intertwined but for the sake of considering psychotherapy I find it useful to distinguish them. That is, at times and with certain kinds

of therapeutic advances a progressive, conditioning, learning task is primarily involved, while at other times a regressive, destructive, unlearning task is primarily involved. By my very choice of words here we can surmise that the progressive learning direction is usually marked with a positive sense of emotional success while the regressive unlearning direction is usually marked with a sense of emotional distress—at least during the detection and dismantling phases.

Freud likewise was clear in what he was up to in his choice of the word analysis—a de-structuring based on the metaphor of chemical analysis of his time, i.e., to take a complex compound and to treat it so as to break it down into its component parts which he surmised were biological drives. He explicitly sought to set up a treatment procedure—hypnosis at first, then free-association and interpretation later—that would serve to break down a learned neurotic complex of misery into ordinary, understandable, and workable human misery.

Another way of considering human growth is to invoke three familiar learning models. The first model is the mug-jug metaphor in which the learner is the empty mug to be filled up by the mentor who is the full jug. The second model is the potter-pot model where the skill of the mentor lies in shaping, in molding, the learner like a potter at a potter's wheel. The third model is the gardener-plant model. The gardener plants a seed and carefully creates conditions for its optimal growth. The mystery of the seed is unknown. The mystery of why the plant flourishes or withers under various conditions is also unknown. But the skillful mentor watches carefully and continuously monitors conditions in order to produce optimal growth for this particular seed and this particular learner. Whatever psychotherapy may be about, the mentor—whether the therapist or

the supervisor—certainly borrows on all three models of learning with the accent being on the third model—the cultivation of a learning environment that will allow optimal growth for the client or therapist—however we may choose to define psychotherapy or supervision.

Getting slightly ahead of my game here, I want to introduce the notion of the frame, which I will elaborate further later on. All human teaching and learning necessarily occurs in some sort of social framework or frame. Think of anything truly important that you have learned and you will immediately know from whom you learned it. Human growth of either the progressive or regressive type is essentially a social experience—meaning that it occurs within a social context or framework. True, we are genetically endowed with the capacity for complex learning, but being born essentially helpless to survive, we are also endowed with the capacity—nay the necessity—of being able to demand emotional and cognitive support from the human milieu in order to survive and grow. How the social frame operates in didactic teaching and learning of conditioned human skills is intuitively obvious and well-studied in various progressive, constructive, cognitive-behavioral growth settings. But how the social frame operates in various kinds of analytical-relational growth settings that require regression and deconstruction is more complex and less obvious. This is all I want to say for the moment by way of preparing us to consider the critical importance—from the standpoint of a subjective sense of safety—of the social contract or frame in which the complex regressive growth tasks involved in psychotherapy and supervision necessarily occur.

"Follow the Fox"

My favorite paper in the supervision literature, *Follow the fox: An inquiry into the vicissitudes of psychoanalytic supervision,* was prepared by Edgar Levenson for a 1981 weekend conference on supervision held by the Interpersonalist group of psychotherapists at a retreat center that was once a large estate known for its fox-hunting events. Speaking in a setting occupied by ghosts of horses, hounds, and to-the-death chases in search of elusive foxes, Levinson likened the therapy and supervisory tasks to the famed and fabled fox hunt. Tongue in cheek for the occasion, Levenson says:

> Oscar Wilde, my favorite aphorist, took a particularly dim view of fox hunting. It was, he said, a marvelous example of the *unspeakable* in pursuit of the *inedible!* With a very slight shift, much the same might be said about the process of supervision. It is a marvelous example of the *infallible* in pursuit of the *ineffable!*
>
> This may appear to be a rather strained bit of punning, but I have something quite specific in mind. First, there is something oddly infallible about the experience of doing supervision; and secondly, as we would all agree, something ineffable (or beyond words) in the process of doing therapy. In the ordinary course of my work, I spend (as I'm sure we all do) a very considerable part of my time perplexed, bored, confused, and at sea. Sometimes I dream of a mid-life career change to something simple, clear-cut, say dermatology; but when I supervise, *all is clear to me!*[202]

Levenson's purpose, of course, was to say to his audience that no matter how we search to define the essence of psychotherapy or supervision what we find in the end is an interpersonal relational process that defies words and definitions—a process that is real enough, but just when we think we have caught it we find it has either escaped us completely or our definition is utterly useless to us—inedible, ineffable. I will later return to Levenson's very useful discussion on supervision, but now a series of lenses with which to consider the regressive nature of the therapeutic and supervisory relationship.

1. The Logos, Identity, Dissociation, Otherness and Multiple Selves

This section may be difficult to follow unless you pay close attention and watch the psychological soup I am brewing. I will consider five psychological concepts that, taken together, help us think about how complex intimate relationships truly are: (1) The *Logos*, (2) Otherness, (3) Identity, (4) Dissociated Self-States, and (5) Multiple Selves.

The Logos

The ancient Greeks referred to the system of symbols—gestures, mimetics, language, and grammar—that we use to express ourselves as the *Logos*, meaning the word. As a psychological concept the *Logos*, the system of human symbols we use to define ourselves, is understood as necessarily alienating us from our bodies. That is, we are born into the world living in our bodies, exploring and expressing with our physical being who we are and what we can do. But rapidly the human environment gives us meanings from the constructed *Logos* that is handed down the generations to us and we come to express ourselves in language and symbols that are not properly our own but are constituted by reflected socio-cultural realities.

It was Jacques Lacan, in a 1938 paper, “The Mirror Function” who noted that while birds, dogs, and some fish notice and respond to the mirror, there is only one species that plays with and uses the mirror.[203] He defines a mythical moment in human life when a baby playing with a mirror points and says, “that’s me.” At that moment two things occur simultaneously: (1) the child is forever alienated from her kinesthetic body self, from knowing who she is by what she does and feels and (2) she enters the human reflective system of symbols and symbolic thought. The net result is that we come to use language, gestures, bearing, and symbols to define who we are but none of them does us justice, none is able to capture the richness of our subjective lives. Now, for the second ingredient to this soup.

Identity

Likewise, the human world quickly identifies us—first with a family name, then with qualities that flow from perceptions and projections of others as well as concepts from the *Logos*—we are said to be cute, bright, willful, strong, active, passive, colored, middle-class, catholic, handicapped, etc. We, of course, participate in creating our personal identities, but by and large, it is the world around us that tells us who we are and who we are to become. Over time, using the tools of speech and symbolization afforded by the *Logos* and the tools of identity bestowed upon us by the human social environment surrounding us, we develop certain consistencies of thought and behavior so that our personalities or characters become “known” to ourselves and to those around us. But the words and symbols of the *Logos* and the personality descriptions constructed to identify us are necessarily incomplete and faulty in many ways—since

each of us as a human being is far too complex and ever changing to be captured by such limited and static descriptions.

Nevertheless, when two people approach one another hoping for an intimate emotional relationship, they each bring a host of socio-cultural reflected realities and self-definitions with them that tell them who they are, how they are to be with each other, and what they can reasonably expect from each other and from the relationship.

Each relating partner has a lifetime of accumulated ideas, fantasies, images, and reflections of who they are thought to be, of what each believes to be real, and of how life in various kinds of relationships is "supposed to" be experienced. But in fact, we have no idea whatsoever what to expect from each present moment of encounter with our intimate relating partners. Now let us consider together the next two ingredients to relating.

"Otherness" and Dissociated Selves

For a lifetime we have worked to disown or to disavow various parts of ourselves that don't fit well with our accepted versions of ourselves. Yet these disavowed, disowned, dissociated aspects of ourselves have a way of showing up at inconvenient times, when we are least expecting or least wanting to deal with them. The same can be said for those aspects of our relating partners that she or he has disavowed or that we have chosen not to notice in them. Disowned and unnoticed parts of ourselves and our partners keep cropping up to confuse, perturb, or often even to frighten us. Psychologists speak of these unwanted, unrecognized, un-comprehended parts that feel alien or strange in ourselves and in our partners as "other" or "otherness." While otherness in ourselves and in our relating partners can be disruptive and even

frightening in any intimate relationship, in the psychotherapeutic and supervisory relationships it often becomes an important part of the process to find ways of dealing with the unformulated experiences of otherness that have been shunted off into the realm of “Not-me.”

Multiple Selves Too!

Now to add to the psychological soup I am brewing is the fact that we don’t have simply one self, but, it turns out, multiple selves or multiple self-states. Psychologists now generally recognize that multiple dissociated self-states are the developmental norm—that we all have developed multiple frames of mind that appear at separate moments and in differing relational contexts—some of them quite ugly, some of them quite crazy, many of them quite enjoyable, and many of them not very comprehensible.[204] At any given moment in time we are living in a certain self-state with a particular version of who we are and what we want activated in the present relational moment. Yet other unwanted aspects of ourselves keep popping up, or keep clamoring to be heard.

A central dilemma that faces us all the time in intimate relationships is how to be consistent, sensible, and reliable when some unruly thought, feeling, or fantasy is tugging in some other direction. In intimate relationships there is always a strange “otherness” lurking just around the corner—both in ourselves and in our partners. At times this strangeness is experienced as elusive, mysterious, and very exciting. At other times this strangeness may be confusing, distressing, or frightening.

By way of summarizing this soup, we use our human capacity for symbolization (the *Logos*) not only to forge our personal identities, but to dissociate inconsistent or

unwanted selves in various relational contexts so that they become experienced as "not-me" or "otherness." Being in intimate relationships is about representing or mentalizing, putting into thoughts and words, these strange experiences of "otherness" as they inevitably arise in the course of relating, and in so doing, creating some mutually transformative relational moments—*Now moments* in which two get to know themselves and each other in never before imagined ways. These processes are active in all emotionally intimate relationships and can help us understand some of the ineffable qualities of therapy and supervision.

2. The Anthropological/Sociological Web of Intimacy

The person who has undoubtedly done the most comprehensive study of the web of human intimacy—lust, love, and attachment—is anthropologist and sociologist Helen Fisher in two truly remarkable books, *Anatomy of Love: A Natural History of Mating, Marriage* and *Why We Stray and Why We Love: The Nature and Chemistry of Romantic Love*.[205] After massive immersion in research data from around the world and reaching to before the beginning of human time, Fisher states: "I came to believe that romantic love is *a primary motivation system in the brain*—in short, there is a fundamental human mating drive."[206] Summarizing her research Fisher says:

> Romantic love is deeply entwined with two other mating drives: lust—the craving for sexual gratification; and attachment—the feelings of calm, security, and union with a long-term partner.…Lust is associated primarily with the hormone testosterone in both men and women. Romantic love is linked with the natural stimulant dopamine and perhaps norepinephrine and serotonin. And feelings of…attachment

> are produced primarily by the hormones oxytocin and vasopressin….All three of these brain networks—lust, romantic attraction, and attachment—are multipurpose systems. In addition to its reproductive purpose, the sex drive serves to make and keep friends, provide pleasure and adventure, tone muscles, and relax the mind. Romantic love can stimulate you to sustain a loving partnership or drive you to fall in love with a new person and initiate divorce. And feelings of attachment enable us to express genuine affection for children, family, and friends, as well as a beloved.[207]

From Helen Fisher's monumental research we can see that the long evolving web of intimacy includes romantic love, lust, and attachment and that this web is sustained by a series of crucial neurotransmitters running throughout our bodies. Following this brief mention of some Psychological, Anthropological, and Sociological concepts we are in a position to focus on regression, progression, and the frame.

3. Regression in the Service of Progression

One of the most difficult concepts relevant to supervision is *regression in the service of progression*. Since Freud's earliest cases it has been known that a curious part of therapy is that in the intimacy of the therapist-client relationship "regression" regularly takes place. The term over the years has come to mean different things in different theoretical and clinical contexts. But what is common to most meanings of regression is that in therapy the client allows her- or himself to experience the therapist and/or the therapeutic situation in emotional ways that are characteristic of earlier periods in life. Freud first called these experiences "transference" and saw them as obstacles until he

realized that these regressive experiences were *essentially relational memories brought from childhood, unconscious memories of intimate childhood relationships that become re-experienced in the course of the emotional intimacy of the therapeutic relationship.* While this is not the place to go into the history of the study of transference and to the resistance to transference remembering in therapy or to the countertransference—the therapist's counterpart—let it suffice to say that for a century the study of emotional relatedness memories transferred from childhood relationships into later life has held center stage in one way or another in all forms of psychotherapy.

This regressive transfer process occurs, of course, in all intimate relationships but in therapy there is opportunity to study carefully how it works with a slow motion camera, as it were. Thus, regression in therapy so that implicit relational memories can be experienced and studied in the therapeutic relationship has generally been understood as *the mode by which therapeutic progression ultimately occurs*. An early statement of this came from Kris in the form of considering artistic and creative endeavors as *regression in the service of the ego*.[208] The Hungarian psychoanalyst Sandor Ferenczi based his therapeutic work on regression to a point of emotional fixation so that a "new beginning" would be possible.[209] Another Hungarian, Michael Balint, used a geological metaphor of regressing to the "basic fault" where development first got off track, so that one could initiate that new beginning.[210] Viennese-Chicago psychoanalyst Heinz Kohut spoke of regressing so that a "new edition" of relational experience would become possible.[211] Other innovators have developed many ways of speaking about the therapeutic necessity of what British psychotherapist Donald Winnicott called "regression to dependence," a state of self-other involvement from which new

differentiation toward emotional independence could occur.[212] All of these theoreticians and clinicians—formulating in many different ways—emphasize how terrifying it can be to "let go" of later developed ways of perceiving and experiencing in the course of therapy and to "go back to the drawing board" of early relationship experiences that were in fact traumatic in order to master the early relational fears with a sense of adult maturity. The key feature that allows therapeutic regression in the service of progression is the provision by the therapeutic relationship of a sense of *interpersonal emotional safety*. Herein comes the importance of considering the frame.

4. The Function of the Frame

The concept of the psychotherapeutic and supervisory frame is a concept sometimes considered in the sense of a framework or structure but perhaps more usefully considered like a picture frame that complements or augments with clarity what is to be framed. I have already indicated that all learning is accomplished in a social context, frame, or framework that supports either an educational (constructive) or an analytic (destructive) learning process or both. The helpfulness of a mentor in an educational conditioning of new knowledge and skills is patently clear. But how exactly does the frame function in analytic or de-constructive learning processes, processes in which emotional regression in the presence of a witness is required for later progression to become possible?

The person par excellence who has studied the frame in psychotherapy and supervision is American psychiatrist Robert Langs.[213] I will present some of his very important ideas about the frame and then discuss where his insights are invaluable and where, in my opinion, he misses crucial elements.

Langs begins from an evolutionary standpoint with the assumption that what is bedrock for all mammals is the fear of predators and death anxiety. Over time, the human species has collectively arranged group defenses against predators that allow us to deny our fundamental fear of death. Predator fears and death anxiety are stimulated by all humans and relationships. But to surrender ourselves, to allow a regression to dependency not only stimulates primitive death anxiety but requires that some sort of social contract be in place to assure a sense of safety. Langs believes that clients in therapy and therapists in supervision crave the safety of a securely held contract or frame in order to keep death anxiety at bay. He cites various frames: the parent-child frame, the marriage frame, the worker-boss frame, the teacher-learner frame and the therapeutic and supervisory frames—all of which serve to ward off predator and death anxiety. He has devoted a professional lifetime to studying and specifying the elements in the professional frames that are essential for emotional-relational safety.

According to Langs, the optimal supervisory frame includes:

1. A totally private and professional setting with an effectively soundproofed office.
2. A private referral of the supervisee to the supervisor, and the absence of prior personal or professional contact between them.
3. A single setting for the supervision, with a set fee, a defined length and frequency of sessions, and a fixed appointment time (usually once weekly for forty-five minutes).

4. Complete privacy and confidentiality for the supervision, with no recording of any aspect of the supervisory presentation or teaching experience by either party to the supervision. Thus, for both the supervised therapy and the supervision itself, there are no process notes, tape-recorded or videotaped sessions, or jottings of any kind made by either party to the supervision. Similarly, no reports on the supervisory work are made to others, nor are evaluations or assessments released to third parties.
5. A reconstruction by the supervisee of the therapy hour under supervision from memory and in strict sequence without the use of notes.
6. The instruction and other comments offered by the supervisor to be based entirely on the material of the session under consideration in a given supervisory hour. Both parties to the supervision refrain from extraneous comments, including anecdotes and stories of a personal or professional nature. In particular, neither supervisor nor supervisee should allude to colleagues, friends, relatives, or other patients—the supervision is concerned exclusively with the material from the sessions with the patient whose therapy is under supervision.
7. The relative anonymity of both the supervisor and supervisee. This means that there are no personal revelations and no offer

of personal opinions or suggestions, other than those needed for purposes of teaching and learning in connection with the reported case material. All comments on both sides closely adhere to the presented material and its implications—and the interventions they call for. In all, then, the teaching and learning is based entirely on the material from the sessions with the supervised case.

8. Confinement of the contacts and interactions between supervisor and supervisee to the supervisory setting and to the allotted time. The relationship is maintained entirely on a professional level, without gratuitous favors or shifts to other types of interacting and relating.
9. There is no physical contact between the parties to the supervision except for a handshake at the beginning and end of the supervision.
10. All teaching efforts to be carried out in predictive fashion and subjected to a search for encoded validation. All of the interventions that have a bearing on supervision—whether from the supervisor or the supervisee (to his patient or, on occasion, to the supervisor)—should be confirmed unconsciously by means of encoded narratives. The relevant imagery may come from the presented case material or from a coincidental narrative told by the supervisee—or unthinkingly by the

> supervisor. Most importantly, every significant teaching assessment and recommendation made by a supervisor must find encoded confirmation in the subsequent material from the supervised patient before it can be considered to be correct. Supervision is not conducted by fiat; the encoded communications from the supervised case is the final arbiter of the validity of a supervisor's teachings.
>
> There are, of course, very few supervisory experiences that have been or are presently being conducted within the ideal framework for supervision as universally validated by deep unconscious systems. Nevertheless, compromised settings and ground rules and modifications to the frame during a supervisory experience not only interfere with conscious learning, they also unconsciously direct and motivate supervisees to use interventions that are harmful to their patients—and to themselves as well.[214]

Further, in his “communication” approach to therapy and supervision Langs believes that any deviation—necessary or unnecessary—from a rigidly maintained frame causes problems for the relating couple and he provides countless impelling examples of clinical and supervisory processes gone awry as a result of subtle frame deviations that were not attended to. He well-demonstrates in his written work as well as in his public teaching and consulting work how breaks in the frame become subtly “encoded” in the “deep unconscious” where they signal danger to our predator-fearing instincts and disrupt our capacity to relate freely and spontaneously. He convincingly demonstrates

how breaks in the frame are manifest in encoded conscious content of clinical hours and can be de-coded and repaired if attended to adequately. Both members of a therapeutic or supervisory couple have a responsibility for attending to the frame, but the more experienced or mentoring partner must hold the frame rigidly in place and take full responsibility for repairs when necessary. “Must”, of course, introduces a moral imperative into the already complex tasks of psychotherapy and supervision.

Despite his penetrating understanding and illuminating clinical material, Langs holds what I consider to be a rigid doctrinal position regarding the moral imperative for both parties to adhere to the frame and for the mentoring partner to take primary responsibility for firmly and unambiguously maintaining it at all times. Holding the frame is good, deviating from the frame, allowing enactments from the unconscious, is bad—it’s that simple for him.

I do not wish to do a systematic or thorough critique of his position but merely to suggest that the most advanced human evolution of the prefrontal cortex that organizes the rest of our brain develops and functions according to the human relational environment available to each member of the species is startlingly recent but well established. While later evolutionary events never completely eclipse prior ones, and the human fear of predators and death can hardly be said to have entirely left us, These are massive implications from our recent studies in infant research, neuroscience, and intersubjectivity that point toward a balance between a human milieu organizing our brains with a sense of human relational safety versus primitive predator fears being always treacherously on the loose. Further, can anything that has evolved over thousands of years—such as a conflict between human social safety and primordial

predator danger—not have its own adaptive value *as conflict*? Here I follow the lead of Malcolm Slavin who has, perhaps more than any other psychologist, studied the adaptive design of the human psyche and believes that whatever has evolved for us over time—including conflicts—cannot be a matter of chance but a crucial adaptation of our species.[215]

Therefore, I speculate that along with the prolonged period of dependency required for advanced human development has evolved a species-specific social cohesion with a built-in developmentally-sensitive sense of safety that balances out or conflicts with predator and death anxiety and that this is a fundamental adaptation of our species. True, intrusive focal or strain trauma in early childhood or even in later life can teach a person that the human milieu is not safe in certain ways. I maintained that while we cannot ever leave our primitive predator fears of death totally behind, that our species has evolved so that each infant is born into and nurtured for twenty plus years in a social environment that she has evolved to expect and to depend on for health, nurturance, continuity, and safety.[216] I hereby accuse Langs of the same (forgivable) limited view of human life that Freud in his time evidenced when he sought the fundamentals of human existence in biological drives rather than to take into account what we now know to be our fundamental emotional-relational nature as evolved through our capacities to organize our entire brains and neurological systems according to the earliest emotional-relational milieu available to each person. That is, when considering either the conflict between safety and danger or between relational drive and biological instinct we can now take into account recent research from many fields that demonstrates clearly that *safety and relationship trump danger and instinct in the*

human species—unless a specific traumatizing environment has been offered to a particular person.

The question of evolutionary possibilities having been addressed, I would also like to remark that therapy and supervision are difficult enough to engage in considering the host of variables involved without adding constant moral constraints such as required by strict frame-oriented technique. We have laws to protect children and elders, vows and laws to protect spouses, labor laws, sexual harassment laws, and laws to prevent boundary violations by teachers, clergy, therapists, and supervisors. We have professional ethics that provide further protections and we have specific demands of agencies and insurance companies for the standards we practice. All of these laws, ethics, and standards acknowledge social context and the importance of social contract or frame. I am not personally in favor of adding any moral imperatives to psychotherapy or supervision beyond these widely agreed upon legal, institutional, and ethical constraints. In fact, as I have considered the crucial importance of different developmental levels of relatedness possibility involved in therapy and supervision, I have advocated "variable frame responsiveness" that necessitates varying forms of framing in order to secure differing levels of relational development for therapeutic study.[217] I will later review my work on these Listening Perspectives that provide different ways of safely framing relational fears originating at different developmental levels.

There are additional impelling reasons to avoid morally-generated rigid boundary and frame rules and these considerations arise from the findings of contemporary interpersonal, intersubjective, and relational schools of psychotherapy—all of which I

would surmise Langs would disapprove of. Later, as I discuss various theoretical approaches, I will address these considerations; but let it suffice for now to say that the "deep unconscious" spoken of by Langs now has a variety of definitions in psychotherapy and supervision.

In the next section I will speak to our developmental understandings of how boundaries are at first merged in infancy and earliest childhood, then mingled in various ways through toddlerhood, and only later provisionally separated into constant self and other configurations, making clear that *attaining empathy with various developmental levels of psyche indeed requires a number of different kinds safely framed interpersonal boundary crossings*—though absolutely not personal, legal, or ethical boundary violations. Fundamentally agreeing with Langs that a sense of subjective safety is essential for regression in the service of progression to occur, I believe there are many ways of framing regressive experiences so that a sense of safety can be maintained and that these methods have to be tailored to each relating couple in psychotherapy and supervision.

Relational Perspective 9

Guidelines for Good and Bad Supervision

Our elusive, ineffable fox appears again when the question of what makes a good or a bad supervisor comes up. What makes a good or bad therapist? What makes a good or bad person or a good or bad lover? These are all matters of context and personal taste. But some guidelines for thought have been put forward.

Teitelbaum in his classic paper on supertransference lists a number of problems that arise in the supervisor:

- General personality characteristics such as narcissism when the supervisor has an excessive need to be liked or admired.
- Or when the supervisor's need to control leads him or her to attempt to coerce the therapist to conform to his or her way of thinking rather than constructively contributing to the therapist's developing individual therapeutic style.
- The supervisor's narcissistic investment in the supervisory situation leads him or her to develop exaggerated and unrealistic expectations of the therapist.
- Frustration, irritation, and criticism may follow when the therapist's goals, aspiration, or performance do not meet the supervisor's expectations.
- Transference reactions to the characteristics of a particular therapist, such as aspects of personality that threaten or gratify the supervisor's narcissism.

- Or a different theoretical orientation or technique is seen by the supervisor as resistive or provocative.
- Situations that stimulate sadistic or competitive impulses in the supervisor, such as a perception that the therapist may be more intelligent or competent.
- Situations in which an unperceptive, unempathic or overly defended therapist frustrates the supervisor's need to produce a therapist who functions at a superior level.
- A clinical situation of crisis or trauma and the way the therapist handled it may stimulate an over-reaction on the part of the supervisor.
- Counter-reactions of the supervisor to the transference of the therapist toward her that result in a loss of objectivity leading to a supertransference.
- "As a consequence of the supertransference being played out… the supervisory atmosphere will be affected in the following ways: (a) the therapist will be confused about how he perceives the supervisor's interest in him, (b) he will ultimately feel rejected by the supervisor, and (c) he will be more mistrustful in subsequent supervisory sessions and reluctant to reveal himself and his work to the same degree as before."[218]

Teitelbaum summarizes pitfalls of the supertransference:

> Although the anxieties, authority problems, mirroring, and idealizing transferences on the part of the supervisee are significant aspects that

> color the supervisory process, the contribution of the supervisor's blind spots has heretofore received insufficient attention. I postulate that such factors as the supervisor's narcissistic investment and needs, his or her expectations of the therapist, reactions to the personality of the therapist, and counter reactions to the therapist's transferences to the supervisor strongly influence the course, flow, and outcome of the supervisory experience. The term supertransference is used to describe those difficulties which emanate from the side of the supervisor.[219]

In a later contribution Teitelbaum concludes:

> What we are coming to acknowledge to a greater degree is that not only the therapist, but also the supervisor, brings a set of needs to the supervisory relationship. The supervisor-supervisee relationship is made more complex by the *legitimate narcissistic needs* of the supervisor, such as the wish to mentor, that is, the need to feel she is making a meaningful contribution, along with more neurotic needs, such as disciple-hunting; competitiveness with the therapist-in-training, other supervisors, or the therapist's training therapist; the need to bolster or enhance her reputation…and so forth. It is of central importance to recognize the nature of these anxieties within the supervisor, and to understand the ways in which they impact upon what takes place in the course of the supervision.

> Given these complexities it is understandable that there are many supervisory impasses; I believe that these impasses occur much more frequently than has been previously acknowledged. Another cause of supervisory failures and misalliances comes about as a result of the supervisor's difficulty in shifting gears, that is, in not modifying her teaching position vis-á-vis the therapist, as the latter's needs change during the course of the supervision.
>
> I also believe that there is a growing atmosphere of openness in studying the causes of supervisory impasses, rather than simply defensively attributing the problems to the 'difficult supervisee.' It is a reflection of progress that supervisors of today are freer to acknowledge and explore their own contributions to supervisory misalliances than heretofore, when the prevailing view was that the supposedly well-analyzed supervisor did not bring his own unresolved issues to the supervisory setting.[220]

Interpersonalist Fiscalini, a great champion of the need for supervisee and supervisor to form a robust and ongoing conversation about their relationship, uses Sullivan's concept of parataxis to point toward transferential distortions naturally occurring in the therapist/supervisor dialogue. He quotes Sullivan as saying that an "… integration is parataxic,… when, besides the interpersonal situation as defined within the awareness of the speaker, there is a concomitant interpersonal situation quite different as to its principal integrating tendencies, of which the speaker is more or less completely unaware."[221]

Sullivan referred…to parataxis as one of three modes of human experience, developmentally intermediate between prototaxic [psychotic] and syntaxic [normal] experience. Parataxis, in this wider sense, includes non-rational (prelogical) intuitive processes, along with irrational and distorted experience.…[222]

In addition to triadic sources of parataxis [in the supervisory triangle], many other issues, such as characterological differences, different analytic styles, cognitive styles, uses of language, differences in metapsychology, world view, view of the client, and institutional pressures often provoke parataxic supervisory interaction….[But] There remains the issue of parataxis in the supervisory situation itself, stemming from transference-countertransference of supervisor and supervisee vis-à-vis each other….

In pyramid fashion, the supervisory relationship is a relationship about a relationship about other relationships. Both supervisee and supervisor interact in an interpersonal field in which each is, in Sullivan's words, a 'participant observer.' In the supervisory hour, the supervisee is not merely telling a teacher about the supervisee's relationship with another person (the client); the supervisee is constantly interacting and relating with the supervisor in the process. Irrational aspects of the supervisory relationship, when dissociated, inattended to, or inarticulated, will inevitably affect the therapeutic

> relationship by affecting the nature, use, or understanding of supervisory information about the therapeutic relationship….
>
> In supervision, as in all human relationships, parataxis is inevitable. Its shape and its consequences are, of course, infinitely varied. Supervisory parataxis may be minimal and relatively insignificant; or it may be intense, pervasive, and disruptive, in some instances leading to a supervisory impasse, and crisis. The point that I wish to emphasize is that when significant parataxic aspects of the supervisory relationship are not directly addressed in that relationship, they rob the supervisory situation of its potential richness as a learning experience and adversely impact on the therapy in which the supervisee is engaged. Collaboration in supervision does not imply the absence of parataxis, but rather a commitment to dialogue; that is, an openness to candid review of their participation by both supervisor and supervisee.[223]

Psychoanalytic researchers Caligor, Bromberg, and Meltzer report a number of trends from their supervisory research data that bear on the question of supervisory styles and methods. Their research involved a supervisor's group in which audiotapes of supervision sessions were played back and discussed with illuminating results. They report the following observations or patterns that have emerged.

> …Each supervisor has a very personal supervisory style that is identifiable when he or she is working with different supervisees. It is not based on the supervisor's theoretical orientation, which is in fact

> extremely hard to discern from listening to or observing a supervisory session. Instead, a supervisor's 'signature' seems to result in large part from those particular therapeutic events or issues in which he is interested or knowledgeable. For example, a supervisor may consistently single out dreams, or the client's first comments in the hour, or transference issues. He may consistently make his focus client centered or therapist centered. Or the supervisor may focus on the supervisory relationship itself, and so forth. There are also clear differences in the supervisor's attitude as to whether he sees himself or the supervisee as having ultimate responsibility for the case. Stylistic variability is also striking in the degree of formality with which the supervision is conducted and in the level of activity that the supervisor feels comfortable in bringing to the process. This includes the degree to which he is confrontational, the freedom he appears to feel in presenting his own ideas or giving alternative formulations, and how much a supervisor will tend to say—overall. While it is difficult to be more than speculative about stylistic variables and their sources, there is some degree of evidence from our observations that a certain supervisor will adopt a manner with the supervisee that he hopes will be a model of identification for the supervisee as an therapist.[224]

Strean, following Sullivan, notes that all clients, all therapists and all supervisors are more human than anything else and that all participants in the supervisory triad are subject to internal conflicts and infantile regressions when their life circumstances are

strained and/or when the supervisory context stimulates them. He notes that one place where senior therapists will be prone to countertransference problems is in the supervisory situation.

> Often the supervisor…assumes this role when his or her own children have left home and therefore it is a time when he or she is experiencing loss and often yearns to be a parent again. Consequently, many supervisors may unconsciously want to use the analytic therapist in the service of buttressing lowered self-esteem, refueling lost narcissism, or finding a lost child. Assuming a supervisory position is quite similar in many respects to becoming a parent. Therefore, the supervisor inevitably has to cope with old and new conflicts that emerge or reemerge from old and new parent-child relationships.
>
> Just as most analytic clients and therapists have the potential to collude with each other to gratify certain illusions of the client, such as the latter's yearning to be the therapist's favorite child, or to symbiose with the therapist and become omnipotent like the therapist appears to be, similar illusions can be present in the teaching-learning situation in which supervisor and supervisee can also collude. Supervisor and supervisee can share the illusion that the supervisor is omniscient whereas the therapist and client know next to nothing. They can suffer together from the illusion that the supervisor is exempt from pathology, ignorance, and blind spots, whereas the therapist and his or her client

> are both struggling to maintain their sanity. The learner and his or her mentor can delude themselves into believing that the supervisor's sexual and aggressive fantasies are in superb control whereas the client and the therapist are either too inhibited by their punitive superegos or too expressive because of their superego lacunae.[225]

Grinberg reminds us that although the supervisor has completed his own training therapy this does not mean he has overcome his neurotic or character conflicts. His can easily be re-opened and even worsened under certain circumstances. Grinberg believes that the supervisory situation especially invites old conflicts to be reawakened. As examples, he discusses paranoid and depressive trends in the supervisor's personality and how they may become activated to stifle learning.

> A supervisor with paranoid characteristics in his personality may have to face serious problems in the performance of his function. As he fears the therapist may try to deprive him of his original ideas, he will be very cautious in his teaching, giving as little of himself as possible and restricting his work to general concepts. He will avoid exposing himself to what he experiences as a theft of his concepts and ideas. Needless to say, a supervision that develops in this atmosphere is bound to be vitiated; it lacks an essential in teaching, namely the teacher's capacity to transmit his experience openly and deeply….This phenomenon appears, to a certain extent, in any teaching process and is part and parcel of the teacher–pupil relationship. As he communicates his knowledge the teacher cannot help feeling he is

> giving it away. The pupil will receive this knowledge and use it as if it were his own because of his having assimilated it….It has to be accepted that in this specific relationship the teacher gives and the pupil receives. It is what Erikson called the 'generativity', that is 'the concern in establishing and guiding the next generation'….
>
> There also exists the opposite case, that of a supervisor who has a depressive personality and a masochistic tendency in his work. Owing to his conflictual fantasies related to guilt feelings, this supervisor will endeavour to give all he knows and has in a compulsive way. He will find it hard to draw the line and the therapist will be overwhelmed by the avalanche of knowledge he receives.[226]

Jungian analyst Lionel Corbett highlights the importance of supervisors remaining perennially uncertain rather than presenting themselves defensively as bastions of knowledge. He addresses the problem of the supervisor's ignorance.

> One of the supervisor's worst difficulties is his area of ignorance, which burdens therapists most when it is denied or unconscious. This problem manifests itself in lofty attitudes of: 'my analysis and training were so good that I have all the answers, and now I'm just passing on the doctrine.' It is much more preferable to value one's own doubts. I used to bemoan the fact that my own analysis and training were incomplete, but now I see this fact as an essential part of my individuation. This incompleteness has forced me to constant inquiry, instead of allowing intellectual laziness, and I know that my own clients

> receive better treatment than I did. If the idea of being inadequately analyzed and trained is intolerable, one is then forced into an omniscient, defensive position which requires that we hold onto theory to make up for what we did not receive in our analysis and training. Adherence to theory is used to buttress self-esteem and stifle doubt, in ourselves and our supervisees. Such a supervisor deals with the therapist, and his colleagues, authoritatively instead of with an attitude of mutual exploration. As T.S. Elliot puts it, if we want to discover something, we must approach it by way of not knowing, not by way of already knowing….[227]

Another Jungian analyst, Wilke, expresses doubt about the essential connection between "old and wise" in the Jungian archetype of the Old Sage. He points out that our use of the myth of the wisdom of old age can be quite destructive.

> Guggenbühl-Craig considers our use of the myth of the Old Sage corrupt and prejudicial, helping instead to repress the reality of the weakness of old age. Biology and medicine teach us that the final and latest onto- and phylogenetic acquisitions are also the most vulnerable, easily damaged and diminished. Many abilities necessary for analysis and supervision are acquired later in life and therefore are more susceptible to being damaged or diminished by the aging process. According to my observation, there are three abilities specifically used for analytic training and teaching which, if impaired or destroyed by the

process of aging, strikingly affect the supervisor's performance and self-esteem.

1. The ability for self-critical perception and reflection which is especially cultivated during the analytic process.

2. The ability to monitor with a preverbal sensibility the social interactions in analysis and supervision with a special attention to a sense of shame and tact. This ability is a part of the sensation function and it enables us to perceive and respect the other's threshold of shame, avoiding embarrassment.

3. The ability to cultivate and maintain an extroverted interest in the particulars of the outer, concrete world. As we age, this ability often gives way to a more introverted attitude and an interest in more basic and general concerns.

Wilke confesses that after 25 years of being a supervisor that trainees often become amused at different topics that interest him. Only a few years ago he would have been embarrassed but now he is used to feeling out of date.

> I share only in a limited way the interest of the trainees, their fascination with new theories of neurosis, the mind, and human beings. At this point in my life, I am more interested in general, unvarying, constant factors; expressing simple things in a clear way; finding expressions and formulas in language which simply summarize a whole variety of things. At this stage of life, my point of view bundles the ‘whole variety’ into simple formulas. The trainee may consider such

simple formulas in our profession as no more than a verse from the 'Maxim of the People.' But, perhaps such formulations are an essential part of the meaning and world view of this stage of life. Perhaps such simple formulations will help our trainees better understand the psychological life of the elderly….

Denying the natural process of aging with the help of the archetype of the Old Sage can produce a generation gap, through which understanding and interaction may be impeded. In supervision most problems of aging are produced by the reduction of self-critical perception and reflection, a reduced threshold of shame and the increase of introversion. In order to reduce the resultant conflict dynamic, the authority-oriented-learning experienced during training might be compensated by introducing learning in peer-groups.[228]

Four psychoanalysts in training, Martin, Mayerson, Olsen and Wiberg, in the late 1970's became concerned about a series of problems in psychoanalytic supervision and set out to provide some guidelines that have greatly impacted subsequent training. Out of this study evolved an important document for evaluating supervisors, the main dimensions of which are still in use in many locales.

Evaluation of Therapeutic Supervision

1. How well does the supervisor make a clinical evaluation of the client?

   a. Strengths and weaknesses

   b. The various metapsychological [theoretical] points of view

2. How well does the supervisor facilitate the therapist's understanding of the therapeutic process:

   a. Technical issues in the beginning phase—office arrangement, fees, missed appointments, etc.

   b. Development of the therapeutic alliance

   c. Identification and use of unconscious themes and constellations

   d. Use of dreams

   e. Identification and use of transference and countertransference reactions to the client

   f. Analysis of the defense transference(s) [resistances]

   g. Development and resolution of the transference neurosis

   h. Working through

   i. Termination

3. How well does the supervisor work with the therapist around issues that arise in the supervisor-therapist relationship:

   a. An ongoing evaluation of the therapist's learning needs and the learning process—making an [ongoing] educational diagnosis

   b. The development of a learning alliance

   c. Identifying and working with transference and countertransference reactions within the supervisor-therapist relationship

   d. Detection of both growth and regression in the changing needs of the therapist

   e. Facilitating the development of the therapist's own, individual therapeutic style

   f. Working toward a collaborative supervisory relationship and, ultimately, independent therapy

   g. Ability to facilitate self-analysis on the part of the therapist

4. How well does the supervisor:

   a. Work with beginning versus advanced cases

b. Adjust his supervisory technique according to the learning needs of the therapist at that point in his training.[229]

Reporting on several years of workshop experiences at the International Congresses for Analytical Psychology, Speicher has much to report on the ideal qualifications and qualities of good and bad supervisors. But of significant impact to a supervisor's way of working and ways of self-improvement is the supervisor's willingness to reflect questioningly on her own supervisory experiences.

> Reflection on one's personal experience of being supervised leads to increased awareness of the supervisory process. It is a consciousness-raising endeavor. Questions to be explored might include: What were the styles of my supervisors? Which style of supervision was the most useful (and least useful) to me at what point in training? Why? What were the gaps in my supervisory experience as a therapist? How would I wish to fill them? What functions of supervision were most relevant in the training process: focus on learning needs; focus on practice, clinical understanding, combining of theory and practice; understanding the client, the analytic process, the intrapsychic and interpersonal dynamics, the personal and/or archetypal aspects, the transferential field, issues of personal development that affected the analytic field? What was my experience of the interplay between the teaching and the evaluative aspect of supervision? Were evaluations discussed? If not, why not? How would I have liked to see them handled? As prospective supervisors review

and discuss their experiences, awareness of important components of the supervisory process will increase.[230]

In this supervisory relational perspective we have noted many ideas about what goes into good and bad supervision. French psychoanalyst Lebovici does perhaps the best job of summing things up.

> It is generally accepted that the responsibility for supervising therapists rests with the more experienced therapists. But…supervision is not the teaching of technique. It is a relationship between two persons which requires knowledge of all the subtle transference displacements that are facilitated and complicated by the therapist's personal analysis. Supervision is a pedagogy of confrontations and concerted efforts, and requires that the therapist in charge of it does not use the authority conferred on him by experience to assert himself dogmatically, and that he allow the therapist to see him functioning in his presence as a therapist elaborating upon the analytic process which is being developed in the client of the therapist. It requires that the supervisor keep a certain control over the treatment without totally neglecting the interests of the client. Finally it is a method of evaluation of the future therapist's aptitudes.
>
> For all these reasons we should organize the transmission of the techniques and methods of supervision. This does not mean that we should proceed to give theoretical teaching of supervision, but rather that we should consider the possibility of supervising the therapists

> who are in charge of it. The training of therapist supervisors could be carried out through seminars or groups of both experienced and younger supervisors who could attend with the purpose of confronting their cases. We could also think of having the future supervisor attend or participate in an *ongoing* supervision [as part of the requirement for being a supervisor].[231]

Case Study: Fiscalini: Parataxic Distortion in Supervision[232]

Fiscalini describes one of his own early supervised cases, an aspiring young journalist. The client is described as a narcissistic and paranoid man who sought therapy because he felt stuck in moving forward in his profession and his relationships. His father died when he was very young and he had been raised as a “special” child by his depressed, insecure and overwhelmed mother who still maintained a symbiotic relationship with her mother. Fiscalini initially sympathized with his client who took a passive-dependent position characterized by perfectionism, projection and defensive use of abstract language, all of which gave him a forlorn and "sad-sack" quality in his awkward and tense physical manner.

Initially the client angrily complained of how he was taken advantage of by everyone in his life. “He was unaware of how his injustice-collecting, ‘helplessness,’ and self-justification covered his lack of responsibility and desire to have others take care of him, and also masked his profound feelings of inferiority and inadequacy.”[233] He reports that his supervision focused on his hesitancy to inquire in detail and on his selective inattention to the client’s narcissistic expectations.

> My supervisor emphasized the importance of confronting the patient's hostile security operations and his self-centered disregard of others. In the analytic relationship, I began to attend more closely to the patient's transferential competitiveness, contempt, and hostility toward me which previously I had unconsciously parried and not confronted or inquired about. My countertransferential blindness to the patient's hostility and grandiosity stemmed in part from my countertransference wish to like him, to think paternally of him as a hurt orphan (as he thought of himself) who needed comfort and reassurance, and my wish to avoid his rage….These countertransference trends were, of course, multiply rooted in my personal history, and reflected, in part, some identification with the patient. (p. 594)

Fiscalini reports that under the influence of supervision his initial sympathy with the client's plight gave way to interpretations that highlighted his "hostile and alienating defensive operations." For example, when he was angry at his girlfriend's wish to end the relationship, Fiscalini focused on his "faultfinding, provocativeness, and insatiable demandingness." With hindsight Fiscalini can see that while he was focusing on valid therapeutic issues, they missed what his client most needed at the moment. In this example he had missed the man's terror of separation which was compounded by the therapist's abandoning interventions.

> During this phase of our work, I thought, at times, uneasily,… that I was focusing too narrowly on the darker side of the patient's psyche, perhaps even exaggerating it. I dismissed these intuitions as residuals

> of my earlier countertransference; that is, as indicative of my earlier analytic timidity and over-protectiveness….I did not raise these questions with the supervisor for complex transferential reasons. Thus, I precluded the possibility of consensually validating my…experience. My (transferential) [distancing] difficulties with the supervisor, manifested in our dialogue, meant, in other words, that I was not able to confirm my intuitions or to correct them….[234]

Fiscalini transferred to a second supervisor who was able to show him his parataxic difficulty—that his anxiety and anger in the therapy as well as in the supervisory relationship made it difficult to approach the client's experience with sensitivity.

> I began to see his pathology from a more empathic perspective, recognizing its survival value….The patient, in turn, became less defensive and felt more understood.
>
> In the supervisory situation, the supervisor focused on my anxiety in the supervision as well as on my anxiety in the therapy. The supervisor's initiative in addressing this directly and respectfully opened the way to a more candid relationship in which I felt more free to express my thoughts and perceptions and to examine differences or disagreements with the supervisor. This more candid dialogue included a frank review of my transferential difficulties with supervisory authority, both in the previous supervisory situation and in this one….The supervisor welcomed my perceptions and thoughts about the analytic (and supervisory) processes. With this focus, a more

> collaborative experience in the therapy and in the supervision was facilitated….No longer adversaries, the patient and I explored collaboratively the salient analytic issues.[235]

Fiscalini realized retrospectively that his countertransference was revealed in the therapy as well as in the supervisory parataxis. In supervision he was a compliant student rather than "a collaborative participant supervisee who could discuss openly, disagree with, and eventually clarify, integrate, or resolve possibly differing viewpoints or emphases."[236]

Relational Perspective 10

Different Theoretical Approaches to Supervision

Until quite recently supervision was simply assumed to be a matter of one practitioner with more experience and skill teaching another practitioner with less experience and skill what she knew. But, as this book has amply demonstrated, more careful scrutiny during the past few decades has made clear that supervision is a relational process that exists on a different plane of abstraction than clinical practice and didactic teaching and that the skillful practice of supervision requires its own considerations and its own learning processes. Training programs for supervisors are rapidly spreading throughout the clinical disciplines as supervisors attempt to delineate and teach the skills of supervision.

It's fair to say that the most important dawning realization is that clinical supervision is itself *a relationship* through which things that cannot be taught didactically can be learned relationally—if both participants are willing and able to surrender themselves to a mutually enhancing relational learning experience. Expectably, each school of psychotherapy uses its own familiar terms and concepts to characterize and study its own expanding vision of the supervisory relationship.

Taking a look at these various slants on the supervisory process has enriched my understanding of what may be at stake in the supervisory learning process. In what follows I make no attempt at being comprehensive nor do I offer a critique, but rather I seek to be suggestive of what thoughts are brewing in various theoretical quarters.

1. A Bionian Approach

Wilfred Bion was a British psychoanalyst who was particularly concerned with how human beings learn to think and to create meanings together. Bionian analyst Yorke focuses attention on "how mind is created from what is known, but unknown, within and between the supervisee and supervisor, through the realizing of meaning that can become available for thinking and ultimately understanding."[237] Yorke reminds us that the one-place-removed reporting of what's going on in therapy—even when aided by recording devices—leaves many gaps in the understanding of *psychic meaning*. Writes Yorke, in order "to gain access to meaning *there has to be an engagement of minds*; only [interacting] minds can deal in meaning.[238] True, we can observe behaviors, study techniques, and apply theories, but when it comes to two people spontaneously engaging one another, together they create a plethora of conscious and unconscious personal meanings that can only be sorted out by the two of them paying close attention to and studying together what is going on inside, between, and around them.

In Bion's book, *Transformations*[239], he uses the metaphor of an artist painting a field of poppies. The field of poppies is an ultimate reality [labeled by Bion as "O"] that cannot be directly known. The artist's *experience* of the field of poppies is represented by paint on a canvas. The artist's *work* is the transformation from her perception of the field into the painted picture. "Following this analogy, supervision is not a reproduction of the therapeutic session, but one in which the supervisee will always give the supervisor something of *the experience* of the therapeutic work, provided the supervisor is receptive and able to understand his or her perceptions."[240] Post-realism and abstract art have liberated us from the tyranny of believing the truth of what is portrayed, instead

allowing us to have an experience of our own which might only approximate the truth of the subject or the artist. “In supervision the reconstructed session or the verbatim account can [be viewed similarly]. If such a reconstructed session is regarded as the true subject, this can create a tyranny whereby the unconscious, allusive and invisible communications and meanings remain unrealized…. Subjective intuitive processes are often mistaken for feeling, but feeling is a rational function of the psyche. The *psychic* dimension is irrational, and access to it in supervision requires skills with intuitive and irrational methods of working. It is this aspect of supervision—that is, the irrational aspects of the experience with the supervisee—which is the 'royal road' to the exhibition of ‘O’ as the supervisory object. Its unknowable truth, and ultimate reality, is not accessible merely in the reconstruction.”[241]

To readers unfamiliar with Bion’s theories of meaning these formulations may at first seem difficult to grasp. But the bottom line is that whatever that elusive fox of the therapeutic relationship is about, its whereabouts is even more elusive in the once-removed situation of supervision. It seems that Yorke in his own Bionian way is echoing the growing awareness that at least some aspects of the elusive relational truths of therapy can become known as two create in supervision their own personal and irrational experiences and perceptions of the relational realities at play. Bion himself used strange, idiosyncratic, and non-rational procedures in therapy and teaching and Bionian supervisors are trained how to be relationally present in ways that probe and search out the supervisory situation for clues to relational meanings that are being generated in the therapeutic dyad as well as in the supervisory dyad. To go beyond this

brief summary would be to enter the complex world of Bionian analysis which is beyond the scope of this book.

2. A Jungian Approach

Jungian analyst Kruger notes that there are different kinds of Jungian supervisors. There is, “for example, the holding and confirming supervisor who sits in silence saying almost nothing, the pedagogical supervisor who teaches theory and technique, and who amplifies through mythological images and cross cultural parallels, the metatherapeutic supervisor who approaches supervision largely as an extension of the therapist's analysis, the Zen supervisor who continuously creates an atmosphere of creative disorganization, constantly calling into question the therapist’s unconscious assumptions and fantasies. And, there are, of course, many half breeds of these, as well as many other styles of supervision. How do we become more aware of our own unique approach to supervision and remain conscious of its shadow aspects?”[242]

Kruger further asks, “How [do Jungian typologies] influence the supervisor? Does a feeling type focus more on empathy, while a thinking type emphasizes insight and consciousness? Does the intuitive supervisor look to the capacity for imagination, while the sensation type values more engagement with reality? And how does the typology of the therapist impact on supervision?”[243] We might add, how does the typology of the supervisor impact the therapist and, in turn by reflection, the therapeutic relationship and the client?

In writing about the greatly respected Jungian supervisor, Michael Fordham’s, approach to supervision, Moore writes:

> Fordham holds that skills are wanted and should be acquired, theory being essential, but that it comes from seminars, not from supervision. He does not give trainees a theoretical framework into which their observations may be fitted, but tries to convey his experience and encourages their own gifts, so avoiding the danger of indoctrination and making possible an empirical, not doctrinal, encounter….An open system view, in which therapist is engaged totally with a client, is taught by Fordham….This open system view, when applied to interpretations, means that their timing takes the therapist as well as client into account in any interchange. This makes for complexity. …An open system implies being unsystematic by intention, with total reaction to the client, countertransference then becoming a source of information and a therapeutic influence on the client….Such a view may mean the supervisee must allow himself not to know what is going on, and to start each session as if he knew nothing of the client….In almost any interview, the therapist may experience hesitations, doubts, groping the dark and false clues that, in the end, lead to a favorable outcome expressed, in each interview, in one or more interpretations that the client could use.[244]

Jungian analyst Corbett invokes the *mentor archetype* to describe the supervisory process:

> Etymologically, according to the *Oxford English Dictionary*, the word 'mentor' means an advisor, from the root men, meaning to remember,

think or counsel. Mythically, the name belonged to an Ithacan noble, a friend of Ulysses. Athena assumed the form of Mentor when she wished to guide and advise Ulysses' young son, Telemachus, during his search for his father. In this mythologem can be seen many of the archetypal elements of mentorship. The search for the qualities of father among the young is facilitated by an older figure, father-like but not exactly father, who is able to embody wisdom, specifically Athena-like qualities. Although Athena is especially a protector and advisor of heroic men, the mentor-mentee relationship is of course found among women, and also between women and men, either one of whom may assume the mentor role.

The mentor is an analog of the 'good enough parent'; he or she fosters development by believing in the mentee and blessing his or her dream. But, importantly, the mentor is not a parent, but rather a transitional figure, allowing the mentee to shift from immaturity to becoming a peer with other adults. Here two additional comments are necessary. First, that the supervisee's relationship with the supervisor, which results in the internalization of technical knowledge and a philosophy of treatment, must be used to build up the professional aptitudes of the supervisee in his own unique way, so that he becomes his own type of therapist, without gross identification with the supervisor. Second, a certain degree of manageable disappointment in the supervisor-mentor is essential for the growth of the trainee. As long as the degree of such

> failure is optimal, it will allow the trainee to take over for himself those functions of the supervisor which he previously relied on his mentor to provide. *The mentor must allow this disappointment to occur, based on his or her inevitable shortcomings, without suffering narcissistic injury, realizing its importance for the supervisee's development.* Indeed, the supervisor's weaknesses can become springboards for the trainee's further knowledge, if the supervisor encourages him to pursue these areas.[245]

Another Jungian analyst, Astor, likens the supervisory experience to Perceval's search for the Holy Grail. He is particularly interested in the value of finding supervision *after* formal training and certification are complete.

> Perceval had a problem of initiation into his quest for the Grail in much the same way as trainees have problems becoming therapists and being apprentices….Towards the end of Perceval's struggle (his training) he discovers the hermit….[The hermit] has something of the wise old man about him, is facilitating and nonjudgmental. He represents the move away from the search for the 'correct' interpretation to 'negative capability'….Perceval [began his training] with the idea that the way to get what he wants is to take it. Indeed, he is advised by his mother that if he fancies a girl's ring he should take it from her finger, and soon after doing just that he kills the Red Knight to get his armor. …[But]…He has to acquire a proper place at the Round Table before he is eligible for the Grail question. …All this constitutes a

long and arduous training to make him worthy of the Grail….The parallels with the training of therapists can be seen here. The crude beginning, the need for training, the requirements of conformity, the loss of initiative and curiosity that trainings produce. …The initial taking of the ring and the armor I liken to the too swift taking up of the supervisor's ideas and knowledge, which are then applied without conviction, not followed up but die…. Of special interest to me is Perceval's experience of the hermit's teaching, which 1 liken to seeking out your own supervisor once the experience of the training and its limitations and virtues have been assimilated. This could be a person, or possibly a group, or for some it comes from immersion in the published work of Jung. Perceval's development, like the therapist's, needs this whole process from its naive beginnings, through the arduous apprenticeship to the eventual recognition of the value of the hermit in maintaining the search for the Grail….Supervision becomes a chewing over, reflecting on, and scrutinizing of the interactions in the session with the opportunity of having the material listened to by another therapist as if it was their own…. But once this has occurred, it has been my experience both as a supervisor of graduates' work and as a supervisee, taking my own work to a supervisor, that this second supervision and concomitant immersion is where individual development can lead to the discovery of your own analytic voice. [246]

Astor further points out that post-training supervision allows us to counteract the "dead hand of inner institutionalization" in our quest for our own creativity, our own Holy Grail, in which work and heart's desire come to merge imperceptibly.

3. A Self Psychological Approach

Earlier in Schindieheim's dream of the lifeguard chair I introduced the Self Psychological approach to supervision. Heinz Kohut in his development of Self Psychology formulated two separate life-long lines of development—love of others (object love) and love of self (narcissism)—and taught that we always need affirming resonance from others whom we use as parts of ourselves (selfobjects), especially in times of stress. Supervision certainly qualifies as a time of stress for therapists in training. Teitelbaum cites Allphin as saying,

> Since the supervisor often is a selfobject for the therapist, Kohut's ideas about the mirroring and idealizing transferences which occur in therapy are relevant to the supervisory process. Therapists… go through something similar to what clients do in their need for mirroring. That is, therapists need to feel validated, acknowledged and understood for what they feel and do….Therapists also often need to idealize supervisors. Idealizing meets the need to feel powerful and affirmed as a result of having a relationship with someone who seems stronger and who can be a guide in learning and development, until one can experience more of his or her own strength and knowledge.[247]

Self Psychologists Jacobs, David and Meyer have much to say about Kohut's contributions to our understanding of supervision.

> Kohut's contributions have also greatly influenced the conduct of supervision by heightening our awareness of the development of the sense of self and the vagaries of injuries to self-esteem, not only in the clients reported upon but in the supervisees themselves. His work…has made us more attuned to the possibilities for shame and humiliation in supervision, an educational process that calls for an ongoing revision of the sense of self. [It has been] pointed out that the therapist's… sense of identity…opposes the pressures and expectations of training. The necessary change in her sense of herself could not be realized without considerable disruption and disorganization in her existing ways of thinking and behaving. From this would proceed reorganization and a new professional self.[248]

Case Study: Martino: A Mirroring Selfobject Experience[249]

Martino skillfully applies Kohut's concept of mirror transference to a problem that came up with one of his student supervisees. The therapist had explicitly requested that Martino help him listen to the latent content of his sessions since he had become skilled at responding to the manifest content. Accordingly in a session that followed the therapist presented a therapy session in which it seemed clear that the client had experienced a narcissistic injury in one of their interactions. The incident in question seemed thematic in terms of what all three—client, therapist, and supervisor—had previously agreed was a repetitive problematic relational event. Martino spontaneously

commented on it, but his intervention was too early so that the therapist experienced it as an interruption of the flow of his presentation so that he became rigid and defensively pushed forward his new point. Martino attempts to understand why the disparity between the new understanding and the one that had been previously established that he had commented on. The supervisee withdrew and was then unable to articulate his new understanding. Both experienced an impasse that Martino attempts to formulate with a parallel process perspective. Martino re-stated the core conflict and attempted to show how it permeated both relationships in parallel fashion—to little avail.

> After my feeble attempt at having us both acknowledge our parts in a possible enactment of the core dynamics of the patient being discussed, it still seemed as though something much more real and immediate had taken place between us that had not been attended to. I reconsidered the moments just prior to his presenting this particular session and recalled his look of pride and his opening comments about the fact that the patient had cried in a session for the first time with him. Clearly the supervisee's need at that moment was not to have me follow along as in the usual process of a session, but instead was to have me provide a mirroring selfobject experience. I had failed him in that I did not allow him to present a piece of what was "good work" in its entirety, without interruption, and then to be appropriately commended for it. Upon reflection I then said to him, "I think I missed the boat here in terms of what it was that you were looking for from me today. You really felt a sense of accomplishment with this patient

because of the amount of affect that had emerged during this session. I think that you wanted me to be a witness to your good work, and I came in too soon with what I thought the patient meant. You needed me to allow you to present the session in full as it unfolded to the place where you felt you had facilitated a breakthrough with her." I observed that his rather rigid posture had softened quite a bit and he replied, "I'm really glad you said that. I was also aware that we were derailed and wasn't quite sure what I was feeling until now."[250]

Case Study: Martino: The Need for Selfobject Experience in Supervision[251]

Martino reports on the supervision of a case of a young man who wanted therapy so he could compete better in his doctoral program. The client experienced severe anxiety that occasionally necessitated spending several days in bed. Both parents were high achievers with advanced degrees in their professions. For as long as he could remember they were emotionally distant, often missing cues that he needed emotional attunement. They both emphasized academic achievement and held to the maxim, 'You are what you achieve." The parents' inability to provide soothing and consolidating selfobject experiences left him with few mechanisms to fall back on other than taking pride in his intellectual achievements so that the transference took on a highly intellectualized debate-like quality in which the client would dominate each session recounting his achievements.

The therapist was a bright and articulate doctoral candidate whose transference to his client focused on his higher functioning attributes. He presented sessions in supervision with an admiration for his client's intellectual capacities and he formulated

his interpretations on what he viewed as oedipal strivings and conflicts rather than on pre-oedipal deficits. The transference interpretations expectably created a distancing effect in the relationship between therapist and client, and the client could only respond to the therapist with superficial compliance and in short order began to exhibit symptoms of fragmentation.

> Parallel to the empathic failure on the part of my supervisee to recognize [the client's selfobject longings] was my own empathic failure in relation to the supervisee. I, too, failed to consider… the selfobject need and motivational priority of the moment (motivation as it relates to self-cohesion and the pursuit of selfobject experiences that eventuate in the shaping of a sense of self). In fact, the teaching point that I was making about the case was the very same matter that had caused a failed selfobject experience for my supervisee.[252]

In one supervisory session the therapist seemed caught in an enactment of the parents' grandiose and idealizing expectations. In being enthusiastic and supportive of the client's accomplishments the therapist had unwittingly replicated the parental roles in the therapy. This interaction resulted in increasing fragmentation leading to missed sessions. In supervision Martino attempted to get his supervisee to reflect on what was transpiring in the interaction. He decided to introduce the notion that the client's grandiosity about his ambitions was a defense against his fragile self—"a self that never had the opportunity to explore his unique self-experience around phase-appropriate ambitions and skills, or to appropriately integrate the feeling states which accompany these strivings."[253] The supervisee responded with, "Well, that's your opinion."

Martino realized that this impasse has resulted from his own need to have his supervisee understand his way of formulating the case when it was quite discrepant from the way the therapist understood the case.

> In the subsequent session I explored with him the experience of the previous session. He described feeling force fed by me and he revealed that he had experienced a level of anxiety that impeded his ability to hold on to his way of organizing his understanding of the case. After acknowledging my failure and then supplying a much-needed mirroring selfobject experience, he was able to reconstitute and further explore his points about the priority he had given to the oedipal strivings of the patient. In addition to the mirroring selfobject experience, there was another type of selfobject experience that was needed by the supervisee. For the first time he was exhibiting with me the importance of an [idealized] adversarial selfobject experience…which I had failed to recognize in the process of the moment. In the very same way the patient was struggling with his self-object needs versus his autonomy, so too was my supervisee. His need was to experience a developing professional self in opposition to me, and thus to confirm a partial sense of autonomy without risking the loss of any self-sustaining responsiveness from me….I had failed to recognize that the acquisition of skill was secondary. More important was the provision of a selfobject experience that would function to

> maintain the structure and cohesion of his developing professional self.[254]

Martino holds that in order for supervisees to be able to take in new and discrepant points of view it is necessary for the supervisor to assess the order of the therapist's learning priorities—starting with an assessment of the therapist's selfobject needs. He reports that when his supervisee's professional selfobject needs were attended to it was possible to establish a more mutual collaborative working relationship.

4. An Intersubjective Approach

Intersubjective theory highlights the intricacies involved when the two subjective worlds of experience brought by client and therapist enter into an intersubjective field—often designated as the third vector or subject in an interpersonal engagement. Earlier in this book I introduced the work of Robert Stolorow and his colleagues in intersubjective theory and practice. This same understanding can be used to study the intersubjective field created by therapist and supervisor in what has been called by intersubjective theorists Brown and Miller, a "triadic intersubjective matrix." They state, "the intersubjective field, whether dyadic or triadic, is not only an arena in which the subjectivities of the participants interact, but [in which]…the interactions of the subjectivities create a new superordinate subjectivity that has a life of its own in the intersubjective field."[255] This formulation is consistent with Ogden's concept of a third overarching force impacting any dyadic relationship and with my formulation earlier in this book of a "fifth voice" that "speaks" to participants in the client-therapist-supervisor triadic transference-countertransference matrix.

Speaking of the intersubjective field created by the supervisory triad, Berman says,

> An intersubjective focus cannot be limited, however, to the therapist and client alone. It also pulls us into the intersubjective reality created between supervisor and supervisee. We might think of supervision as the crossroads of a matrix of object relations of at least three persons each bringing her or his psychic reality into the bargain, creating a joint intersubjective milieu….The supervisor-supervisee relationship, I suggest, is always a rich and complex transference/countertransference combination, even if supervision is utterly impersonal teachers are always a major focus of transference feelings. Naturally, the more personal approach I advocate may add complexity and intensity to the process. It may undermine some of the more defensive modes of avoiding anxiety in the situation and increase the fear of intrusion and humiliation. On the other hand, as a partial remedy, it may allow greater awareness and better resolution of supervisory conflicts and crises, by encouraging the joint exploration of the supervisory relationship itself. The supervisor's fuller awareness of moments in which he or she was experienced as intrusive or insensitive, for example, may make reparation possible and serve as a springboard for more tactful work, taking better into account the supervisee's sensitivities, once these were more openly articulated….An intersubjective focus should turn difficulties in the supervisory relationship into a legitimate topic within the supervisory

> discourse. Their avoidance may pose a bad role model, undermining the supervisor's encouragement of constant attention to affective nuances in the analytic relationship and of their bold verbalisation. Empathy towards the client that is unaccompanied by empathy towards the supervisee is a confusing mixed message… Acknowledgement of the supervisor's possible role in difficulties… is not only crucial in creating a non-threatening atmosphere, but is also vital for a rich truthful understanding of the dyadic process.[256]

It is fair to say that, perhaps more than any others, the thinking of Kohut and the Self Psychologists in the analysis of selfobject experiences and of the works of Stolorow and his colleagues in the analysis of intersubjective engagements have profoundly affected not only contemporary understandings of the relational underpinnings psychotherapy, but also the evolving relational practices of supervision that call for a critical and respectful examination of the participation of the therapist and supervisor in their respective roles of the supervisory triangle.

Case Study: Brown and Miller: The *Triadic* Intersubjective Matrix[257]

In the curious trialogue to be reported, the supervisor, Dr. M., recounted a dream he had and disclosed to the therapist, Dr. B. The disclosure prompted a dream by Dr. B, which was also discussed by the two. The two dreams led to a discussion of the parallel process and the triadic intersubjective matrix they were involved in. Shortly thereafter the client, Jon, produced a dream that enabled supervisor and therapist to see how enmeshed the three psychologies were with each other and how all three were colluding in a resistance to a three-way termination in which they were all participating.

The case study is rich in detail so I can only skim across the surface to highlight the three way intersubjective matrix that appeared.

The client, Jon, was in therapy with Dr. B from ages 13 to 18. He had been brought because of poor school performance, a lack of friends, and underlying troubling feelings.

Jon's resistances blossomed in full force and were expressed through many missed sessions. His helplessness wooed Dr. B into giving advice and help which Jon then found inadequate and refused. The therapy was arduous and trying for Dr. B but Dr. M was able to encourage him to hang in there with confidence that in the long run the relationship would pay off. As high school graduation approached Jon announced his intention of going away to college. When Dr. B mentions the therapy coming to a close Jon jokes that he will take Dr. B along to be his “shrink on call.”[258]

When Jon was at the height of resisting his termination feelings, the supervisor Dr. M, had a dream: *Dr. B was giving Dr. M a haircut* and there was some anxiety connected with the dream. Dr. M offered some associations about ‘coming of age’ and anxieties about the younger generation taking over. Shortly afterwards, Dr. B dreamed:

> I'm watching John Travolta, who is sitting somewhat slouched in a plain black straight chair. He's wearing a grey, full-body, work suit with a zipper or buttons down the front. It has short sleeves. There's a man behind him who I can't make out. He has an electric razor and is going to shave him. He starts to shave the back of the neck and upper shoulders. It is pleasurable to J. T. and I can identify with the pleasure. The work suit is loosely fitting and the man puts his hand through the

> right arm opening and starts to shave J. T.'s chest from under the garment. An uneasy feeling starts to develop. He moves the shaver around his chest and then removes his hand. I notice a round hole in the garment around J. T.'s crotch. I start to feel increased anxiety as he moves his hand towards this hole with the shaver buzzing. I awaken feeling scared.[259]

Though Dr. B and Dr. M were both personally involved themselves in graduations of sorts, it seemed clear that both dreams dealt with the coming of age of Jon and of the simultaneous ending of the supervisory relationship. As they discussed Jon's therapy it became clear that Dr. B's interpretations had addressed Jon's defenses against sadness and loss but had not yet dealt with the frightening aspects of growing up, of becoming one's own man. Shortly after this discussion

> Jon dreamed that he was sad to say goodbye to his best friend, A, and learned that A was dying of AIDS. This sadness turned to terror as Jon discovered in the dream that he too had AIDS, having contracted it from A. A explained that they had anal intercourse in childhood, that A's living cells remained inside Jon, and that these cells had become infected with the AIDS virus.[260]

Discussion of the dream led Jon to acknowledge his homosexual anxieties as he considered what aspects of Dr. B and his father would remain inside him. With affect he acknowledged the intrusiveness and abusiveness of his father and how he had acted

provocatively toward Dr. B in order to invite intrusiveness in the transference. Jon missed no more sessions for the two remaining months of therapy.

Brown and Miller discuss the dynamics of the case in detail but focus in particular on the *three-way intersubjective matrix* and how three psychologies had conspired not only to deny separation but to resist coming of age anxieties that universally recur in one form or another for a lifetime. They note that in keeping with Ogden's formulations of the intersubjective field, that the three interacting subjectivities create a superordinate subjectivity that has a life of its own. In this sense then dreams no longer are the exclusive possession of the individual dreamer but take on the cast of all participating subjectivities. They further cite Berman's views on the triadic intersubjective matrix that forms when there is a supervisory triad in which all participants are inextricably psychologically tied to one another.

Brown and Miller conclude that an intersubjective matrix is active in all supervisory situations. But the extent that it can be relied on to shed light on the transferences and countertransferences involved is dependent on the ability and willingness of all participants to disclose and discuss the processes involved and their subjective reactions to them.

5. A "Modern" Approach

The school of "modern psychoanalysis" as spearheaded by Hyman Spotnitz some years ago is aimed at treating profoundly disturbed individuals wherein repression or dissociation of murderous rage either at the self or at others is a central issue. While this is not the place to discuss the theory or techniques of "modern psychoanalysis," I want to cite a paper on supervision authored by Spotnitz himself that, while seeming

radically different from most other approaches, is uncannily similar in its emphasis that the *supervisory relationship itself is central to developing and sustaining a robust treatment process.* Spotnitz sees three goals in his approach to supervision.

> The first goal is to enhance the therapist's understanding of the client's psychodynamics….The second goal is to help the therapist tolerate the feelings that are induced in him in the treatment relationship with a schizophrenic client and to use these feelings to facilitate the progress of the case….The third goal of this method of supervision is to help the therapist communicate appropriately with the client….
>
> The supervisory relationship is not an appropriate framework for purely intellectual learning. The therapist is given the freedom to learn experientially and piecemeal, and usually he learns from the client himself. The therapeutic rationale for the case he is treating under supervision is thus developed indirectly. For instance, after observing the client's characteristic modes of dealing with aggressive impulses, the therapist may ask why the client attacks himself or why he is silent rather than coming out with his hostility. The therapist is encouraged, by questions and directions, to formulate his own explanations of the client's behavior and therapeutic needs in the immediate situation.
>
> In addition to reporting the feelings and thoughts verbalized by the client he is treating, the therapist is helped to report his own reactions to these thoughts and feelings. He is very much inclined to fear such reactions in himself, and he is also afraid to base his interventions on

> such emotional understanding of the client. Thus the therapist requires a great deal of help in recognizing and understanding the feelings that the client induces in him….The purpose of helping the therapist recognize and report his feelings and thoughts is to get him to experience his own resistance. The therapist experiences much self-opposition to becoming aware of his thoughts and feelings about the client, particularly those that are realistically provoked by a client's dangerous or threatening behavior and communications….
>
> The supervisor also needs to become aware of his own negative feelings for the supervisee….If the supervisor is unable to deal with his own negative feelings appropriately, the supervisee will be inhibited from revealing his true feelings about the supervisory relationship, from expressing criticism of the supervisor, or from asking him for one or another type of assistance that the supervisor has failed to provide.

Over time it has become clear to therapists and supervisors everywhere that dealing with what are generally called primitive or psychotic psychological constellations in people requires specialized techniques and a more direct relational intervention style that is taxing for most therapists. Modern psychoanalysis in this form of resistance training seeks to liberate resistances to therapists experiencing their own primitive parts and to being able to use their own strong feelings in the therapeutic relationship.

6. An Interpersonal Approach

Interpersonal supervision has developed simultaneously with Interpersonal theory and practice of therapy so that the supervisor is implicitly understood to be a participant

in the process. Just as transference and countertransference are seen as complex interactive phenomena in the therapeutic relationship they are understood to be equally viable in the supervisory relationship that exists in a yet more complex triadic field. Interpersonalist Sugg summarizes several interpersonal views on supervision.

> Goldberg (1990) classifies models of supervision on the basis of how the client, therapist, and supervisor are organized in an interactive triadic field. According to his schema, the different models of supervision are: (1) client-focused, concerned mostly with history and psychodynamics of the client and interpretation; (2) therapist-centered, concerned primarily with countertransference, counteridentification, and so on; (3) process-focused, in which the triadic field is explored; (4) supervision process, in which the supervision itself is the focus of supervision.

Some Interpersonalists, such as Fiscalini,[261] see the creation of transference and countertransference between therapist and supervisor as something occurring in its own right and not necessarily something passed on from client-therapist to therapist-supervisor. This conception focuses on the supervisory process itself and can be seen as what Goldberg describes as the fourth model of supervision, in which the supervisory focus is on the supervisory process itself. From this supervisory perspective, the supervisor-supervisee relationship can be explored with a subsequent effect on the analysis. As Fiscalini states: “Perhaps it is axiomatic…that the dyadic relationships within the supervisory triangle of client-therapist-supervisor may provoke triadic consequences for both. That the nature and quality of the supervisory relationship will

affect and influence the analytic relationship seems self-evident. After all, the supervisory situation is arranged explicitly to have impact on the analysis and the therapist."[262] Further,

> In this expanded view of the supervisory field, Interpersonal writers focus on the complexity of the situation: the therapist and client are involved in an analysis; the supervisor and therapist are involved in supervision; each individual has a conscious and unconscious effect on the other whether or not that person is physically present in the room…What is presented and what is analyzed are affected by the three interacting participants, each with his or her own set of transferences, countertransferences, and individual unconsciousness. Once this new conceptual position had been accepted, the supervisor was seen as less of a teacher and clarifier and more of a participant in a complex field of inquiry expanded to attend to the importance of each participant's influence on the others' behavior….
>
> Warren Wilner emphasizing the element of creativity, calls attention to the importance of the supervisor's primary experience in the supervision as a way of getting "organized minds to places they have never been". The supervisor proceeds in a manner that keeps the client and supervisee as the central focus at the same time as the supervisory experience is moved to a new level of understanding. This is similar to Wolstein's concept of expanding the field of inquiry through

> analysis and supervision to develop a particular perspective on metapsychology, given a particular therapist and client.[263]

I have already introduced my favorite paper, “Follow the Fox: an inquiry into the vicissitudes of psychoanalytic supervision,” by Edgar Levenson, noted leader of the Interpersonal school. Tongue in cheek, Levenson has likened the relational experience of psychotherapy to the elusive, ineffable and inedible fox being chased by horses and hounds. Likewise, he has noted the supervisory enterprise as the infallible in search for the ineffable. Citing the logical typing arguments of Bateson and the nature of abstraction as noted by Count Korzybski, Levenson maintains that when supervising we seem to have such a clear view of things which, were we to be actively embroiled in the relational exchange of therapy, would not be so clear at all. When we are struggling with a client to make sense of our experiences together we are in a constant muddle, forever uncertain and frequently at a loss to make sense of things. But when supervisor and supervisee *talk* about the client and the therapeutic process they are operating at a totally different level of abstraction—one in which they are talking about a *class of clients* and a *class of events*, merely using the current therapeutic exchange as an example. Korzybski makes clear that higher levels of abstraction are always clearer because of the abstraction process and because we are not at that moment involved as a member of the class being discussed in generalized terms. Springboarding from the realization that we are not helping the supervisee with a specific client so much as with understanding a relational process, Levenson offers a system of classification of six kinds of supervisory stances and interventions—of which he favors number three, the “algorithmic”.

1. *Holding*: a supervisory strategy Levenson exemplifies by his own supervision with interpersonalist Clara Thompson who neither said or nor directly did very much—but carefully followed and questioned the process, thereby providing an immensely supportive learning environment. The holding approach “establishes no structure to the supervision at all, but allows the therapist to listen to and feel for the movement of therapy.”[264]

2. *Teutonic, or by the numbers*: Levenson likens this method of supervising to following a manual of prescribed situations and responses. It is lock-stepped into a metapsychological theory that is authoritarian and omniscient. For each move by the client there is a prescribed counter-move for the therapist that is dictated by the theory—not unlike painting by the numbers. Levenson points out that while this approach is simplistic it has considerable appeal, especially among students who want to believe that someone knows. Further, such supervisors do radiate the great confidence and cheer of people who are sure of themselves and ready to share their certain knowledge with others. He reminds us of Sullivan’s famous aphorism, "God keep me from a therapy that goes well, and God keep me from a clever therapist!"

3. The *algorithmic* approach:

> This method is superficially like the authoritarian, or by-the-book way of teaching psychoanalysis, but it has some extremely important and subtle differences. An algorithm is defined as a series of systematic steps that lead to the solution of a problem. The algorithm is so designed that one step leads to the other. Now, here's the important distinction: the algorithm simply claims that, if one follows the steps,

the outcome results. It doesn't claim that it has an intrinsic relationship to the problem itself. Let me clarify that. The book method, the interpretation-by-the-numbers method, claims that therapy works because the theory is right, and if the theory is followed correctly, and applied correctly, and timed correctly, the outcome will be correct. Therefore, a successful outcome demonstrates the validity of the metapsychology. It is a tautological device. In contrast, an algorithm is simply an operational series of steps. It may or may not have a theoretical idea behind it, but it makes no claim that the theory is necessarily related to the outcome. As a very simple example, in the Middle Ages there was an algorithm for preventing the ague. They knew that you had to close the windows at night (i.e., avoid night air), build your house on high land and make sure there was no stagnant water in the house or surrounds. Now, this was based in some way on the assumption of the evil effect of humors and night air. They didn't know about the anopheles mosquito, and they didn't know about the malarial protozoan; but they had a step-wise procedure, an algorithm, for preventing malaria, and if one followed it, it worked….The function of supervision is essentially to supply the supervisee with an algorithmic approach to the analytic process, with the caveat that this algorithm facilitates treatment only through an indirect relationship to how treatment works. I suspect that very probably the algorithm taps into some deep structure, as does the treatment for ague, but that our

> hermeneutics, our explanatory systems, really may be irrelevant to that. In other words, therapy depends, not on the rightness of the hermeneutics, but on the relevance of the algorithm.[265]

4. The *metatherapeutic* approach: This approach views the supervisory process as analogous to or parallel to the therapeutic approach in that the supervisor is working with the countertransference and takes liberty in asking personal questions that probe the therapist's transference and resistance to the therapeutic process. The supervision is seen "as an opportunity to help the therapist to expand his self-awareness and to see where his anxiety points are located. Thus, [supervision] becomes the analysis of countertransference, either (in the classical sense) to minimize it, or (in the interpersonal sense) to utilize it."[266]

5. The *Zen* method: "This technique is one in which the supervisor confronts the ineffable by creating an atmosphere of creative disorganization. He harasses, raps, interferes, until the therapist, the supervisee, in the Zen term, 'opens the fist,' that is, lets go all of his preconceptions and tightness out of a sense of despair….If one is screamed at long enough, one gets despairing and suddenly lets go, stops thinking, and to one's absolute amazement, discovers that the activity now seems natural and easy."[267]

6. *Preceptorship*: Here, the therapist learns by watching what the supervisor does with the same situation. This is the technique that Searles, Caligor and Bromberg wrote about, as "parallel or reciprocal process"….The supervisee brings the therapy into the supervision process by playing out (albeit unconsciously or automatically) the interaction with the supervisor in such a manner that the therapist plays the role

of the client. The supervisor can then, at first hand, experience the intersubjective therapeutic situation and react to it. It has the value of showing the supervisee the homeostatic power of systems, but I don't much like this method, because: although it illuminates the therapy for the supervisor, so that he can formulate more clearly what's going on, it seems to me quite passive-submissive, in as much as it treats the supervisee as something of a conduit."[268]

Aronson summarizes how Levenson envisions the algorithmic approach to supervision:

> Ultimately, the algorithmic method that Levenson advocates is, for him, a three-step process. Step one involves establishing the arrangements that are made around the psychoanalysis (fees, times, and so forth) as well as the expectations, goals, and motivations for treatment. Levenson also describes how, in the initial part of the treatment process, the therapist "defines and frames his own limitations and areas of competence". The second step is beginning the extended inquiry—listening to the client's story, looking for the gaps, continuities, and leitmotifs in the client's life. It is a "textual enriching" of the data, which often utilizes a wealth of associations and questions on the therapist's part. Finally, the third step is to transfer the issues under inquiry into the transference, so that the issues being looked into, in fact, become enacted within the transference-countertransference. Levenson advocates helping the supervisee learn an algorithm of treatment, showing the trainee where he has deviated from the

process, and eventually letting him develop his own way. The trainee ultimately discovers that by examining the client's life, he is also interacting with the client and begins to notice these interactions, or in Levenson's words, begins to “ride the process rather than carry the client.” Finally, Levenson notes that when the supervisor finds himself or herself in the “role of supervisor,” then both participants are stepping outside the process, which can easily lead to a supervisee becoming passive, accepting the supervisor's comments as if from on high. This may lead to the Teutonic approach, which Levenson ultimately feels is both unimaginative and authoritarian.[269]

Levenson concludes his study of the different types of supervision:

> What appeals about the algorithmic approach is that it's useful to have a method that works, even when you can't be sure why. I'd like to think that this algorithmic approach would work with any metapsychology. Supervision is not therapy. It operates, I repeat, on an entirely different level of abstraction. To confuse supervision with therapy is, in Korzybski's famous aphorism, to confuse the map and the territory. I think we best grapple with the process of supervision by focusing, not only on the value of what we're teaching, but the phenomenology of learning. To do that, we have to involve the supervisee in the process. What is his experience? Not only, how do we teach, but how does he learn? If we are the infallible in pursuit of the ineffable, we're "following the fox." Our problem from this perspective is how to teach the

> supervisee what we know but simply cannot clearly say. We are in hot pursuit of the elusive truth. *Rather, I think the problem is closer to how to teach the therapist a procedure which calls forth a process which carries us all—supervisor, therapist and client*.[270]

7. A Relational Approach

Perhaps the cutting edge of psychodynamic psychotherapy and psychoanalysis is best captured by the word "relational." As early as 1999 Stephen Mitchell and Lewis Aron declared a relational tradition that stretches as far back as Ferenczi, Freud's close companion and friend. It runs through the interpersonalist position of Sullivan, the selfobject studies of Kohut, and the intersubjectivity work of Stolorow to the relational work of Greenberg and Mitchell and the group of "relationalists" beginning at New York University and now extending through the International Association of Relational Psychotherapy and Psychoanalysis throughout the world. Relational Psychotherapy and Psychoanalysis is avowedly not "yet another school" of therapy but rather is being organized as a tradition of multidisciplinary studies that focuses on the importance of understanding relationships and how they operate in human life. What follows are some views on the relational approach to psychotherapy and supervision. Teitelbaum has this to say:

> As a result of increased awareness of the realm of psychoanalysis as a two-person psychology, many theorists maintain that the role of the therapist is not that of a detached observer and interpreter of what goes on within the client, but rather that of a participant in the therapeutic process and an integral part of the very process she is

> attempting to observe and understand. The relational model, with its emphasis on how participants in the therapeutic relationship impact upon one another in a variety of ways, which in turn influence the course of treatment, has a carryover effect to the field of therapeutic supervision.[271]

Yerushalmi models his view of relational therapy and the special culture created by two participants in therapy and supervision on a model of two people relating across cultural lines and creating their own private third of a shared language and a jointly created subculture.

> Supervision is the most important tool in shaping and influencing psychotherapy trainees with respect to their value systems, their beliefs, and the organization of their professional selves. Interaction that is as open as possible and allows the supervisee to influence, not just to be influenced…, will go a long way in diminishing resistance to the process of influence and toward alleviating the suspiciousness that is built into the supervisory interaction…..
>
> In supervision, co-construction of therapeutic reality of clients' lives, and of the supervisory relationship itself, is never and can never be complete. It is an ongoing process of probing for newer, richer, more pertinent formulations that offer ever greater freedom of action. Every new spiral involves subsidiary processes of deconstruction and reconstruction, each of which enhances the meanings that the participants can attribute to the supervision and to the nature of their

> relationship. …This process leads eventually to a construction of a "shared world" of meanings, no matter how narrow its domain, and links the participants, deterring the feelings of loneliness and alienation that so often plague the work of the psychodynamic therapist….
>
> When people from different cultures (or speakers of different languages) wish to establish a shared emotional world and an authentic relationship, they establish new and idiosyncratic cultural or linguistic structures. Likewise the supervisor and the supervisee create their own idiosyncratic structures. Though shared, these structures include aspects of each of them, and thus create an intermediary space that constructs and strengthens their relationship.[272]

The book that for me does the most comprehensive job of defining and elaborating the supervisory relationship is Gail Frawley-O'Dea and Janet Sarnat's *The Supervisory Relationship: A Contemporary Psychodynamic Approach*.[273] They review the history and many of the leading ideas about the supervisory process, centering on the differences among:

(1) *the client-centered approach* to supervision (i.e., the classical) in which the supervisor's expertise is on the issues presented by the client;

(2) *the supervisee-centered approaches* to supervision (i.e., ego, self, and object relations theories) in which the supervisor's response to the supervisee depends on her expert knowledge of the therapeutic process; and

(3) *the matrix-centered or relational approach* to supervision in which the expertise of the supervisor rests in the processing and negotiation of interpretations about the relational processes occurring in the therapeutic and supervisory dyads as well as what's going on in the triadic relational matrix.

Say O'Dea and Sarnat:

> In a relational model, the supervisor's authority derives from her capacity to participate in, reflect upon, and process enactments, and to interpret relational themes that arise within either the therapeutic or supervisory dyads….Relational themes are assumed to reverberate between the supervisory and therapeutic dyads, and themes are also expected to enter the supervisory and therapeutic relationships from the organizations in which each is embedded….The mode of participation of the supervisor may include exploration of the many aspects of unconscious engagement of the various participants and the inevitable enactments that permeate the supervisory and therapeutic relationship; the supervisor may participate in a range of ways—imparting information, serving containing or selfobject functions—but always with a relational consciousness and readiness to acknowledge the mutuality of the supervisory interaction. With the privileging of relationship and the emphasis on the inextricable, mutual embeddedness of the interpersonal and the intrapsychic elements inherent in relational theory, relationships become the primary

constituents of psychic structure. *Mind becomes organized by units of internalized relationships.*[274]

Matrix-centered supervision as considered by O'Dea and Sarnat heavily depends on contemporary relational theory.

> Relational theory emphasizes the active, albeit unconscious, insistence of the client repetitively to co-construct with another familiar maladaptive relational patterns. …Relational theorists hold that it is essentially meaningless to speak about the client without considering the influence of the therapist on the client, or to speak about the therapist-at-work as functioning independently from the impact of the client….Thus, transference and countertransference paradigms are mutually determined and shaped by each of the two participant observers of the analytic dyad….Reality and truth are viewed as perspectival; they are constructions mutually derived by and discussed by therapist and client….It is not agreement but, rather, respectful and persistent identification and explication of many possible meanings that constitute relational analysis….Relational theory accepts that the person of the therapist inevitably influences the development and course of transference and countertransference paradigms. The therapist's own unique tapestry of historical and current relationally mediated experiences, affects, cognitions, somatic states, and multiple organizations of self all are present in the consultation room and engage with those same aspects of the client's psychic apparatus to

> co-create a new, unique interpersonal field. What transpires during any analytic journey, therefore, is mutually determined and mutually negotiated by therapist and client within their admittedly asymmetrical relationship.[275]

In a later paper by O'Dea she bravely extends her thoughts to include that supervision, like psychotherapy, must also be considered a real and intimate relationship in which regressions, dissociations, and enactments regularly and expectably occur in both supervisee and supervisor. She speculates why we have been so long in coming to this realization.

> …Donnel Stern (1997) suggests that there often is a lag between the beginning of cultural change and its verbal expression in cultural outlets. It is understandable, then, that therapeutic supervision may just now be starting to be reformulated to fit better the great changes in therapeutic culture that have occurred over the past 15 or so years.
>
> By fostering the development of an optimally creative and flexible potential supervisory space, a relational model of supervision accepts as inevitable, and therefore welcomes, regressions, defined as affectively intense, cognitively primitive, usually nonverbal experiences, in supervisor and supervisee alike. Far from considering regressions within supervision as suspect phenomena better reserved for the supervisee's own analysis, the relational supervisor believes that valuable information about the supervisory relationship, as well as the therapeutic process, may be gleaned from explorations of regressions

taking place within the supervisory dyad. Similarly, dissociative experiences in either supervisor or supervisee are considered potential postcards, communicating as yet unformulated self-states or transference-countertransference reactions relevant to the supervisory relationship, the supervised treatment, or both.[276]

…As happens between therapist and client, supervisor and supervisee engage in enactments of conscious and unconscious, verbal and nonverbal transference and countertransference constellations cocreated by them during the supervisory process. In addition, supervisor and supervisee may enact relational configurations that, although bespeaking elements of their own relationship, represent as well currently unformulated features of the treatment relationship. The relational supervisor holds that it is crucial to live out mindfully with the supervisee and eventually to make explicit with him relational patterns set in play within their relationship.

Herein lie the excitement, the richness, the potential, and the terror of supervision. Through the dyad's ever-more complete delineation of the analytic relationship, mediated in substantial measure through increasingly deeper and wider elaboration of the supervisory relationship, more becomes possible. The client comes to know about and be able to speak more about herself, her intrapsychic functioning, and her relational patterns—her affects, cognitions, body states, and fantasies. These changes occur in part because, within supervision,

> the supervisee develops a capacity for more—more theoretical and technical knowledge, more insight into his own intrapsychic and interpersonal capacities and limitations, more affect, and more confidence in his abilities as an analytic practitioner. In this way, the supervisory relationship is second only to the supervisee's own treatment in potentiating the clinician's development as a therapeutically informed therapist. Finally, of course, the supervisor, too, discovers more possibility as a teacher, learner, and analytic instrument.[277]

8. A Lacanian Approach

The Freudian School of Psychoanalysis in Paris led by Jacques Lacan has generally held that a psychoanalyst is authorized by the completion of his own analysis and that a request for supervision represents a resistance to that analysis. While many find the Lacanian perspective enigmatic it has its own rationale. One's personal symptom, as it were, is maintained by the transference delusion that there is a subject who knows. In analysis the transference is to "the subject who is supposed to know" until one finally unknows-knowing. The personal symptom is thereby replaced by the therapist's authorizing "synthome" known only to himself and a few other therapists who know that the therapist is no longer seeking knowing. The therapist, more than being identified with a profession or with the name and gain associated with professional expertise, is a metaphor for the subject who knows about not knowing. The therapist knows about the unconscious as the nonconceptual, or beyond conceptual, and therefore about what is

never fully totalized as a theory. A gap or a lack always remains as a space between the subject or the therapist and the doctrine and institution of psychoanalysis.[278]

According to Moncayo, a Lacanian analysis ends by virtue of the client's own 'unknowing-knowing'[279] In 1967 Lacan proposed that the analyst authorizes himself at the end of his analysis. By the Rome Congress in 1974 consensus was building that the growing institutional requirements of psychoanalysis world-wide represented a resistance to analysis—that so many hours of this and that functions as an obsessional defense against the inherent difficulties of analysis and dealing with the field of transference. Lacan believed that problems the therapist encountered should send him back to analysis not to the resistance of supervision. "Julien…has written that, during supervisions, Lacan avoided transmitting a total and closed knowledge. Lacan would refuse to tell his supervisees what to do and how to proceed."[280]

Says the Lacanian analyst Moncayo:

> The transference to the authority of the doctor on the basis of the subject who is supposed to know functions as a resistance to recovering unconscious knowing about experiences of lack and of loss, whether real, imagined, or symbolic: privation, frustration, and castration….It is the unconscious knowing of the subject within the therapist that can make use or work with the unconscious knowing that the client attributes to him or her in the transference. The therapist is one step ahead of the client, because therapists know that they do not know. The therapist is enlightened about his or her own ignorance and

therefore can help the client discover what he or she knows within himself or herself….

Unknown knowing is also important for supervision because often supervisees do not know that they already know about matters concerning their client. The supervisor has to hear what appears in the discourse of the supervisee regarding his or her client, that the supervisee has not recognized or does not know that he or she knows. The answers to the supervisee's questions lie in his or her own unconscious or unknown discourse regarding his or her client. The supervisor merely points to what the supervisee already unconsciously knows (unknown knowing).

The general manifestation of human transference is to identify and love the other as the subject who is supposed to know or its reverse, the other as the subject of the lack, which is how Lacan (1964) defined the negative transference. One hates the person whom one deposes from being the subject who is supposed to know. Here the other is seen as incompetent and lacking….If a subject is slandered or humiliated, it is precisely because he or she is perceived as the one who knows rather than vice versa. In the positive transference, the subject who is supposed to know conceals or covers over the lack in the other or the subject, whereas in the negative transference, transference reveals the lack, but only in the other rather than in the subject. The subjective

> position of psychoanalysis consists of accepting and appreciating the lack in the other and in the subject. (pp. 533-535)

Hardly daring to paraphrase such a complex formulation regarding the supervisory process, I will only say that the function of supervision in the Lacanian view is therefore to demonstrate to the therapist that he/she is relating to the client on the basis of knowing rather than unknowing. It follows then that if the function of analysis is to come to know that one does not know, that the therapist's unconscious knowing is a resistance to his or her own analytic work. The supervisor therefore probes and questions the therapist in such a way that the therapist's knowing is given up to further analysis.

9. Some Other Approaches to Supervision

In this final section I will mention briefly several positions regarding supervisory issues that are taken by experts in the field.

Teitelbaum has coined the term *supertransference* to denote the supervisor's blind spots that may arise in supervisory conflicts and/or stalemates. That is, he considers not only the therapist's problems in learning but the supervisor's problems in teaching.

> I am using the term supertransference in two ways. In the general sense it is meant to refer to all inappropriate and countertransferential reactions on the part of the supervisor in response to the supervisee. These include responses and feelings to such things as the therapist's manner of presenting case material, the therapist's personality, the

> therapist's feelings and attitudes toward the client, institute, and/or supervisor, and issues related to the supervisory contract.
>
> From another angle the term supertransference is intended to convey a blind spot or error which because it emanates from the supervisor rather than the therapist, and is of considerable magnitude insofar as it may have impact on the therapist's professional development, self-esteem, and work with his or her clients.[281]

As examples he cites Geller's note that supervisors need to feel purposeful and involved so that to be affirmed as a good teacher fulfills an appropriate narcissistic need if it is not excessive. Geller urged supervisors to consider how his or her teaching is being enhanced or diminished by such things as the therapist's manner or defensive style. That is, supervisors are urged to examine the sources of their adverse reactions to supervisees. Says Teitelbaum, "Although this is a productive endeavor for the supervisor to pursue, he or she needs to take the further step of standing back and examining his or her own contribution to supervisory conflict and misalliance. In general, therapeutic supervisors are reluctant to do this, defensively depriving themselves of a valuable pool of information.[282]

Philip Bromberg maintains that the therapist not only has to be a skilled participant observer but that she must also be able to observe herself participating in order to relay to the supervisor the crucial information required for effective teaching and learning. He sees in supervision a paradox attempting to teach rules, one of them being spontaneity. Referring to Reik's listening with the third ear, Bromberg compares a therapist in

training to an actor who must walk out on a stage forgetting whatever he has studied in order to live the performance with spontaneity and affect.

> Therapeutic supervision, in order to be successful, must, in my opinion, provide a set of conditions that facilitates this kind of growth. I have referred to it…'a change in the self-representation out of which behavior will organically and naturally reflect reorganization of the self at increasingly higher levels of interpersonal maturation'….
>
> In supervision the therapist must be able to scrutinize what he already does. He must have an opportunity to hear his sessions, to hear himself with his client and his client with himself, in a way that goes beyond what he heard during the sessions as they were in progress. What he hears must be more than that which fits comfortably into his current perspective; but he must also be able to take in what he hears as compatible enough with his current perspective so that his need to protect his self-esteem does not get in the way of his gradually integrating the new into the old as he works.
>
> I am interested in what the supervisee hears, and primarily in that context, what he does. What he does, informs me of what he is hearing. What he is hearing informs me of a number of different things that can then be addressed individually depending upon their relevance for a given therapist; how he is listening, how he thinks, his ability to conceptualize as he hears, his depth of knowledge, his values, and his possible blind spots due to unresolved personality

> conflicts of his own. I will frequently make suggestions that relate to principles of technique, but I try not to comment often on "what he is doing" per se. I try to address the relationship between his actions (including silences and voice tone) and what he hears and does not hear; what material he uses and does not use. I pay particular attention to how much of a discrepancy I perceive between the effect of client and therapist upon each other during a particular session or period of time, and the effect of each upon me. If the discrepancy is great, I think about whether there may be something going on between them that is systematically being unacknowledged, or whether the discrepancy is more likely due to something in myself. I am also interested in helping the therapist to think about how he relates what he is hearing on the tape to how he conceptualizes that particular session, how he is viewing this particular client, and to his developing overview of the therapeutic process as a whole.[283]

Aronson invokes Bromberg's work on the multiplicity of selves in order to discuss supervision. The notion of standing in the spaces between realities experienced by different self states without losing any of them—that is, the ability to feel like one self while being many selves is a skill to be cultivated by a therapists as well as a supervisors.

> Standing in the spaces may be another way of conceptualizing what needs to go on in supervision for the therapist. Supervisees enter training with professional and personal lives, selves, and identities

> whose integrities may then be threatened upon entering supervision. A seasoned therapist becomes a trainee, a teacher of therapists becomes a therapist of teachers, a parent, in some form, becomes a child. In addition, one cannot help but encounter a variety of supervisors and supervisory styles, as Levenson has described. An overriding goal for the therapist in training, then, becomes bridging these gaps, deciding what is me and what is not-me, achieving some kind of coherence in one's self-representation as therapist, all the while being in one's own personal psychoanalysis. This is no small feat![284]

Gee, after studying numerous tapes of supervisory sessions he has conducted in a paper entitled, “Relating then defining,” found it illuminating to see the kinds and frequency of different types of interventions he has made. Of special importance he concludes is the function of pondering aloud with the supervisee.

> …I have found it helpful to ‘ponder’ aloud on the material that the supervisee brings; in this way the supervisor can encourage the supervisee to ‘ponder’ on the material. By ‘ponder’, I mean allowing oneself to consider the possible meaning and purpose of the material in a relatively non-directive way, allowing the material to ‘sink-in’ while waiting for a thought/feeling/image/insight to arise out of one. During this pondering I believe that there is a dialogue taking place between the conscious and unconscious parts of the self. I think that it is generally accepted that the supervisor is not aiming at imposing one style of working onto the supervisee; however, the supervisor is trying

> to help the supervisee to develop an appropriate analytic stance. Under this heading I would place such considerations as the nature of interpretations; helping the supervisee to listen to the client's material; using oneself as an ‘instrument’; living with ‘not knowing’; carefully observing the client's behaviour; and valuing the therapeutic relationship.[285]

And finally, Jonathan Slavin in a paper on supervision considers the nature of personal influences. Supervisors by the nature of their role seek to influence yet they fear having undue influence. But the process is not one-way, the supervisor must likewise be vulnerable to being impacted, influenced as well.

> The essential question is how the kind of personal influence that clients and supervisees truly want and need—but also fear—can be enabled in a context of safety, without the kind of wounding that occurs too often in both supervision and treatment….How can supervisees be taught to trust themselves and to trust in the usefulness of their unpreconceived, seemingly countertransferential responsiveness?...
>
> The question I bring to this discussion is whether the kind of personal engagement that promotes and creates change can take place—either in the therapeutic setting or in the supervisory one—without therapists or supervisors themselves being vulnerable to being influenced, to being affected, to being touched, and to being wounded from the other direction (i.e., from the client and the supervisee). As I see it, if beginning therapists are to be able to “give themselves”—to live with

> the potential danger of feeling completely “lost” in it with the client—they need to find, in the supervisory relationship, exactly what a client needs to find in treatment: a sense of safety and the feeling that their needs, their agenda, and their capacity to have an influence will be recognized….
>
> One can ask what it is that creates safety and the capacity for this kind of openness to being affected deeply in any relationship. I believe that there are two fundamental ingredients to the experience of safety….(a) the sense one has that the other person has some investment not only in one's own agenda but in that of one's partner (i.e., the belief that the other person will see one as a subject in one's own right), and (b) the feeling that the other person shares some measure of what I have been terming vulnerability in the relationship…. It is the belief that they can have an impact—and are not simply going to be the recipient of influence—that enables individuals to trust that they will be recognized for themselves….This kind of safety is necessary for influence to take place, and it is created precisely by the capacity to be influenceable and, indeed, vulnerable.

Slavin asks what it takes to teach someone to be vulnerable to influence either in therapy or supervision. His answer is that the relational theory of mutual influence provides the necessary safety and holding for participants to anticipate that powerful processes are inevitably going to take place and that personal responses are expected to be useful aspects of this work. He further asks how supervisors can safely decide

how to be open to influence and to be potentially more vulnerable with their supervisees? Slavin's answer is that relational theory likewise provides a holding environment for supervisors that allows an understanding and anticipation of the inevitably powerful impact on them of the work to come. Some of the issues in becoming more vulnerable as a supervisor are addressed in the following case by Strean.

Case Study: Strean: Three-way Symbiotic Yearnings[286]

Strean begins with the observation that very often the client, therapist and supervisor are maintaining some sort of symbiotic collusion and then describes a supervisory situation he is involved in.

Mr. B. was a 24-year-old, single graduate student in treatment with Dr. V. who was in an advanced training program. Mr. B was doing well in graduate school but as he approached writing his dissertation he began losing interest in his work or people, had difficulties sleeping and felt very depressed. After nine months of treatment Mr. B., who had heretofore been cooperative began to question the value of treatment. He felt that Dr. V. had been helpful but that she was "cold, detached, and emotionally unavailable" and perhaps too inexperienced to help him. He expressed that he felt "very much alone here—as if you are not in the room."[287]

Based on his history of being overly attached to a controlling, overzealous mother it seemed clear that much of his detached and negativistic attitude was a defense against emotional dependence on his therapist. The negativism was similar to the way he had come to feel about his studies.

Dr. V. experienced feelings of helpless and tongue-tied in the situation and when he began badgering her with questions she gave him half-hearted interpretations to placate him.

> When the supervisor pointed out to Dr. V. that she appeared very intimidated, angry, and impotent with her patient, Dr. V. rather quickly withdrew from the supervisor and had almost nothing to do with him in the next several supervisory sessions. On the supervisor's commenting about Dr. V.'s withdrawal, the therapist appeared very reluctant to discuss anything with him. Instead, like Mr. B. in the therapy, Dr. V. in supervision began to ask many theoretical and technical questions about merging and symbiotic longings, and expressed her doubts about whether “these early pre-oedipal problems can ever be resolved by an therapy.”

The supervisor took her dilemma of how to help Dr. V. to her supervisor’s group only to realize that he was reenacting with Dr. V. the helplessness in supervision that Dr. V. felt in therapy and that Mr. B. felt in his life.

> As the supervisor discussed with his colleagues how both Dr. V. and her patient, Mr. B., appeared discouraged, disappointed, and despondent, it occurred to him that Dr. V. reminded him of his daughter who had recently gone out of town to college. Speaking of Dr. V., the supervisor said, “I'd like to take her in my arms as if she were my daughter and say, ‘Everything will be all right.’ Instead, I'm acting ‘too

> proper' and 'too stiff' and damn it, that's what she's doing with her patient."
>
> As the supervisor felt understood and accepted by his peers in the supervisory seminar, he could become more sensitive to Dr. V.'s difficulties. Instead of trying to answer her questions or mechanically throw them back to her (as Dr. V. was doing with Mr. B.), the supervisor suggested to Dr. V. that from a position of feeling quite optimistic about what psychotherapy could offer, she had become very doubtful. From conversing easily and spontaneously with the supervisor, she was asking many questions. He suggested, "Perhaps we can figure out together what's happening between us—then maybe it will be easier to see what's going on in the treatment?"[288]

The session was stimulating to Dr. V. who upon reflection realized that both she and the client were avoiding each other and wondered why. The supervisor recalled her earlier comments to the effect that the resistance Mr. B. was experience was to experiencing his symbiotic longings in the transference. Dr. V. was grateful for the reminder, saying,

> 'I would not have thought of that in years!' With tears she said, 'I feel embarrassed to tell you how close I feel to you and how highly I regard you!' Slowly, Dr. V. was able to share with her supervisor her strong desire to have 'a feeding mother,' how difficult this was to face in her own therapy, and 'how much I would love to be that mother for Mr. B.'

> As Dr. V. could face her own symbiotic wishes in her supervisory relationship, she could more easily accept her desire to be 'the pre-oedipal mother' for Mr. B. and help him confront his deep desire to have Dr. V. infantilize him the way his own mother had done. To help Dr. V. do this, the supervisor first had to face his own symbiotic longings for his daughter. When he was not feeling so defended, he could be a more enabling figure for Dr. V., who could then be the same for Mr. B.[289]

Strean points out that all three members of the triad were defending themselves and each other from experiencing the power of symbiotic longings. Only when the supervisor could resolve some of his own resistances toward his symbiotic yearnings for his daughter could the supervision and the therapy move forward. With these general theoretical approaches in place it's time to turn our attention to supervisory processes conducted in groups.

Relational Perspective 11

Group Supervision and Case Conference Seminars

Group supervision takes many forms and has been studied and written about in many ways. What was surprising to me in my survey of the literature was that every writer I could find who has group supervisory experience, without exception, favors it as a special form of learning. The only caveats I could find were that group supervision is different from and therefore cannot replace individual supervision. And also that if not properly run and contained there is the ever-present danger that one or several of the group members may become destructively critical of other members. In what follows I will bring together some thought-provoking insights of group supervisors and then list a series of aspirational principles for group supervisors.

Caligor in his classic 1981 paper on parallel and reciprocal processes in supervision has this to say about group experience.

> I find that having two therapists share supervisory sessions can be most valuable….[A] three-some makes for less transference on the part of the therapist; less probability of countertransference to any one therapist by the supervisor; there tends to be greater criticality operative on the part of all; and different affective perceptual and cognitive grids examining the same data tend to make for a broader perspective. Also, there tends to be less regression than can occur in the one-to-one, because the supervisor is perceived much less as God, the authority, and the therapist therefore feels freer to be critical of his contributions and to verbalize his own. It is humbling for the

> supervisor when the therapist comes forth with superior insights and recommendations, frequently better than his own. All this makes for the analytic ethos of equality and dialogue leading to insights broader than available to one person. Finally, it teaches the therapist how to be constructively critical of another's work, to be actively engaged as a participant in the supervisory process—a helpful education for his own future work as a supervisor, and, hopefully, some day as his auto-supervisor.[290]

O'Dea and Sarnat in their comprehensive text on supervision sum up the major values inherent in group supervision:

> The group supervisory situation differs from the dyadic situation in several ways that hold great potential for learning. In individual supervision, for example, it is easy for the supervisor to overlook his own impact upon the unfolding of the supervisory relationship, and because of the power differential between supervisor and supervisee, the supervisee may feel unable to point out this omission. However, in a group, a third party is always present to witness the interaction of any dyad. This presence of an observing third is a source of enormous potential for understanding the complex relational themes that unfold in any supervisory situation, if the leader's orientation gives members permission to notice and to comment. Thus, for example, when the case conference leader views the difficulties that the presenter is having with the client as due to the client's problems only, or to the

presenter's problems only, or if the leader has a negative interpersonal impact on the presenter of which he is unaware, the rest of the group is there to observe and discuss the transaction.

The group supervisory situation also provides the possibility for a more free-flowing associative process than does the dyadic situation. In case conference, a kind of group brainstorming can take place that is richer and more emotionally immediate than what generally occurs in dyadic supervision, just as two heads are often better than one, so multiple heads can be better still, if their emotional and cognitive synergies can be effectively channeled.

And finally, the group situation provides a marvelous opportunity for experiencing firsthand the reality that truth is perspectival, that there is no such thing as a single ‘objective’ observer or a single valid narrative. Because case conference members inevitably have a variety of different responses to the same clinical material, individual conference members can learn to relinquish their search for an absolute ‘truth,’ and instead learn something about their own ways of organizing the world, and their own areas of sensitivity and insensitivity. They may also have an opportunity to observe and appreciate the process of negotiation, through which the group struggles to construct a single more or less coherent narrative from its members' multiple perspectives.[291]

Using the format of a continuous case conference, Sachs and Shapiro in their paper on parallel process demonstrate that “the therapist-presenter develops unconscious identifications with the client which are especially intense when difficulties (resistances) arise which he cannot resolve. The presenter then enacts these identifications in the seminar giving rise to responses from the seminar members which repeat the difficulties of the therapy”.[292] In their group work Sachs and Shapiro encourage empathic responses from the participants which lead to an elucidation of the unspoken elements of the therapeutic resistance. For example, a therapist struggling with silence on the part of the client may feel anxiety that they will not have ‘good material’ for the conference. Other therapists may experience difficulty in front of the group dealing with a client’s threats to end therapy. Or with an angry client who attacks the therapist’s competence. “Time and again therapists have revealed their belief that they should always know what to do. This perfectionistic attitude made them feel helpless”.[293] But with empathic discussion the feelings evoked by the treatment can be expanded and better understood in the group process.

> It is extremely important that the conference leaders be aware of the destructive potential of the nonverbal interaction between client and therapist. If this is not made an aspect of the therapy that is discussed and thereby converted from an enactment to verbal representation, the same vicious cycle can be repeated in the conference. This time the therapist is in the position of the client, wanting instant help or relief, and the conference is in the position of the therapist. When the conference fails to provide the 'answers', the therapist is likely to be

> disappointed and may, like the client, act out his disappointment. For example, the therapist may return to the client and play the disappointing role by doing nothing for the client. Thus, the conference can intensify the problems in the therapy. But, if the conference leaders try to tell the therapist what he should have done, he may feel humiliated. The solution in the conference, as in therapy, is to interpret the problem.[294]

Bromberg is savvy to many kinds of difficult interactions that can come up in group supervision. He has stigmatized one effect as “case conference cleverness”—the uncanny ability of group members to see what the presenting therapist missed—not unlike Levenson’s earlier quoted comments to the effect that supervisory abstractions are easier to make than therapeutic formulations.

> The presenting therapist's reaction varies. Sometimes he may feel he missed something he should have heard; sometimes he may state that even though he did not hear it he was aware of the issue but working on something else; sometimes he may be the only one in the room who insists he does not hear it. Most often, however, there does seem to be something approaching a core experience of hearing with the group—hearing what the group hears, and sometimes a bit painfully, hearing it for the first time even though he was there originally. He does not necessarily feel, however, that what he missed is what was ‘really’ going on, as is sometimes implied by the group.

The phenomenon is so common and cuts across so many levels of expertise, experience, and character styles that it is clearly reflecting something ubiquitous in the human communication process that is not exclusive to psychoanalysis. At the moment of the original event, which the therapist is now hearing in a different way for the first time, what the therapist 'missed' took place when he was functioning more as a participant than as a participant observer. In any aspect of life, when a person is involved in something that is commanding his full, or almost full, attention in a highly focused way, at that moment he relinquishes his broader perspective. He is more solely a participant and less likely to register the event in which he is participating, with a 'third ear.'…

An outside observer—a supervisor or a member of a case conference—will *always* be potentially capable of hearing what the therapist is 'missing,' because he is not participating in the event. He is only an observer. He can therefore see the therapist and the client from a perspective not limited by his own focal involvement in the event. It is only when the therapist's participation becomes enmeshed with the client's transference that we normally talk of countertransference and can, with any justification as supervisors, label what we hear as something that was being *missed* or that was *really* going on. It is not countertransference simply because the therapist does not hear it and we do, but because it reflects a theme that seems to remain *systematically* outside of the therapist's

> participant-observer function. He cannot hear it with the ‘third ear,’ and falls victim to what Freud warned against as *perceptual falsification* and what Sullivan called *selective inattention.*[295]

Epstein takes the concept of selective inattention further. On the one hand the group and the group supervisor attend to the content of the therapy session and make contributions toward its elucidation. But at a process level the supervisor, as well as the group members, are alert to ongoing tensions that might be building in the group causing them to perceive or not to attend to certain details. The leader works with whatever resistances seem to be operating in the group to verbalizing latent or withheld thoughts and feelings they might be having toward the presenter, the leader, to other members, the client, or the processes involved.

> In the process of conducting group supervision the supervisor gets feedback that is rarely forthcoming in the one-to-one tutorial situation. From such feedback I have learned the following:
>
> Most standard supervisory interventions that are spontaneously offered to the presenting supervisees, either by myself or by others, are likely to be experienced as unhelpful or critical, making the supervisee feel anxious, wrong and inadequate, thereby, increasing his reluctance to present cases in the group. In effect this means that the 'supervisory impulse', if acted upon without being internally processed for its possible impact on the other, is, more likely than not, to be unresponsive to the supervisee's need.

> I also learned that the more I follow the practice of explaining and formulating whatever it is that I might feel like formulating and explaining, the more I will be admired by the group members yet the worse they will feel about themselves. The connection between my behavior and the supervisees' reactions is not usually immediately apparent either to myself or to them. They might report during the group session that they are feeling depressed, or they might later report that they left the session feeling depressed, or during a given session members might report that they feel some resistance to being in the group that day. It is through investigating such symptomatic negative reactions that the latent connection becomes clear.[296]

While this is not the place to survey various theories of groups, group behavior, or group therapy that have been developed in sociology and psychology, O'Dea and Sarnat in their comprehensive text, *The Supervisory Relationship: A Contemporary Psychodynamic Approach,* certainly do cover this very important ground. O'Dea and Sarnat have also offered a relational theory of psychotherapy and supervision—complete with exposition and illustration. My purpose in this section is simply to provide a perspective from which to consider issues that arise in effectively conducted group supervision. O'Dea and Sarnat describe the relational approach to group supervision:

> Our model…emphasizes the importance of creating a potential space that invites affectively engaged participation from supervisee, supervisor, and, eventually, client, in which more becomes imaginable, sayable, and 'playable' for all participants. By exploring the case

conference group process, much can be learned about the therapeutic process. To the degree that it is safe to ‘know’ one’s feelings within the interpersonal field of the case conference, the presenter will also feel freed to ‘know’ what is happening in the therapeutic relationship and to facilitate the client's freedom to ‘know.’ A relational case conference leader works to create a learning environment in which affects and other experiences evoked by the client, the presenter, or any aspect of the process, can be owned and acknowledged by members, without criticism or accusations of being ‘unprofessional.’

The leader thus takes responsibility for nurturing a generative atmosphere within the conference. Yet he simultaneously recognizes the limits of what he alone can do. The leader views himself as involved in co-creating that atmosphere along with group participants. He also views himself as dependent upon the authorization of the case conference members themselves for much of the power that he does possess.

The leader makes no claim to knowing an ultimate truth. Clinical truth is viewed as mutually negotiated and never finally settled. Sometimes, of course, the leader will function as ‘clinical expert,’ giving his personal view of the client, the therapist's technique, and how the therapeutic process is unfolding. And depending upon the composition of the group, he will do so from a position of somewhat greater experience and expertise than other conference members. But his

> participation in the role of 'clinical expert' is always tempered by his understanding that his view of what is happening in the case and in the conference is relationally embedded, perspectival, and continually subject to revision. Thus, his contribution will become part of a developing series of understandings within the group rather than being a kind of 'last word.'[297]

Borrowing on O'Dea and Sarnat's relational model and integrating their experiences with mine what follows is a series of aspirational principles to guide group supervisors in facilitating a robust and intimate group supervisory experience:

- The group supervisor functions as a discussion leader facilitating the expression of ideas and feelings regarding the therapy and the group supervision process.
- The supervisor clarifies and synthesizes what the group comes up with and encourages the ongoing collaboration of others in this process.
- The supervisor encourages openness to all ideas and feelings, encouraging alternate formulations and robust dialogue and disagreement whenever possible.
- The supervisor creates a safe place for the presenter, quickly nipping in the bud destructive criticism of any type.
- The supervisor maintains the position that the presenting therapist has special knowledge of the client and therefore special authority.
- The supervisor assumes that reality is perspectival and encourages a plurality of opinion and points of view.

- The supervisor holds the realization that since supervision operates at a different level of abstraction from therapy that certain clear formulations can be made but are not necessarily the only valid ones.
- The supervisor guides discussion in the direction of defining *what is* rather than what might have been or should have been, given the greater distance from the therapeutic fray that supervision affords.
- The supervisor encourages multiple *understandings* and discourages *advice*.
- The supervisor encourages participants to explore their reactions to the presenter and the case as reflections of their own relational themes rather than as objective perceptions.
- The supervisor serves as emotional container for the group emotional arousals as well as individual affective experiences. Therapy material and perspectival realities create tensions in the process that need to be addressed and contained by the leader even as she encourages all members to reflect on what is happening and to offer their insights.
- The supervisor facilitates group discussion around the group reactions to the case and to the supervisory group process as possibly informative about what is going on in the case and how group discussions and interactions may be affecting the treatment situation itself.
- The supervisor assumes that much of what will eventually be seen as important material for the therapy will come from various emotional states, group interactions, and enactments engaged in by all participants.

- The supervisor considers all experiences and enactments in the group as potential carriers of unformulated experience and dissociated self-states of the client and therapist.
- The supervisor notes and brings to the attention of the group various tensions and rigidities and encourages members of the group to work with them and to use them in learning about the three way processes involved in supervision.

In conclusion, O'Dea and Sarnat give an inspirational vision of what group supervision in a relational mode can offer.

> The group process is viewed as the intersection of multiple subjectivities, including those of the client, the presenter, the members of the group, the leader, and possibly others. The group process is a composite of relational themes emerging between case conference members (including the leader), relational themes originating in the supervised treatment, and possibly themes from the presenter's analysis and the organization(s) in which the treatment and/or case conference are embedded. These various themes exist in dialectal tension with one another, alternatively becoming foreground and background. Because there are multiple subjectivities in the room, each mind attuned to particular aspects of the case, a rich pastiche of affects, images, dissociative phenomena, and regressive experiences emerge within case conference, and the gathering up and exploring of these phenomena can deepen the presenter's understanding of her

client, herself, their interaction, and the broader contexts in which the treatment is embedded….

A relational case conference, rather than being tightly structured, will instead allow for a free-flowing group process that facilitates the emergence of unconscious and affectively alive contents. Relatively unconstrained and unselfconscious material-generating periods will tend to alternate with more reflective material-processing periods. Negotiation of how the group will work is also an integral aspect of this free-flowing discussion process. Group members will be actively encouraged to speak up if the process begins to feel unsafe or if they begin to experience undue levels of anxiety. And the leader will actively monitor the presenter's comfort with the group's discussion, and will stand up for her if the group begins to become judgmental or critical….

Case conference can be one of the most difficult experiences in clinical training, fraught with the potential for the presenter and other group members to feel attacked and narcissistically injured. Given the tendency of group members to get carried away with their own affects and processes, case conferences can feel, at times, like a kind of powder keg waiting to go off. The choices that leaders make about structuring their conferences—such as whether to tightly structure the conference, and whether to encourage examination of group

process—are often motivated by efforts to cope with anxiety about these powerful forces.

The case conference leader who works from a relational model is able to view these forces with less anxiety and more interest. Affective experiences, rather than being considered a distraction from the primary focus of the conference, are at the heart of the conference's work. The challenge to the case conference leader is to find a way to allow these experiences to be safely and constructively represented within the conference, to hold these experiences, and to help the group to work with them analytically, in order to better understand the client, the therapist, and the therapeutic dyad's relationship. In the context of a well-contained group setting, associative freedom and the regressive potential of groups can present an opportunity for the expression of dissociated and otherwise unavailable aspects of the therapeutic dyad's experience, and an opportunity for transformation. The presenting therapist and the rest of the group can then see those affects and relational themes played out in front of them, and can learn both from watching and participating in the unfolding drama.[298]

Part III. Developmental Listening

Developmental Considerations and Supervision

Everyone who observes children for very long quite naturally forms theories about human development. Some developments come to be seen as quite good and others seen as quite bad, but most are seen as a range of average, expectable, and normal. Observers tend to categorize developmental milestones into stages and phases that become defined by psychologists and educators as gifted, normal, and challenged. We have witnessed the psychological categorizations made by Abraham, Freud, and Erikson, cast into “psychosexual stages” based on how a child’s natural drives interact with its nurturing environment. We have witnessed learning stages defined by Piaget according to his principles of assimilation (taking new things in and integrating them into old templates) and accommodation (conforming currently existing knowledge to new templates). Anna Freud with her slant on ego development has categorized progressive stages of ego development as various areas of ego mastery. Pediatrician-psychoanalyst Donald Winnicott has provided a series of early relational events between mother and child featuring a balance and negotiation between epigenetic maturational processes and various aspects of the facilitating environment. Margaret Mahler has organized her understanding of early relational development into a theory highlighting the child’s early psychological merger with mother that is followed by a series of stages in the separation-individuation process leading to psychological independence. All of these developmental models feature expectable sequences of growth that can be enhanced and/or thwarted by fortunate or unfortunate endowment and/or favorable or unfavorable environmental circumstances. While all these developmental theorists allow for

individual variations and overlapping phases, there remains nonetheless a lock-step progression motif that explicitly or implicitly differentiates good and normal developments from faulty and pathological developments. The notable exception to this general pattern is the Russian psychologist Lev Vigotsky who, in a surprisingly modern turn, understood growth more as depending on relational processes—though he tended to see some stages naturally unfolding from prior stages.

In my 1983 book, *Listening Perspectives in Psychotherapy*, I began two major study projects for myself that have extended into the present—one epistemological (i.e., what is the nature of knowledge about humans) and the other developmental (i.e.. what can we reasonably say about human development and how might it help us in our psychotherapy work?).

My first project—epistemology—deserves brief mention. In my psychological and therapeutic training in the late 1960's and early 1970's I had been bothered by the prevailing tendency in psychological theories to reify (make into things) and to personify (treat things like people with intentions) psychological concepts that were to me clearly interpersonal/relational processes. Citing the philosophical work of Gilbert Ryle and Ludwig Wittgenstein, I took the position that it was misguided in psychotherapy to form theories about things that were thought to be operating "inside" of people like homunculi (little people with intentions). I later expanded my epistemological concerns based on the essentially perspectival work of philosophers Richard Rorty and John Searle. Citing the work of psychoanalyst Heinz Kohut[299], I took the position that in contrast to the natural sciences that use tools of extrospection (i.e., collecting data based on external or objective observations), psychotherapy uses observational tools of introspection and

vicarious introspection (empathy), (i.e., collecting data based on observing what subjectively seemed to the client to be going on "inside" her and on what subjectively seemed to the therapist be going on "inside" both client and therapist). In my book *Listening Perspectives in Psychotherapy* I took the position that theories about psychotherapy are optimally centered on subjective observations about the interpersonal/relational context of the psychotherapy situation itself—not on some abstract, reified, and personified version of the "truth" of the human mind. My position was based on my belief that the human mind, whatever it may be, is by now known to be so infinitely complex and convoluted that it is, in principle, forever unknowable. Further, the human mind is based on millions of years of evolved group living giving rise to language and culture and to the gradual evolution of developmental processes that depend upon familial and interpersonal relationships for transmission so that it makes no sense to speak of an individual mind in isolation from evolved cultural, linguistic, and interpersonal contexts of the evolving human mind. Citing the 1926 work of Bridgman, I held that the best we could hope for was to establish "operational definitions" (pre-selected vantage points) from which to study human interactional processes and human developmental processes. In psychotherapy that meant developing "Listening Perspectives" from which to listen—in the broadest possible sense of listening with ears, eyes, nose, and all sixth senses—to what was happening within and between the two participant-observers of the dyadic process.[300]

When in 1982, I showed up in my mentor, Rudy Ekstein's, consulting room, having sent him a draft of *Listening Perspectives* some weeks earlier, the first thing he said was, "how could you possibly have written this book? Where did you learn this

approach?" I was stunned by his question but answered immediately, "from my philosophy of science professor at the University of Iowa, Gustav Bergman." Rudy nearly jumped out of his chair with delight! "You know my good friend, Gustav?! We were part of the Wiener Kreis in Vienna, you know, he somewhat ahead of me. But when I came to America several years after he did fleeing Hitler, I did stop by the University of Iowa on my way to Topeka to visit him. You were once his student, so that explains it! I hang my head in shame over how little one knows one's students." I was then regaled with delightful tales about the high culture at the turn of the century in Vienna and the Wiener Kreis, a multidisciplinary group given, among other things, to the philosophical conviction that human knowledge was necessarily based on perspectives and constructions rather than on objective realities. Rudy loved my book that organized a century of psychoanalytic studies into four interpersonal/relational developmental listening perspectives that I called, following Edith Jacobson, "self and other psychology." Rudy instantly envisioned a sequel to the book called "talking perspectives" based on the same interpersonal/relational dimensions but fine-tuned to the way people in therapy—clients as well as therapists—*talk* about themselves and their relationships. Having studied the supervisory process for a professional lifetime, Rudy declared that it was in supervision that we could most readily appreciate what was going on between client and therapist by the way they each talked and listened—in the broadest possible sense—to each other. "In supervision talking is not simply a didactic endeavor aimed at applying theory to practice, but an ongoing study of the way client and therapist as well as therapist and supervisor listen to and talk with each other." He spoke briefly about how the mutual listening and talking processes of the supervisory

situation so often reflect or parallel the mutual listening and talking processes of client and therapist in the teaching and learning of psychotherapy. By “listening and talking,” of course, he wasn’t being concrete but referred to the entire cognitive-emotional-conative exchange of psychotherapy and supervision. Later in my 1992 study of Freud’s account of how his friend and colleague, Joseph Breuer, had listened to and spoken of his therapeutic interactions with Bertha Pappenheim—in what has come to be known as the case of Anna O., “the specimen case of psychoanalysis”—I learned that it was from the way that each participant observer had come to represent—to listen to and talk with—each other that Freud felt he had first understood the unconscious.[301] In a few days Rudy sent me the forward to my book in which he says these things in his own words. Thanks Rudy.

All of my subsequent work bears the mark of this philosophical slant so that everything I have attempted to formulate and/or illustrate with case work is presented in terms of interpersonal/relational processes framed by listening and talking perspectives. While I was aware in 1983 of the intersubjective work of Robert Stolorow and Thomas Ogden on the West coast, it was not until the mid-1990’s that I became aware of the contemporary work of the Interpersonalist and relationalists developing on the East coast—so much for living in geographical isolation in the Cleveland National Forest and for not having the internet in those days!

The second project I began in *Listening Perspectives* was a developmental one. There I organized the main historical, theoretical, and clinical trends in psychotherapy, as I knew them at the time, into four Listening Perspectives based on metaphors borrowed from studies of human development—chiefly those set out by Margaret

Mahler.[302] My earliest formulations were based on modes, styles, and patterns of relational interaction that were observable at different stages and phases of child, adolescent, and adult relational engagement and how different kinds of therapeutic interaction are required for safely framing each level of relatedness experience.[303] I clearly understood that these modes, styles, and patterns were primarily a learned (internalized) part of our character and personality formation and that most relational modes were a regular part of interactions participated in by of all of us on a daily basis for a lifetime—not simply lock-step stages or phases to be gone through or transcended. That is, what was important to grasp in considering any interactional/relational developmental schema was the notion that while human relatedness modes can indeed be classified from earlier-learned simpler self and other modes to later-learned more complex self and other interaction modes, we are all quite capable of—and in fact continuously live out in various ways what have more recently come to be called multiple "self-states" in different relational contexts throughout every day of our lives. Thus, you see how easily even I have just been trapped by careless reification and personification of the concepts of "modes, styles, patterns, and self-states"—as if such things actually existed somewhere on the planet intentionally influencing our every move every day! Reifications and personifications such as these that we slip into so easily lead ultimately to nonsensical formulations. I consistently maintain—and it's very hard for many people to get—that it is critically important in interpersonal/relational listening and talking *not to think or talk in reified and personified ways!* True, artificial reifications and personifications such as these may help us stay in our consulting room chairs during times of interpersonal stress, but we need to keep

such concepts in mind as inventions, constructions, and vantage points – operational definitions, as it were – that may at times help us think but that have no objective reality in themselves.

In psychotherapy there is only relationship and the ways two people come to represent their relatedness to themselves and to each other. When we think and talk otherwise, we start thinking of ourselves and others as things with intentions—not people struggling to relate to each other's subjective life. Further, reification and personification deviously foster conscious and unconscious illusions that we know what we are doing, that we know what we are talking about, that we should do such and such next, and so on—all of which I am firmly convinced are lethal to the authentic, spontaneous interpersonal relational tasks of psychotherapy and supervision. More deviously, when whatever we have done, said, or conceptualized "works," we then tend to convince ourselves that the ways we are thinking and acting must be good or true so that we can think that way and do it again—all this rather than to sustain the much more difficult task of continuous unknowing processing—listening and talking with each other as human beings working on understanding ourselves and each other at various points in time. Remaining in perennial uncertainty allows us to remain authentic and spontaneous in our therapeutic and supervisory relating—easy to say and difficult to accomplish, I know. How often have I pointed out in my books and in teaching that many of our most our spontaneous and joyous relational moments in life are experienced in the most simple relatedness modes characteristic of delighted infants. While many of our most painful relational moments are based on highly complex self

and other relatedness modes that require self-restraint, consideration, empathy, and agonizing identifications with people whom we have come to love and respect.

As the years went by, I later clarified my partially reified formulations of personal modes, styles, and patterns into a series of more or less universal “relatedness potentials” or “forms of emotional memory” that indeed could objectively be seen to have a general maturational sequence, but which were, in the final analysis, highly subjective idiosyncratic ways of being in the world—depending on the relational possibilities present in each child’s early development. At all times I have formulated these developmentally-based interpersonal/relatedness potentials as *metaphors* within the context of my commitment to a postmodern, constructivist, and perspectival epistemological outlook. I have tended to see the epigenetic thread that loosely links self and other lifespan maturational relational possibilities as one for conceptualizing the continuous expansion of one’s *interpersonal/relational flexibility*—or not, depending on fortunate or unfortunate early as well as later interpersonal experiences. The tension that runs throughout my theorizing is between honoring objectively-derived infant, child, adolescent, and adult developmental observations and theory, while at the same time formulating subjectively-derived listening perspectives in terms of what might be of greatest service to each person in a consulting room witnessing—listening to, talking with, experiencing—the relational expressions of oneself and another.

My studies, beginning in 1983, have organized the central concepts of therapeutic practice—transference, resistance, countertransference, and counterresistance—along the lines of progressively complex internalized self-and-other relationship possibilities as they come to be known through the here-and-now mutual participation and observation

of the psychotherapy process. This move makes it possible to conceptualize an infinite set of individualized patternings of relational possibility that can be reconstellated in an endless variety of ways in the context of every psychotherapeutic (and personal) relationship. With the potential data pool of psychotherapy thus expanded to an infinity of relational possibilities comparable to the expanded data pool of the other 20th-century sciences, questions can then be entertained, following Bridgman, as to what operational definitions or listening perspectives on the forever elusive data of mind one might choose to define and observe, and for what purposes.

Paralleling the development of the listening perspectives approach has been another vigorous set of studies aimed at understanding and working with clinical experience that were spawned by Jay Greenberg and Stephen Mitchell's 1983 book, *Object Relations in Psychoanalytic Theory*. The relational psychotherapy and psychoanalysis movement they inaugurated became sufficiently defined by 1999 for Mitchell and Aron to declare the clear emergence of a tradition stretching as far back as Freud's early mentors Charcot and Janet including both Ferenczi[304] and Reich[305], early disciples of Freud, and running through the interpersonal school of Sullivan[306] developed chiefly at the William Alanson White Institute in New York and later the New York University Department of Psychoanalysis. By January 2002 the First International Congress of Relational Psychotherapists and Psychotherapists was convened in New York City under the auspices of the Stephen F. Mitchell Center for Relational Psychotherapy. While the West Coast work of Ogden[307], Stolorow et al.[308], Spezzano[309], Oremland[310], Renik[311], Grotstein[312], and their colleagues has all along been integrated into the relational movement, it is only since the publication of philosopher-psychoanalyst Orange's[313]

work on the importance of conceptualizing psychotherapy in terms of perspectives rather than truths that increased interest has been shown by relational theorists in the listening perspectives approach.

Developmental Listening Perspectives for Understanding Relational Experience

The self-and-other relatedness paradigm that has accompanied the widening scope of psychotherapy to include what have been called pre-neurotic or pre-oedipal relatedness experiences is characterized by six fundamental features formulated in diverse ways by different contributors.[314] The prioritization on relationship in the self-and-other paradigm marks six shifts in emphasis from previous thought paradigms:

1. Healing as a medical preoccupation gives way to interpersonal consciousness-raising experiences;
2. Purely objective science, long ago abandoned as a way of thinking and working by "hard" scientists, now gives way in psychotherapy and supervision to a systematic study of subjectivity and intersubjectivity;
3. The search for historical truth gives way to formulating interpersonal narrational truths;
4. the search for empirical truths of the classic and relativistic scientific approaches yields to the quantum, chaos, and complexity approaches of defining positions and stances from which to make observations of happenings that interest us for various reasons, i.e. Listening Perspectives;

5. defining the mythical nosological beasts of descriptive psychiatry gives way to the formation of subjectively viable frames of reference (in psychotherapy formulated as theoretical perspectives from which to listen to subjective and interpersonally constructed realities); and
6. a presumptive, a priori frame for studying the therapeutic dialogue gives way to moment-by-moment variable frames and techniques for focusing, sustaining, and studying the meaningful interactions of that exchange.

We can no longer afford to imagine that our accumulated wisdom in psychotherapy and psychoanalysis is anything other than a series of ways of thinking or a set of ideas to orient us to human listening/relational situations.

Hedges' Four Relational Listening Perspectives

The number and ways of defining Listening Perspectives from which to study the transactions of the psychotherapeutic encounter is entirely open-ended and arbitrary. But a century of therapeutic study suggests four distinctly different relational Listening Perspectives that have served the purpose of framing self-and-other relatedness patterns that operate in the interpersonal field (or, differently said, the constructions arising from the transference-countertransference-resistance matrix). Traditional scientific-objective approaches pre-specify in various ways the presumed nature of psyche, what kinds of structures and contents a psychotherapeutic observer is likely to see, and the ways in which the therapeutic search for transference and resistance memories are best framed. A more interpersonal/relational Listening Perspective approach simply defines an array of human relatedness possibilities that could serve to frame, for mutual consideration, whatever idiosyncratic narratives and narrational

interactions and experiences emerge for observation in the course of here-and-now relationship development.

Internalized relatedness habits or patterns from the lived past of each participant (as well as novel configurations emerging from the interpersonal engagement of therapy) will be an expectable focus of discussion as the therapeutic relationship unfolds.[315] Emotional honesty and limited disclosure of spontaneous affective experience on the part of the therapist will be an expectable part of the emerging therapeutic relationship.[316] The development of a personal creative style of relating that integrates, like postmodern art, a variety of ideas and interventions into the specific therapeutic exchange will be another expectable aspect of the emergent dialogue.[317] A multiplicity of ways of viewing and working together with the internalized patterns of both people, and the emerging configurations of interaction characteristic of the couple, can also be expected.[318]

The four Listening Perspectives that follow are based on developmental metaphors of how a growing child potentially engages and is engaged by others in interpersonal interactions that build highly personal and idiosyncratic internal habits, structures, and patterns of relational experience and expectation. Differential framing of developmentally-based relatedness potentials secures for psychotherapeutic study the structures, patterns, configurations, and/or styles and modes, and enactments of internalized interpersonal interactions that have characterized the past relationships of both participants and that are unconsciously transferred into and resisted conscious awareness and expression in the current mutually developing psychotherapeutic and supervisory relationships. Listening Perspectives do not represent a lock-step type of

developmental schema, but rather serve to identify a general array of relatedness possibilities lived out each day by all people and brought to the psychotherapeutic and supervisory situations for expression and study.

Thus, it can be seen that while my self-and-other Listening Perspectives approach highlights listening for experiences that have traditionally been defined as transference, countertransference, and resistance, it is completely consistent with a recent statement made by Interpersonal/Relational psychoanalyst Donnel Stern:

> All we can really specify is the degree of freedom or rigidity that characterizes a person's approach to experience, and even that specification must be understood as a judgment, vulnerable to unconscious influence. The only clinical question about transference and countertransference that really matters becomes how thoroughly willing and able each person is, under some specified set of circumstances, to consider alternative meanings.[319]

Relational psychotherapists and psychotherapists, rightly or wrongly, have been repeatedly criticized on the basis that there is little systematic attention to transference, resistance, and countertransference in relational work. In contrast, the interpersonal relational Listening Perspectives have been explicitly defined for the purposes of bringing out the unconscious transference/resistance and countertransference/counter-resistance relatedness dimensions perennially at play in the therapeutic and supervisory relationships. Relational theorists have also been criticized for failing to have a viable developmental understanding of relatedness. As a counterpoint, Donnell Stern faults developmentalists for failing to come up with a theory of therapy that allows for safe

framing of all levels of relatedness development.[320] But, in fact, Hedges' *Listening Perspectives* defines four distinct developmental levels of relatedness possibility and specifies how each can be framed so that "regression in the service of progression" can safely occur—for both participants.

The four listening perspectives are summarized in Tables 1 through 4 as well as graphically depicted in Figures 5

Table 1 summarizes the developmental metaphors used to describe the four distinctly different types of patterns of self-and-other relatedness to be listened for and responded to in the evolving self-and-other transference-countertransference relatedness matrix of the analytic listening situation.

Table 2 outlines the comparative features of each listening perspective in terms of the traditionally held diagnosis, the developmental metaphor employed, the way the affects are thought to be organized, the varieties of transference which are commonly expected, the ways resistance and counterresistance are thought to manifest, the mode of listening and responding believed to be most efficacious, the technical or therapeutic modality generally recommended for this mode of transference/resistance experiencing, and the ways that countertransference relatedness dilemmas are often perceived to arise.

Tables 3 and 4 show the relationship between listening perspectives used to define transference-countertransference-resistance and the features characterizing the intersubjective field, or analytic third.

Figure 5 was developed by British psychologist, Robert Rentoul, in his wonderful 2010 book, *Ferenczi's Language of Tenderness: Working With Disturbances from the Earliest Years*, in which he summarizes Hedges' Listening Perspective approach and puts together all of these modes and levels into one helpful chart. Thanks Robert.

It is necessary to study these tables and figures in some detail in order to grasp the crucial importance of framing different relatedness possibilities with different thought systems, or Listening Perspectives.

TABLE 1

Four Relatedness Listening Perspectives

I. The Organizing Experience

Infants require certain forms of connection and interconnection in order to remain psychologically alert and enlivened to themselves and to others. In their early relatedness they are busy “organizing” physical and mental channels of connection—first to mother's body, later to her mind and to the minds of others—for nurturance, stimulation, evacuation, and soothing. *Framing* organizing patterns for analysis entails studying how two people approach to make connections and then turn away, veer off, rupture, or dissipate the intensity of the connections.

II. The Symbiotic Experience

Toddlers are busy learning how to make emotional relationships (both good and bad) work for them. They experience a sense of merger and reciprocity with their primary caregivers, thus establishing many knee-jerk, automatic, characterological, and role-reversible patterns or scenarios of relatedness. *Framing the* symbiotic relatedness structures entails noting how each person characteristically engages the other and how interactive scenarios evolve from two subjectively formed sets of internalized self-and-other interaction patterns.

III. The Self-Other Experience

Three-year-olds are preoccupied with using the acceptance and approval *of others* for developing and enhancing *self*-definitions, *self*-skills and *self*-esteem. Their relatedness strivings use the admiring, confirming, and idealized responses of significant others to firm up their budding sense of

self. *Framing* for analysis the self-other patterns used for affirming, confirming, and inspiring the self entails studying how the internalized mirroring, twinning, and idealizing patterns used in self-development in the pasts of both participants play out to enhance and limit the possibilities for mutual self-to-selfother resonance in the emerging interpersonal engagement.

IV. The Independence Experience

Four-and five-year-olds are dealing with triangular love-hate relationships and are moving toward more complex social relationships. In their relatedness, they experience others as separate centers of initiative and themselves as independent agents in a socially competitive environment. *Framing* the internalized patterns of independently interacting selves in both cooperative and competitive triangulations with real and fantasized third parties entails studying the emerging interaction patterns for evidence of repressive forces operating within each participant and between the analytic couple that work to limit or spoil the full interactive potential.

TABLE 2

Listening Perspectives: Developmental Frames or Modes of Inquiry

I. The Personality in Organization: The Search for Relatedness	
Traditional diagnosis:	organizing personality/psychosis
Developmental metaphor:	birth – 4 months—focused attention versus affective withdrawal
Affects:	connecting or disconnecting, but often appearing as an inconsistent, generalized, or chaotic clamor to a casual observer
Transference:	connection versus disconnection, rupture, discontinuity, and disjunction
Resistance:	to connections, to channels that are organizing or promise consistent bonds
Listening mode:	connecting, intercepting, linking
Therapeutic modality:	a focus on withdrawal, constriction, and/or destruction of links that results from mutually connecting or from mutual engagement—*interception*
Countertransference:	fear of intensity of psychotic anxieties that arise from interpersonal and intrapersonal connections; withdrawal and defense

II. Symbiosis and Separation: Mutually Dependent Relatedness	
Traditional diagnosis:	borderline personality organization/character disorders
Developmental metaphor:	4-24 months—symbiosis and separation-individuation
Affects:	split “all good” and “all bad”—*ambitendent*
Transference:	replicated dyadic interactions or scenarios
Resistance:	to assume responsibility for differentiating, for renouncing the scenarios
Listening mode:	interaction in replicated scenarios, followed by standing against them
Therapeutic modality:	replication and differentiation—*reverberation*
Countertransference:	participation in reciprocal mother and infant positions—a “royal road” to understanding merger relatedness

III. The Emergent Self: Unilaterally Dependent Relatedness	
Traditional diagnosis:	narcissistic personality organization
Developmental metaphor:	24-36 months—rapprochement
Affects:	dependent on empathy or optimal responsiveness of selfother
Transference:	selfothers (grandiose mirroring, twinship, idealizing)

Resistance:	shame and embarrassment over narcissism, narcissistic rage
Listening mode:	engagement with ebb and flow of experiences of self-affirmation, confirmation, and inspiration
Therapeutic modality:	empathic attunement to self-experiences—self-to-selfother *resonance*
Countertransference:	boredom, drowsiness, irritation—facilitating

IV. Self-and-Other Constancy: Independent Relatedness	
Traditional diagnosis:	neurotic personality organization
Developmental metaphor:	36+ months—(oedipal) contingent triangulation', competitive and cooperative
Affects:	*ambivalence*; overstimulating affects and repressed drives
Transference:	constant, ambivalently held self and others
Resistance:	to the return of the repressed
Listening mode:	evenly hovering attention/free association/equidistance
Therapeutic modality:	verbal-symbolic interpretation—interpretive *reflection*
Countertransference:	overstimulation—generally an impediment or detraction

TABLE 3

Relational Listening I: Development, Transference, Countertransference

Age	Developmental Thrust	Transference	Countertransference
>3yrs	Self and Other Relational Experiences	From Independent, Ambivalently Held Others	Overstimulating Experiences as Distracting or Impediment
24 to 36 Months	Self-consolidating, Recognition Experiences	From Resonating or Injuring Self-Others	Facilitating Experiences of Fatigue, Boredom, and Drowsiness
4 to 24 Months	Symbiotic and Separating Scenarios/ Interactive Experience	From Interacting and Enacting Others– Replication	Resistive Experiences to Replicating Demanding, Dependent Scenarios
± 4 Months	Organizing Merger and Rupturing Experiences	From Engaging and Disengaging Others	Dread and Terror of Unintegrated Experiences

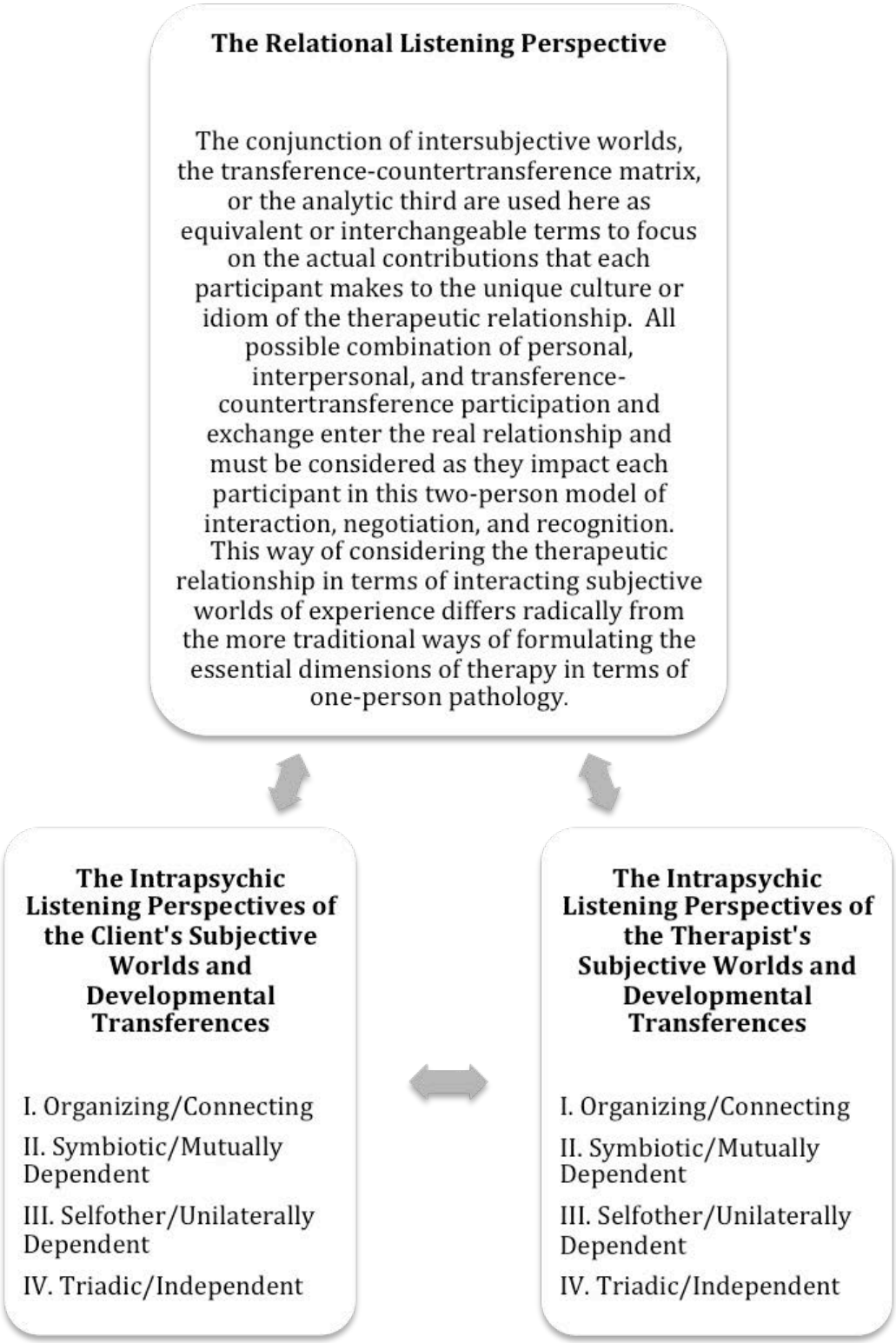
TABLE 4

Relational Listening II: Resistance, Listening Mode, Therapeutic Intervention

Age	Resistance	Listening Mode	Therapeutic Intervention
>3yrs	To the Return of The Repressed	Evenly Hovering Attention Free Association Equidistance	Interpretive Reflection: Verbal-Symbolic Interpretation
24 to 36 Months	To Experiencing Narcissistic Shame and Narcissistic Rage	Resonance with Self-Affirmation, Confirmation, and Inspiration	Empathic Attunement to Self to Self-Other Resonance
4 to 24 Months	To Assuming Responsibility for Differentiating	Replicating and Renouncing Symbiotic and Separating Scenarios	Replication Standing Against the Symbiotic & Separating Scenarios: Reverberation
± 4 Months	To Bonding Connections and Engagements	Engagement: Connection, Interception, Linking	Focus On and Interception of Disengagements

FIGURE 5.

Listening perspectives and transformational relationships—the leading paradigm of psychoanalytic psychotherapy.



Formulating in Terms of Listening Perspectives

The Listening Perspectives approach considers psychotherapeutic and supervisory concepts viable and valuable only insofar as they are formulated specifically within an interpersonal/relational human listening context. Psychotherapeutic and supervisory knowledge cannot be about a thing, the human mind, but rather exists as a body of thought about how people are able to achieve mutually enlivening consciousness-raising experiences in an emotionally alive and emotionally stressful[321] relationship.

Listening Perspective IV, historically the earliest perspective for framing psychologically independent relatedness in triadic self and other constancy experiences of the oedipal (4-6 year old) period, has been the traditional focus for therapeutic and psychotherapeutic thinking for a century and so requires no special attention here.[322] Listening perspective III, for framing self-experience in relation to the psychological use of selfothers for self-consolidation, has been the focus of Heinz Kohut[323] and the self psychologists, as well as Donald Winnicott[324] and has been well documented elsewhere.[325] Listening Perspectives I and II have more recent historical origins.

Listening Perspective II designed for listening to people presenting personality features widely referred to as borderline or various types of character structures and addictions is derived from a metaphor of internalized childhood symbiosis, so that the demands of a tightly intertwined internalized mother-child attachment or bonding dance can be called to the listener's mind.[326] Listening Perspective I is designed for listening to how a person’s earliest attempts to organize physical and mental connections to the mothering person(s) may have occurred and what kinds of events may have thwarted

those attempts and are later memorialized in transference, countertransference and resistance experiences of psychotherapy.[327]

I will briefly elaborate on these last two Listening Perspectives since these will be of greatest interest to us later in locating unformulated and dissociated experiences of "Bad-me" and "Not-me" in psychotherapy and supervision.

Considering Listening Perspective II: Symbiotic Relatedness Memories

Early mother-child experience has been conceptualized by Mahler[328] as an internalized character structuring that she calls a subjective sense of "symbiosis"—not to be misconstrued as a biological/sociological notion.[329] Over time, the internalized *subjective* symbiotic experience has been formulated variously by different theorists. For example, expanding Sigmund Freud's[330] notion of turning passive trauma into active victory in relationships, Anna Freud[331] speaks of identification with the aggressor as a way a child internalizes the parental role in relatedness. Melanie Klein[332] speaks of projective identification as a way of making early interpersonal internalizations known to the therapist and available for study by the therapeutic couple. Hedges speaks of interactive character scenarios[333] and of interpreting the countertransference[334] in such a way that in Listening Perspective II the psychotherapeutic listener often comes to experience and to speak for the child self of the client.[335] That is, not only are early (or pre-oedipal) self-and-other interpersonal schemas or character scenarios internally represented in relatedness forms as they were originally experienced, but their characteristic affects and interactions are internalized in role-reversed forms as well. Both passive (original) and active (role-reversed) representations of early relational patterns appear in transference-countertransference replications. Replicated interactive

forms (symbiotic, borderline, or character level) of transferences and countertransferences stand in sharp contrast to those Kohut[336] defines as (more developed) selfother or narcissistic transferences and to those Freud[337] defines as oedipal or neurotic triangular transferences.[338]

Considering Listening Perspective I: Organizing Relatedness Memories

At the core of all personality functioning lies the infantile experience of environmental limitation. Listening Perspective I provides an interpersonal/relational way of defining a variety of transference and countertransference experiences metaphorically conceptualized as arising from the infant's relational disappointments and traumas during the earliest months of life.[339] Modes of organizing experience can also result from regressive experience caused by cumulative strain trauma[340] or from other kinds of later focal traumas (Davis, J. M., and Frawley-O'Dea, M., date)

Metaphorically considered, from approximately four months before birth to four months after birth, the infant is actively searching, reaching out in various sensory/motor/affective ways, seeking *to organize* reliable physical and psychological channels to environmental sources of safety, nurturance, stimulation, comfort, and evacuation. When an infant's reaching is met in a timely and pleasurable manner by the environment, that way of reaching is reinforced until it gradually becomes a reliable channel for the development of mutually regulating symbiotic scenarios[341], for interpersonal-attachment internal working models, or for bonding schemas.[342]

But when, for whatever reason, the reaching is not met in a timely, satisfying manner or is actively thwarted or traumatized, it is as if a sign were posted in the nascent neurological system saying, "Never go there again. Never expect or reach out for

relatedness in that way again."[343] Difficulties in organizing experiences are conceptualized as foundational and universal, since no early environmental situation ever perfectly meets any baby's complete needs in the sought-after or desired manner. The fragmenting experiences of reaching, not finding, and withering—or of reaching, feeling injured, and constricting—are universal, and the impact of failed extensions leaves a mark on our characters and on our bodies in various ways.[344]

When needful and desirous extensions are not met in a satisfactory or timely manner or are met with trauma or abuse, we observe what Fraiberg[345] calls the pre-defensive reactions of fight, flight, or freeze common to all mammals. We can observe in any mammal the terrified frenzy followed by collapse that results when the warmth and nurturance of the needed maternal body and mind cannot be found. In human babies these pre-defensive reactions to painful or frightening experiences set up memory barriers along paths of possible interpersonal connections so that these paths are not selected again or are employed only with caution and trepidation. Freud, as early as 1895, spoke of these barriers as counter-cathexes. Tustin[346] describes various kinds of autistic and psychotic responses that develop when the needed/desired interpersonal (sensual) connections cannot be established. Infant researchers describe many ways that early interaction schemas develop or fail to develop that might lead to satisfying and satisfactory bonding, attachment, or mutually regulated symbiotic interactions.[347] Current studies in neuroscience specify the various ways in which interpersonal relationships condition synapses throughout the neurological system early in life—so that even central nervous system functions traditionally considered

genetically or constitutionally hardwired are increasingly being understood as products of our personal relational histories.[348]

In therapeutic situations of later life, these pre-defensive reactions can be studied as organizing or psychotic level transference and/or countertransference resistance to safely establishing the interpersonal/relational connections required for basic love, dependency, interdependency, and trust in relationships. Reviving the somatopsychic memories or blocks to reaching out for love necessarily entails consciously reliving agonizing primitive experiences in the here-and-now relationship in a safe interpersonal relationship with a therapist or supervisor.[349] Contemporary neuroscientists support the notion that psychotherapeutic relationship experiences actually function to recondition neuronal pathways.[350] Relational psychotherapists Bromberg[351] and D. B. Stern[352] have called upon Sullivan's[353] concepts of "Bad-me" and especially "Not-me" to describe the dissociate or walled-off parts of personalities that are unformulated, dissociated, and enacted.

The central feature of *Working the Organizing Experience*[354] revolves around the contact or relational moment. The analytic listener's first task is to sort through the often complex and confusing reflexive and nonhuman content to determine where potential points of real and safe interpersonal (cognitive-affective-conative) connection may be possible. Then the therapist learns to track the person's movement toward contact moments that seem as inevitable as any mammal searching for a breast. But somewhere just before, during, or immediately after interpersonal contact actually occurs, "something happens" to make contact or sustained connection impossible[355]. It is the specificity of the contact-rupturing experience that must be coaxed "out" or

brought “forth” and then framed for here-and-now therapeutic study. The person's internal, idiosyncratic ways of rupturing contact are understood as the organizing or psychotic transference/resistance and can be fruitfully studied in the interpersonal setting of psychotherapy and occasionally in supervision. Resistance comes to be understood as the person's all-out efforts to avoid dealing with (a) the contact experience itself and/or (b) the traumatic life-and-death somatopsychic terrifying transference and resistance experiences[356] that must be relived in a safely framed therapeutic relationship if one is to be able to make the connection and to move toward sustaining growth-producing interpersonal experiences.

This listening tool for studying in vivo the connections and disconnections during the course of therapeutic hours is as useful for people living pervasive organizing experiences (i.e., people living so-called psychotic, schizoid, and autistic states) as it is for people who may be much better developed in most ways but who need to explore some aspect of early organizing experience in the course of therapy or supervision.

Early environmental failures and traumas cannot simply fade harmlessly into the past unless something in the present safely replaces them or fills in the gap left by disruptive, failed, or traumatized internalized relational experiences. Bromberg[357] has studied these early developmental phenomena in terms of the mechanism of dissociation and speaks of the developing capacity to “stand in the spaces” between various dissociated aspects of one's personality as the road to psychological health. D. B. Stern[358] specifies how relational psychotherapy permits heretofore unformulated experiences to emerge into the here-and-now transference-countertransference matrix, where conscious formulations at last become possible and the person recognizes

previously unknown or un-representable choices. Hedges' Listening Perspectives approach specifies developmentally-based metaphoric descriptions of an array of relational possibilities including the "organizing" one and specific ways of thinking and being that allow for safe interpersonal/relational framing each level of self and other relatedness potentials for therapeutic study.

For this kind of work to succeed with borderline and psychotic states (i.e., for a working symbiosis and a later cohesive self to develop *de novo*), Kohut[359] believes that the client has to be willing and able to sustain long periods of pre-psychological chaos alternating with long periods of borrowing heavily from the personality of the therapist in order to insure safe regression.[360] The terrifying organizing experience that has been internalized can only be fully brought for analytic scrutiny when there is enough belief established that other ways of surviving the revitalized internalized infantile trauma are possible within the therapeutic or supervisory relationship. It is only within the context of reliable relational therapeutic holding that a person dares to re-experience the terror of the once-perceived somatopsychic life-threatening infantile traumas of the organizing period—which are still silently and self-destructively alive in the personality. Only as the therapist offers a new and better way of safely relating in the here-and-now can the ancient disconnecting traumas be relived and actively relinquished in favor of actualizing in the therapeutic or supervisory relationship more complex and flexible relatedness modes[361].[362]

Elsewhere I have specified various ways in which the organizing transference affects and gives rise to organizing forms of counter-transference.[363] I have also written extensively on how the organizing transference often works to endanger therapists,

giving rise to malpractice suits as well as ethics and licensing board complaints.[364] Not only must the client experience the relationship as safe but the therapist and the supervisor as well.

Four Empathic Modes for Framing the Listening Perspectives

I. Organizing activities are perhaps best met with what may be called interception or interceptive contact. The most basic forms of orienting, organizing, and ordering of affective and sensory-motor response seem facilitated by their being contacted while in active, spontaneous, exploratory or manipulative extension. An infant's, child's, or adult's tentative extensions into the environment may result in a variety of consequences. Those that put him or her into safe and reliable contact with the human environment are those that are met with various forms of reliable, warm, human responsiveness. Orienting, organizing, and ordering extensions not warmly or safely met in a timely fashion result in psychological enclaves of autosensuousness[365] leading to forms of (delusional or hallucinatory) entanglement with dangerous, threatening, seductive, nonhuman, mechanical, or erratic environmental figures or features. Many culturally defined forms exist to encourage patient waiting until an infant is in a position of extension in which he/she may safely benefit from human contact (interception of movement). The therapeutic tradition has evolved a variety of patience-inducing concepts that represent analogous forms for providing availability and responsiveness for the organizing aspects of personality to safely emerge. In persons or areas of a person where there has been an early traumatic history we will be concerned primarily with the way contact, once established, is broken off. The exact mode or style of destroying life-giving contact represents a transference from earliest experiences in

which contact was either not maintained satisfactorily or was traumatically disrupted. Systematic study of the breaking of potential thought links is an important part of knowing about a person's organizing forms.

Considered in contemporary interpersonal/relational terms, the early turning away from various kinds of interpersonal experience due to terrifying or traumatic events creates potential areas of experiences that are blocked off from further development and are spoken of as “not-me.”

II. Symbiotic activities imply a real or fantasized partner who shares a privately co-created culture and relates through a highly personal idiosyncratic idiom known only (or mainly) to the dyadic participants. As people live out their symbiotic structures in subsequent intimate relationships they tend to assume that their way is the right way, the only way, or the most appropriate way. Infants who have available more than one very invested significant other may have a more varied series of symbiotic scenarios derived from diverse mutual cueing experiences. Empathic, safe, interactive contact with symbiotic activity in psychotherapy may be described as "replication"[366] or as the "replicating transference." Much of symbiotic activity is preverbal, and the sense of replication of personal symbiotic modes is likely to arise from positive and negative experiences of active or passive nonverbal patterns of interaction that develop in the therapeutic dyad.

In contemporary Interpersonal/Relational terms those affectively split experiences create what are called the “good-me” and the “bad-me.”

The detection of a replication of a symbiotic mode often occurs via some experience of the countertransference. Conceived broadly as all affective and/or cognitive

responsiveness to the person on the part of the therapist, countertransference at this level of self and other experiencing may be said to represent the "royal road" to understanding various replicated scenarios of the merged dyadic experience. Many culturally determined forms for providing responsiveness to symbiotic yearnings are available to parents and therapists. Responding on cue to important desires and asserting counter cues may ultimately lead to mutual affective regulation and interpersonal boundary definition. This separation-individuation experience can only follow on the heels of an experience of intense symbiotic merger[367]. The separating phase is often accompanied by depression and/or anger, registering the person's resentment that the dyadic symbiotic mode that spells attachment, connection, bond, or love is being violated by separation and individuation experiences. Even if the old modes were dreadful or abusive, people tend to cling to them out of addictive habit and experience severe panic withdrawal, and depression when giving them up as a result of immersing themselves in a new relationship.

III. Self-Cohesion activities are thought to be performed in relation to another, the "selfother." [368] Mirroring, twinning, and idealization activities constitute forms in which the other person in the relationship functions in an affirming, confirming, or inspiring manner. These self-cohesive activities initially performed by an other are thought, through positively experienced repetitions, to become part of the activity repertoire of the growing person. The developmental continuum from archaic to mature forms of selfother resonance might be characterized as a shift from compulsive searching for (archaic) selfothers to the development of a capacity to generate and to use creatively

affirming, confirming, and inspiring engagements with others for many kinds of personal enrichment and for personal sustenance during times of stress.

Perhaps Kohut's most useful clinical contribution is the manner in which he viewed tension regulation in relation to self-consolidation. He defines a cycle in which insults to self-esteem lead to tension increases and a search for tension relief. Tension related to issues of self-esteem and self-cohesion is typically lowered when a selfother is available for some sort of affirmation, confirmation, or idealization. The significant moment in therapy is one in which selfother empathy fails in some regard, thereby producing increased tension. Kohut formulates that a temporal breakup of previously established cohesion tends to produce crude lust and aggression as fragmentation byproducts. However, with the restoration of selfother empathy (from the therapist or supervisor) comes the restoration of self-esteem and the resultant lowering of tension. Repeated experiences of empathy failures followed by favorable selfother tension relief (restored empathy) are thought to lead toward the personal establishment of a capacity for lifelong creative and comfortable self-to-selfother resonance.

Practically speaking, the listener may be doing the utmost to be there, to attend, to understand, or to provide whatever empathy the person seems to need as the tension runs high. But sooner or later the empathy fails and the person feels let down, disappointed, discouraged, and perhaps even depressed or enraged at the empathic failure of the listener. Kohut argues that what is crucial is the listener's capacity to perceive the failure and to remain steady in understanding as well as possible all aspects of the reaction to the empathic breach. The selfother or narcissistic transference is from a failing parent figure who was not able to understand the failure

and empathize with the bad or nonsupportive reactions that disappointments inevitably bring out in us. Self-psychologists had defined and illustrated an array of ways through which selfothers regularly are able to respond to disappointment with affirming, confirming, and inspirational activity.

IV. Self and other constancy or interdependence activities are thought to arise out of the establishment of an experiencing self that can be more or less reliably differentiated from various experiences of others. Even so, repressed unconscious fantasies regarding one's personal relationships are thought to play a significant role in how one continues to perceive and chooses to engage others in all manner of triangulated interpersonal relatedness experiences (e.g., the Oedipus or Electra complexes).

Ascendancy to full constant, independent, oedipal experiencing involves relinquishing to a large degree the earlier-learned organizing, symbiotic, or separating modes of relating to others. Full freedom to engage in the complex oedipal activities of lust, competition, fear, and injury also involves to a large degree the relinquishing of predominant reliance on reassuring selfother modes in deference to more complicated contingent and triadic forms of relatedness. A readiness to tolerate the intense stimulation associated with ambivalent feelings of attraction, rivalry, jealousy, completion and injury permits the assimilation of social codes on a different plane than previously possible—the so-called crystallization of the symbolic and the superego. Full emotional capacity to consider others as separate centers of initiative with separate interests and motivations introduces the realistic possibility of personal injury in complex triangular relationships (e.g., so-called oedipal castration) and gives rise to various forms of distrust. That others' personal and narcissistic investments constitute an ever-

present danger is a reality to be reckoned with, Kohut says. Not to notice in oneself or in others unacceptable forms of attraction, aggression, jealousy, or injury is the dominant way of dealing with these intense forms of stimulation in the oedipal mode. Freud formulated this policy as one of not noticing, as unconscious defensive activity, which he categorized as various forms of repression. In order to master the intensity of the Oedipus complex, a person must learn to sublimate or at least (defensively) not to notice stimulation that would disrupt the continuity of the sense of self in triadic relationships.

Historically, empathic contact with repressed oedipal activities through carefully timed and tactfully delivered verbal-symbolic interpretations has been the central thrust of the therapeutic and psychotherapeutic enterprises. Freud's insistent advocation of a strictly verbal-symbolic, interpretive approach and his gradual limiting of the population of the analyzable clients to well-developed neurotics has led to much dissension in the field and spawned a widening scope of theory and practice. At present, Freud's obstinate consistency can be seen as limiting to analytic work with preoedipal issues, but as clarifying with regard to the value of abstinence and verbal interpretation (i.e. the triadical frame) for understanding and analyzing personal (neurotic) activities constellated and integrated in the abstract symbolic mode of Oedipus, who blinded himself, symbolizing his wish not to see (be overstimulated by) relating others.

Kohut[369] has argued convincingly that optimally empathic oedipal figures in childhood are successful to a large degree in limiting overstimulation during this period, thus preventing the formation of excessive defensive activity and neurotic constellations. It can be added that empathic responsiveness to self-cohesion modes

from important others prevents excessive fragmentation during self-consolidation or for that matter at any stressful point in life. Furthermore, appropriate empathic responsiveness forestalls extensive good-bad splitting in the symbiosis and separating modes as well as needless searching and floundering in organizing modes. Kohut[370] has maintained that the traditional therapeutic emphases on lust and destruction have overshadowed the positive trends of stimulating love and assertiveness that are possible with positively resonating parental selfothers. In addition, emphasis on self fragmentation, good-bad splitting, and chaotic or bizarre behaviors have also tended to overshadow the positive aspects of developmentally determined modes and activities when more appropriate forms of empathic responsiveness are available from the parents and/or the therapeutic or supervisory listener.

Empathic Modes as Forms of Listening and Responding "from Above"

The gradual refinement of developmental theory and technique has made possible the extension of the concepts of safe framing and empathy to at least three preoedipal modes that do not include verbal-symbolic interpretive activity as a consistent response. Interception of organizing activity, replication of symbiotic and separating interactions, and repetition of selfother resonance all represent major modes of framing, listening to, and empathizing with various preoedipal aspects or features of personality. These empathic modes have evolved to supplement the traditional empathic mode of verbal-symbolic interpretation first envisioned by Freud and later adopted by essentially all schools of psychotherapy. In order to avoid confusion, a mode is here conceptualized adverbially as a way of seeking and engaging in interpersonal contact.

In many instances, what passes for empathic response differs little from sympathy and, by itself, has little or no useful effect in psychotherapy. Everyone has seen or heard of instances in which a therapist has continued for a protracted period of time in genuine sympathetic immersion with a person who has realized only limited personal gains as a result. The effect is at best benign or helpful in promoting an ameliorated life adjustment. One might liken such a situation to transitivism or sympathetic parallel play in young children who, though they may enjoy one another and may react intensely to each other's play, are quite unable to elevate their level of mutual relatedness without intervention of the kind that recognizes or implies higher (more comprehensive or flexible) relatedness options.

Children can be told to be considerate and they can indeed be taught not to create a ruckus with one another, but differentiated capacities for self-confirmation and mutual consideration come from somewhere else. From where? Clearly from something that can be described as a learning, modeling, or identification effect. That is, empathy if it is to be transformationally effective, must come "from above." And what can this mean?

Returning to our main topic to shed light on the problem of empathy, it can be said that we can only consider others fully when we know what it means to be considered fully (Listening Perspective IV). We can only know how to confirm another struggling self when we know what it means to feel confirmed in our own struggles (Listening Perspective III). We can only tolerate separating opposition when we understand how crucial it is that our opposition be received tolerably (Listening Perspective II). We can only permit ourselves to be drawn into a symbiotic replication when we know how important it feels to have someone fully involved in our subjective world of relationship

merger (Listening Perspective II). We can only know how to wait for and to discern extensions that can be momentarily met if our own extensions have been adequately met (Listening Perspective I).

Different modes of empathy that constitute various forms of safely framing relationships are necessarily derived from identificatory experiences of others listening to us or being with us in increasingly broader, more flexible, or more comprehensive ways, or as it were, "from above," in a hierarchy of complexity in human relatedness responsiveness. In contrast to historically earlier understandings of the importance of fixed framing and verbal interpretive activity in psychotherapy, our recently acquired knowledge from neuroscience, infant research, and relational psychotherapy makes clear that different developmental levels of self-and-other relatedness possibility require variable-response framing as well as pre- and non-verbal relational interpretive activity.

A Kohutian truism, which is confirmable in the more differentiated self and otherness states, relates to the consequences of empathic failure. Kohut predicts increased tension, fragmentation, and loss of self-esteem following an empathic failure. This prediction indeed appears to hold true when it is the self that needs confirming. However, in symbiotic and organizing activities, the results of empathic failure may be manifold and are generally not well described by merely referring to them as increases in tension, fragmentations of the self, or losses in self-esteem. For example, one person may experience a relief at a certain type of symbiotic failure in empathy because, as with the original symbiotic partner, failure means that the experienced battering or abuse (connection) comes momentarily to an end. Conversely, for someone else, certain kinds of intrusion or abuse might signal interpersonal contact and a consequent

relief from a terrible period of isolation and loneliness. By the same token, either an empathic connection or failure to connect to organizing features might, depending upon the original caregiving situation, either permit or prevent a withdrawal into hallucinatory experience, a flight into manic elation, or an escalation of depression or paranoid rage. A placid interval may mean to a mother that the baby is content, while it may represent to the infant a state of depletion resulting in disappointment or failure to attain his or her subjective aims.

Therefore, contrary to Kohut's general assertions regarding empathic resonance at the level of self-cohesion striving, it is not possible in the short run to predict with certainty the consequences of empathic contact or empathic failure in pre-cohesive self-states. Paradoxes and surprises abound in preoedipal activities in which a person's strivings may resemble a young child's attempting to master the nuances of a complex environment with certain limitations in knowledge or communication skills. Misunderstandings between child and caregiver are common occurrences rather than exceptions. However, a persistent baby and a devoted caretaker in time learn to develop a mutual cueing system (the symbiosis), which is a fairly reliable communication system. How many instances have we all encountered of well-intentioned empathic response that failed to meet the mark in terms of tension release?

Empathy, if it is to be accurate, comprehensive, and framing; and if it is to promote greater flexibility, must come "from above," that is, be derived from more encompassing, more abstract, or more flexible forms of understanding. The empathizer must be able to convey a sense of understanding of and tolerance for the personal concerns and positions being expressed, sought after, or presented for interaction or interception.

That a baby will be happier and healthier with a clean diaper is no consolation to the angry, kicking, screaming child who has been interrupted in absorbing pursuits. Mother's understanding and tolerance of the rage and its causes will make it possible for her to survive the infant's attacks without retaliation until soon the two are laughing and cooing together to the smell of fresh talcum and the sense of a clean diaper, a nice baby, and a happy mother. The expectable provocations of "the terrible twos," and "adolescent rebellion" are common examples of personal activities that try a parent's (or therapist's or supervisor's) patience. In these cases empathy can only mean a willingness to engage in a fray so that the opposing self can experience an independent consolidation through opposition activities. There are also various seductions that must be accepted and lived through in some suitable manner. Whether the seduction is to some form of organizing contact, merger, self-confirmation, or incestuous activity, empathizing means receiving the wishes and impulses openly and being prepared to be available, supportive, and responsive when inevitable limits and disappointments arise.

Empathy is not enough if it only means sympathy or if it is limited to the understanding of certain forms of relatedness. Comprehensive psychotherapeutic empathy is based on an assimilation of a variety of developmentally-determined modes and forms by the therapist as well as the supervisor. Indeed, the role of the empathizer is a form. The role inherited by the therapeutic position is endowed with several thousand years of form-filled witnessing tradition in addition to the specific rituals and requirements that twentieth century professional life has added. Empathy is not enough until it includes an understanding of the full human repertoire of developmental patterns, modes, codes, and forms. The therapeutic position is a specially contrived form with a

variety of modes for understanding established patterns of personal activity. Sustaining the therapeutic position fosters the systematic expansion of personal realities through an enhanced process of personal reverberation with the form-filled human milieu via the living presence of the therapeutic listener.

Readers well-schooled in interpersonal/relational two-person approaches to therapy and supervision will note that the forgoing discussion of framing relational possibilities with empathic responsiveness sounds dangerously like old-school one-person therapy and supervision in which an expert is treating or teaching some kind of a lesser client or therapist. This is not my intention; but rather it seems that way because this discussion on empathy that includes the issue of safely framing various developmentally-based experiences seeks to address the asymmetrical aspect of therapy and supervision in which the more experienced member of the pair assumes the primary responsibility for holding a safe frame so that the mutual and reciprocal, spontaneous symmetrical relating can be experienced and expanded.

Part IV. Conclusion

Relational Psychotherapy and Supervision in the New Millennium

The Paradigm Shift of Relational Psychotherapy

Our vision of psychodynamic psychotherapy has taken a radical turn in the past two decades. Spawned by nineteenth century philosophy, science, and medicine, the study and practice of psychotherapy has recently come into its own in quite unexpected ways. No longer a discipline aimed at changing thoughts and behaviors believed to be pathological, symptomatic, or maladaptive, relational psychotherapy has come to be understood as an *interpersonal process of consciousness-raising*[371].

While my 1983 book, Listening Perspectives in Psychotherapy and Greenberg and Mitchell's Object Relations Theory in Psychoanalysis (1983) were apt forerunners, Stephen Mitchell in his 1988 book, Relational Concepts in Psychoanalysis: An Integration (1988), provided the first clear statement of this relational turn. By 1999 the emergence of a relational tradition stretching as far back as Sandor Ferenczi and Harry Stack Sullivan could be discerned in the writings of a number of contemporary practitioners[372].

Recognition theory[373] along with contemporary neuroscience[374], advances in infant research[375], and attachment theory[376] all combine to provide a comprehensive new set of scientific underpinnings for the practice of relational psychotherapy that now aims at increasing relational flexibility[377] and relational freedom[378]. Further, the "expanding scope" of psychotherapy now includes many relational consciousness-raising challenges heretofore seen as impossible or "untreatable"[379].

Paralleling these radical shifts in the theory and practice of psychodynamic psychotherapy have been a series of empirical studies--perhaps best exemplified by the

task force of the Psychotherapy Division of the American Psychological Association (Norcross 2002)--that have regularly reported that the single most consistently important variable affecting the overall outcome of psychotherapy is the relationship between the therapist and client itself. Moreover, what psychotherapy clients report as remembering years later are those emotionally charged relational moments in which they felt seen and responded to by a very real person, their therapist[380].

Beyond these many changes in the discipline of psychotherapy itself have been the sea-changes in the culture at large that have moved the practice of psychotherapy away from more authoritarian and objectivist approaches toward more mutually and reciprocally intersubjective approaches based on principles of egalitarianism and diversity (Aron 1996).

These many shifts in the practice of psychotherapy and in the culture at large have necessarily affected how we have come to understand the teaching and learning of psychotherapy. We have long known that psychotherapy theory and technique can be taught didactically. But that the critical variable of the relationship itself cannot be taught--though it can be learned. The relationship skills essential to good psychotherapy *are learned by being in relationship*. It has long been understood that most of the relational skills required for psychotherapy are generally acquired through the therapist's own personal therapy. But the relational turn in psychotherapy has pointed toward additional relational skills that can best be learned through a relationally-oriented supervisory process. This book has sought to elucidate those processes.

The Paradigm Shift in Relational Supervision

The first perspective on supervision to develop historically was the so-called reflective or parallel process which has been elaborated and expanded by many writers to include a two-way reflective process in which the interactive engagement between client and therapist becomes enacted in the supervisory dyad or the interactive engagement between therapist and supervisor becomes enacted in the therapeutic dyad or both. The second perspective highlights the tension between the teaching aspects and the therapeutic aspects of the supervisory situation. There are many points of view on this set of issues with all writers finally being in agreement that personal issues coming up for the therapist need at all times to be indentured to the learning situation in supervision. The third perspective points to the essential thirdness implicit in the therapeutic dyad as well as in the supervisory dyad that is experienced in the silence of the "the therapeutic instrument" and the process of "internal supervision." Perspective four points to the function of witnessing in all forms of human growth, including therapy and supervision. That is, we come to know ourselves and to be able to expand our purview of ourselves through being seen and recognized by a witnessing other. Like the therapeutic alliance, the fifth perspective highlights the importance of the supervisory or learning alliance essential to growth and development.

The sixth perspective features a developmental trajectory of human learning experiences from the earliest pleasure-pain dimension, through the reflective experiences of pride and shame, to the more complex experiences of competition, victory, and defeat in learning situations. Since all learners have passed through a lifetime of experiences of pain, shame and defeat in learning situations it is important for

supervisors to be prepared for the transfer of these important developmental experiences into the supervisory situation and to find ways of working through them with the supervisee.

Perspective seven highlights a series of considerations involving identity development, dissociation, multiple selves, and otherness in therapy and supervision. Room is made for consideration of a safe frame for supervision analogous to the safe frame we know is required for good therapy. Perspective eight surveys some guidelines that have been provided in the literature for good and bad supervision while perspective nine summarizes a set of different approaches to supervision practiced in different schools of psychotherapy.

All writers and practitioners I have encountered, including myself, who have had experiences with group supervision speak highly of its possibilities if conducted in a safe and respectful environment. In perspective ten I attempt to bring you some of the richness of ideas and experience I have encountered regarding group supervision.

Finally, I have provided an eleventh supervisory perspective based on developmentally-derived relational listening perspectives. I outline the considerations that led me as early as 1983 to advocate an epistemology based on metaphoric developmental listening perspectives rather than an attempt to discover or formulate the truth of the human mind. In a series of now 18 published books I and more than 300 colleagues working in Southern California at the Newport Psychoanalytic Institute and the Listening Perspectives Study Center have presented our clinical work using a developmental-relational approach to psychotherapy. I hope you have the opportunity to

look at some of these contributions and to consider a slightly different angle or approach to enhancing your own clinical presence.

I had the rare pleasure of responding to a case presentation given at the Newport Psychoanalytic Institute on March 16, 2013 by Donnel Stern. He presented the remarkable case of William which is to appear in the lead chapter of his forthcoming book *Relational Freedom* (in press).

I had employed a listening perspective approach in commenting on the case. Stern, in response said, “Relational Listening Perspectives are very useful to have in mind because they draw your attention as a clinician to the various ways you can always hear the material. Sometimes we follow our own paths and forget about the others, and Listening Perspectives offers a reminder that there are always those four ways of making sense and a relational impact.”

Finally, the most impelling theme that emerged for me in doing the research for this book on relationship and supervision was the importance of making a deliberate and explicit effort to communicate with each supervisee at the outset of the supervisory experience that we can both derive the most from our time together by considering all thoughts and feelings we have about our experience together as part of what needs to be processed by us in order to understand ourselves and our work. I might even go so far as to say something like, “We know all relationships contain fears as well as negative thoughts and feelings about each other as well as about our process. If these are not spoken about openly in the ordinary course of relating the experience will soon become flat and false.”

I hope you have found this book enjoyable and helpful. I am excited about the free download mode of publication devised in conjunction by Jason Aronson and the International Psychotherapy Institute that allows a wide distribution. Please pass the word about these free downloads to your colleagues, students and supervisees. I welcome your comments.

Appendix A:

The Challenge Of Robert Langs: The Adaptive Context[381]

One of the few therapeutic writers to address directly the listening process is Robert Langs.[382] His evolving approach focuses on the spiraling communicative network involved in the adaptive context of psychotherapy. According to this view, both client and therapist re faced with an adaptive task. The precise manner in which each party experiences the prevailing adaptive context may be seen as "encoded in derivative communications." According to Langs, the systematic study of needed derivative communications can lead to "mutative interpretations"[383] which validate the listening process. Langs's ideas will be briefly summarized in order to show their relevance to the development of Listening Perspectives.

Drawing upon the long tradition of classical psychoanalysis and the rich awareness of interpersonal interaction of the Kleinian school of psychoanalysis, Langs[384] conceptualizes a "bipersonal field" as a "frame" or framework" with specific limits, controls, safeguards, and boundaries which serve to “contain"[385] or "hold"[386] both the client and the therapist. According to Langs, it is within the frame or framework that the transference can ultimately be "secured as analyzable and illusory."[387] The client's "first order adaptive task" is to recognize and respond to the therapeutic frame.

Modifications of the frame (or the basic therapeutic ground rules) constitute a “therapeutic misalliance”[388] or a "vicious circle"[389] in which the reality of the therapeutic situation, "the outer world," cannot be meaningfully distinguished from the client's "inner

world." Thus the "therapeutic differential" becomes blocked from view. According to Langs, the only proper course for therapeutic action in the case of a modification of the frame (by either client or therapist) is a "rectification" of the modification such that boundaries, controls, and safeguards are once again restored. When a therapeutic misalliance is active, interpretation is not possible, and any therapeutic progress can only be labeled "modification cure."

Langs's concept of the bipersonal field is essentially a metaphor involving two poles (the therapist and the client) and "vectors of pathology" between the two.[390] This conceptualization implies that the "pathology" of the therapist remains realistically active within the frame of the bipersonal field, as does the "pathology" of the client. Conceptualization of the therapeutic situation as a bipersonal field places a special emphasis on the interpersonal interaction and "the reality of the pathology of the therapist" with its expectable influence on the client. Familiar and traditional aspects of the frame or the framework of the bipersonal field are such things as maintaining total confidentiality, fostering an exclusive one-to-one relationship, confining the therapeutic interaction to the space of the consulting room, the therapist's retaining a position of relative anonymity, and the therapist's limiting interventions to a position of relative neutrality.

Langs repeatedly makes the point that it is *the client* via derivative communications who insistently expresses a need for the special frame of the bipersonal field. He further indicates a hierarchy of therapeutic tasks. "First, the therapist must deal with interactional resistances."[391] Either the client or the therapist may introduce modifications of the frame. The first order of attention is the resistance to rectifying

these modifications and to the re-establishment and maintenance of the frame. The second area of priority of therapeutic intervention:

> …relates to the interpretation of interactional mechanisms and interactional contents as well as to containing functions. This brings our attention to both the container and the contained, and the importance of dealing with—by both modifying and interpreting—alterations in the framework and the interactional pathology related to both the therapist's and the client's containing functions. (p. 218)

Langs includes a reference to needs on the part of the therapist to introject and contain "the client's sickness in a non-therapeutic manner." He also refers to "inappropriate needs on the part of the client to accept into (him or) herself the pathology of the therapist who has a complementary need to use the client as a pathological container (p.218)."

The basic maxim has always been to deal with resistances before content. Langs adds dealing with the interactional sphere before the intrapsychic sphere and, as part of that, taking up the intrapsychic contributions to interactional resistances and contents before dealing with the primarily intrapsychic. In defining the priority of therapeutic intervention, Langs says, "It is only when the interactional dimension is under control that we are in a position to get around to the focus on the client's intrapsychic conflicts and pathological introjects" (p. 218). Langs does not think that the therapeutic work with the interactional dimension is a "second order job," but that such work offers:

> …the client crucial cognitive insights and positive introjective identifications with the therapist. In working on this third level—the intrapsychic—in which the focus is on the client's inner world, we again deal with defenses and resistances, before content—core unconscious fantasies and introjects. In all of this work we shift from the present to the past and generally we will tend to go back and forth from the interactional to the intrapsychic realms, stressing one or the other, depending on the bipersonal field and the two participants, (p. 218)

Langs[392] deals mainly with an elaboration of the "spiraling communication network" which develops in the psychotherapeutic situation. He places special emphasis upon listening for encoded derivative communications which reveal the client's experience of the adaptive or interactional context of the therapeutic situation. Langs's studies aim at piercing that area of "mutative interpretations" which Strachey as early as 1934 noted therapists and therapists (defensively) avoid. The client's material, according to Langs, may be organized on three levels: manifest content (the surface of association and behavior); Type I derivatives (inferences drawn from the material based on theory, symbolism, knowledge of the client, etc.); and Type II derivatives (crucial meanings and functions arising from the prevailing adaptive context of the interpersonal situation). Communications relating to the adaptive context are seen to have highest relevance to the treatment process (Type A communications). Communications characterized by a need for action discharge, protective identification and merged identities (Type B) are of less importance while communications based on broken or ruptured interpersonal links (Type C) are thought to disrupt or destroy meanings and to seal off inner and

interactional chaos. Langs only considers interventions validated when (Type II) adaptive context meanings become organized into new configurations via what Bion[393] calls the "selected fact"—a new formulation which introduces order and new meaning into previously disparate experiences. Such validated interventions Langs believes merit the designation "mutative interpretations."

Langs's formulations regarding the listening process involved in understanding the communicative network of the adaptive context are intended to be applied broadly to all psychotherapeutic and therapeutic situations. However, the precise implications of Langs's approach have not yet been studied with regard to listening to various developmental phases of differentiation of Self and Other experience. A problem with attempting to extend Langs's thinking in this regard is a quasi-moralistic *tone* that pervades his writings. His formulations are stated in such a way as to point toward a specific therapeutic approach or technique, i.e., the way "good" psychotherapy "should" be conducted. This tone does not appear fundamental to Langs's ideas but rather seems to stem from his general background in Classical psychoanalysis. As has been previously pointed out, the Classical position owes its derivation mainly to a study of the psychoneuroses, the relatively advanced (oedipal) levels of Self and Other differentiation. Langs's "ideal therapeutic environment" with a secure frame leading ultimately to the analysis of encoded (Type II) derivatives of the adaptive context describes the *developmental capabilities* of persons who have achieved the advanced capacity for repression of oedipal incestuous-parricidal strivings. Langs's "ideal therapeutic environment" also effectively describes a level of development in Self and

Other differentiation *which may eventually become a possibility* for persons arrested at earlier phases of "part-object," "merger-object," and "selfobject" experience.

While the establishment of a secure therapeutic frame may be an eventual *goal* in work with preoedipal developmental arrests, Langs has not yet specified other approaches to "holding"[394] and "containing"[395] which may be appropriate for the earlier phases of therapy with such persons. Whether one thinks in terms of introducing (supportive) parameters[396] so that the client can engage in later analytic work, or whether the therapist introduces various maneuvers to preserve his/her own personal or professional identity,[397] "modifications in the frame" can hardly be avoided if empathic therapeutic contact with less than differentiated Self and Other experience is to be accomplished.

Countertransference factors become a prominent feature in all modifications of the frame. As a result, extensive studies of Countertransference have come to characterize thinking about preoedipal analytic work. By way of analogy, it might be said that for an adult to expect a two-year-old child to relate on the basis of advanced (mutual) levels of Self and Other differentiations is to misunderstand the way the child experiences the world. Such a striking lack of empathy on the part of the adult could only stem from a lack of experience or understanding in how to relate to childhood (merger) experiences or else reveals that the adult had himself not attained a mature enough level of Self-Other differentiation to be able to respond to the child as a separate center of initiative with independent and different Self-Other motivational experiences. For a psychotherapist to remain preoccupied with maintaining the frame and promoting the ideal therapeutic environment when attempting to relate to persons with early

developmental arrests runs the same dangers as parents who attempt to rear their children "by the rule book." The effect—gross empathic failure—may be the same *even if moving* to a level where the frame does represent mutually empathic respect for two independent and separate selves is the ultimate goal. Langs's understanding of this general point is implicit in his ideas on interpretive priority in which he states that the interactional aspects of the adaptive context must be addressed before the intrapsychic. Translated into developmental terms, Langs appears to be saying that the client's experiences of merger and selfobject needs require attention before the realm of intrapsychic conflict (oedipal and constant objects) can be meaningfully addressed.

Developmental considerations regarding the gradual differentiation of Self and Other experience call for a slight alteration in the tone or the vocabulary of Langs's formulations to include the recognition that the "ideal therapeutic environment" is a situation, which implies advanced experiences in Self-Other differentiation. A cautious willingness to permit or engage in various modifications in the frame may represent the therapist's awareness and responsiveness to the earlier developmental experiences of selfobjects, merger objects, and part-objects. In a similar vein it may be possible to understand the natural and expectable quality of Type B and C communications in the treatment of early developmental arrests. Rather than to assume these forms of communication represent the erection of barriers to communication, they may come to be viewed as evidence of developmentally determined inabilities to form consistent communications on more differentiated levels.

Perhaps the most important aspects of Langs's work for the present purposes of establishing Listening Perspectives is the general backdrop his formulations provide.

Just as Freud's topographic model of the mind (conscious, preconscious, and unconscious aspects of mental functioning) provides an end point in the basic conceptualizing of mental development, a goal generally attainable through favorable developmental opportunities; so a personality to adapt to Langs's "ideal therapeutic environment" might be thought of as an end point in conceptualizing early Self-Other differentiation. Psychotherapy addressed to earlier developmental phases might be expected to entail various phase-appropriate adaptations. Langs has indicated an interest in extending his ideas on the listening process to a study of the representational world of Self and Others,[398] so clarifications on these issues will likely be forthcoming.

The capacity to adapt favorably to the therapeutic frame seems to imply a measure of self and object constancy. A securely held frame can provide the backdrop for the gradual unfolding of the neurotic transferences based on intrapsychic conflicts regarding oedipal (parricidal and incestual) strivings. Persons seeking psychotherapy for preoedipal developmental arrests lack the necessary experience of self and object constancy required for this classical treatment technique. Modifications in the frame or holding environment will be expected as the therapist seeks to fully understand the particular style or idiosyncratic quality of Self and Other experience which dominates each preoedipal personality. In therapy with preoedipal arrests the therapist must first permit him or herself to be molded (interactionally) to the particular style or mode of Self and Object experiences which the client lives. Only then is the therapist in a position to understand fully and gradually to block the merger or assert his/her boundaries empathically *against* the client's infantile relationship demands, i.e., rectification of the frame. As in early mothering, it will be the therapist's gradual (frustrating) assertion of

self boundaries within the atmosphere created by the client's needs for repeating part-merger or selfobject patterns, which will permit and foster the separation-individuation experience. This interactional process can be expected to dominate the therapy until self and object constancy begins to appear along with (parricidal and incestual) intrapsychic conflicts. Such conflict will usually appear in direct relation to the therapist who for these persons in fact, comes to serve as the oedipal object. Only in the latter phases of therapy can the frame be secured and intrapsychic conflict analyzed according to classical technique. Langs's focus on the frame and the adaptive context serves as a constant reminder of what the person cannot yet attain and serves to clarify the direction of the therapeutic growth process of Self and Other differentiations. Growth requires that the therapist shift Listening Perspectives as the therapeutic process evolves.

Appendix B:

Informed Consent Regarding Supervision, Case Consultation, Case Conference Seminars and Individual Tutorials

General Purposes

Many licensed therapists of all disciplines wish to further their understanding of themselves and how they work, thereby further developing their skills as therapists. Studying psychotherapy theory and practice is one effective way of broadening the perspectives through which therapists listen to the people who come to them for help. The psychotherapy tutorial experience aims at demonstrating with clarity and depth the varieties of transference, resistance, and countertransference situations that arise in the course of intense human relationships. The tutorial seeks to study the many types of interpretive activities that become possible as the therapeutic process unfolds and different phases of developmental experience are being presented to the therapist for consideration. Occasionally an advanced trainee who is a candidate for licensure may be admitted to a group but only with full written authorization from his or her supervisor.

The Nature of the Case Conference Seminar and Individual Tutorial

Groups of three to eight professional therapists typically meet ninety minutes weekly or biweekly on an ongoing basis. Group members take turns each week presenting some aspect of their work that they are seeking to understand more fully. Group discussion considers the therapist's presentation and the issues it raises for everyone.

Once a month the group may read a notable article or book and spend the session discussing the theoretical and practical issues it raises.

Ethical constraints in a tutorial require that a therapist fully disguise the case material, meaning that the material to be discussed is necessarily partial, selected, anecdotal, or even deliberately distorted. This ethical consideration limits severely the comprehensiveness and reliability of the material to be studied. This means in general that the therapist cannot seek or expect direct advice from the group or from the tutor about the treatment. Nor are the group members free to offer advice about the treatment based upon solid familiarity with the facts. Substantive issues for discussion revolve around the case history, the development of transference and resistance, the emerging countertransference, and general issues about how the relationship is evolving and the kinds of interventions that might be useful. A few recommendations may be made: that the client be referred to a psychiatrist for evaluation for medication, hospitalization, or intensive day treatment; that a substance abuse, eating disorder, or other specialty treatment program be initiated; that action be taken regarding some form of molest or abuse; that some “Tarasoff” or “Ewing” action be taken; that educational, vocational, or other type of outside consultation be sought; that the therapist take the case for ongoing, in-depth case consultation or supervision; or that a third party case monitor be designated. All material discussed in the seminar is understood to be strictly confidential, including infractions of laws and ethics, unless a situation of mandated reporting should occur.

Some General Recommendations to Therapists

1. Brief notes should be kept on all client contacts and detailed notes kept on critical incidents and consultations. Records of all past medical, psychiatric, and psychotherapeutic treatment should be obtained for your files.

2. Transference and countertransference themes should be spelled out in the case record with cautious speculations about how those themes might affect the future relationship and what dangers they may pose to the therapeutic relationship. Disclosures of countertransference material should be judiciously documented for therapeutic intent, content, reaction, discussion, and follow-up.

3. All forms of physical contact should be avoided if possible. Whenever unusual, procedures or acts are engaged in (like touching, hugging, extra sessions, or phone calls) the complete rationale needs to be carefully noted and perhaps third-party opinion sought. "A.A.-type hugs," routine handshakes, or other ritual behaviors may have many hidden transferential meanings that only later may disruptively emerge. There are many ways to work through the avoidance of these forms of contact. The therapist's willingness to engage in such unusual practices may be harmless or at times essential to the uninterrupted or undisturbed flow of the relationship as the replicated symbiotic transference unfolds.

Specific forms of concrete interpretive touching need to be well conceived and documented. But the danger is often that the therapist may be tempted to soothe, comfort, or contain some frantic or fragmented state *so that the therapist's anxiety can be lessened*. This is not generally a valid therapeutic procedure. A written informed consent for physical contact should be used.

4. In-depth third-party case consultation is increasingly becoming a safeguard against malpractice risks, especially if there is a borderline or psychotic feature or a history of severe deprivation, trauma, damage, abuse, or molest. It is now known that when the psychotic aspect of transference finally becomes mobilized, the person in analysis may well lose the capacity to distinguish what is realistic in the therapeutic relationship from the therapeutic transfer of the deep intrusive traumas of the past that are being recalled in the transference relationship. When disturbed reality testing is encountered in the transference, the therapist may become endangered, until and unless the critical interpretive work can be accomplished.

5. An initial psychiatric consultation is recommended on all cases with significant history of trauma and/or symbiotic or organizing (psychotic) pockets so that a baseline can be established for future reference. Follow-up consults should be required from time to time to evaluate the danger of impending fragmentation that might be medically regulated and the potential advisability of hospitalization.

6. Along similar lines with high-risk cases, in-depth individual consultation sought out periodically is good policy. I would recommend a minimum of three to four hours on the same case in close sequence so the details can become known to, digested by, and carefully recorded by the consultant with recommendations that have been carefully thought out by two. Consultation with a specialist on issues about which you may feel uncertain is now an acceptable standard of care.

7. Many times it may be important to consider sending registered letters to clients when you feel strongly that a form of consultation is needed, that some aspect of case management is necessary, or when you are needing to set limits or to terminate them

for any reason. When setting limits or terminating a client, be sure to state in writing your reason, give appropriate time for discussion and action, and give three appropriate (e.g., nonprofit corporation clinics, psychiatrists, government agencies, etc.) referrals. Consultation with an attorney is recommended in connection with such letters. Be sure to send by certified mail or obtain the client's signature that he or she has received the letter.

8. The American Psychological Association Insurance Trust now strongly suggests that we keep summaries of all past therapies and medical reports as well as a case history since many critical details with malpractice implications are often not mentioned in the usual therapeutic dialogue. Periodic case summaries and a termination summary are essential.

9. If you do any type of prepaid or managed health care, be certain that your professional opinion and recommendation regarding patient care are given in writing. Do not defer your opinions to the administrative needs of the third party. You can be sued for failure to assess and recommend professionally. The third party can be sued but persons performing administrative tasks are not licensed, are generally not sued, and have little to lose by their decision or recommendation. Do not compromise your professional opinions to satisfy third-party demands; find some other way of negotiating with the potential referral source. Be clear with your clients, put problems into writing, and obtain client signatures whenever possible.

Case Conference Seminars and Individual Tutorials Contrasted with Supervision and Case Consultation

1. The case conference seminar and individual psychological tutorial represent a form of in-service training *for the practitioner*. It cannot be considered reliable case supervision or consultation on the patient's or client's behalf because as has already been mentioned, ethical constraints require that the material presented in the tutorial be condensed, selected, disguised, and perhaps even distorted so that comprehensive information cannot be provided, meaning that reliable advice is not possible.

2. Supervision in which the supervisor participates with full professional responsibility in the treatment for the purposes of statutory training is of an entirely different nature and is spelled out by state law and the training requirements of each profession and in each training setting. The client must be informed in writing of the supervisory process and sign a form of consent. For California psychologists the required ratio of supervisor hours to patient contact hours is 1:10. Further, the supervisor must be on the premises for at least 50 percent of the time the trainee is actually seeing clients. *Client fees must be paid only to the supervisor or training clinic while the trainee works as a volunteer or paid employee of the supervisor or clinic*. Other disciplines and other locales have similar requirements, e.g., psychoanalytic training is the most stringent with a supervision-to-client hour ratio of 1:4, the four hours being with the *same* client. Only with closely defined restrictions is it possible for the supervisor to gain even close to a complete understanding of the actual treatment process and therefore to be in a position to offer reliable intervention advice.

3. Case consultation is a process in which *the consultant actually sees the client* in a professional role for assessment and or recommendations. A written report should be obtained for the treating therapist's records. Psychological testing, third-party case monitoring, and psychiatric evaluation are common types of consultation.

Summary

Dynamic psychotherapy case conferences and individual tutorials are for the benefit of the professional therapist who wants to further his or her understanding about professional issues. The best vehicle for the case conference or tutorial is the review of anecdotal case material accompanied with parallel readings. *Supervision and consultation are completely different processes* whereby no constraints are placed upon the kind of material that can be discussed, and the frequency and intensity of the contact is such as to permit valid and reliable intervention. The case conference and individual tutorials are strictly educational and personal in nature and carry no professional liability to the client on treating therapist while case consultation and supervision represent a collegial collaboration in a treatment process with shared liability.

Record Keeping and Confidentiality

Formal notes or recordings are not a regular part of case conference seminars or of the tutorial educational experience, though a log in usually kept to document which cases are discussed by whom on what date. The presenting therapist may wish to document ideas and reactions from the tutorial in his or her case notes. With unanimous group permission the presenting therapist may tape record the sessions for his or her private use. In California under the Business and Professions Code Case Conference

and Tutorials generally qualify as “peer group” consultation in that professional and personal issues (countertransference) are discussed. As such a treating professional can claim privilege for the process as with group therapy.

Occasionally the tutor may request to record sessions because the case is of research interest. Any notes or recordings must be treated with absolute confidentiality by all parties concerned. Permission of the therapist (and possibly the client) should be sought before such material can be used for teaching and/or research purposes. All group members are bound by rules of professional confidentiality at all times.

Fees and Legal Costs

Case conference fees are $_____ per session and individual tutorial fees are $_____ on a regularly scheduled ongoing basis whether the learner is present or absent for the scheduled session. In the event that the tutor is ever asked or required to provide testimony of any sort on behalf of any learner, that person (or his/her insurance carrier) will be responsible for paying the tutor's regular clinical consultation fee on a portal-to-portal basis; travel, board and lodging expenses, and an additional regular fee of up to thirty hours of preparation time; and any legal fees that may be incurred for professional consultation or legal representation in the matter. Since the nature of the tutorial is educational, the content partial and anecdotal, and detailed records are not maintained, the likelihood of required testimony seems remote. The learner may wish to claim privilege on the basis of individual and group tutorials being personal and confidential and therefore essentially a form of peer counseling.

The Nature of Individual Psychotherapy Tutorials

One-to-one tutorials in psychoanalytic theory and techniques are offered on the same basis as outlined above for groups. Regardless of what such experiences are called in various settings, in individual tutorials as in group tutorial, case material is discussed for the educational purpose of illuminating psychotherapy theory and practice but on a more personalized basis, more "tailor made" to the individual needs of the therapist. Tutorials are not to be confused with the more intense and closely collaborative work engaged in as statutory supervision with the supervision explicitly designated by the state or training agency as defined by various legal bodies and professional organizations. The tutorial represents in-service training for the therapist. The vehicle for that training experience is the review and discussion of case work. The limits and expectations of the individual tutorial experience are the same as those discussed above under case conference seminars.

What Is Dynamic Psychotherapy?

Dynamic psychotherapy originated with the work of Dr. Sigmund Freud in Vienna in the late nineteenth century. Therapy is both a way of understanding human emotions and of helping people with their relationships and their personal problems. The mature or rational self that functions more or less successfully in the real world is only a part of the total person. The more immature, irrational, or unconscious self functions silently in the background to produce various symptoms and maladaptive behaviors that often intrude into the person's social life, personal relationships, school or work activities, and physical health. In dynamic psychotherapy specific problems are viewed in the context

of the whole person. The quest for self-knowledge is seen as the most important key to changing attitudes and behavior.

Dynamic psychotherapy is based on the insight that our personalities are the result of passing through and solving relationship issues at many developmental stages. At any stage, the way we have reacted to events in our lives may have caused us to get stuck at a certain level of insight or problem solving. While we go ahead and mature satisfactorily, in many ways we may carry within us the parts that didn't have a chance to develop. We can have a mature exterior and be functioning more or less successfully, while internally we may feel vulnerable, confused, depressed, angry, afraid, and childlike. We may not feel able to bounce back from rejection, get past blocks, allow our real feelings to surface, or stay in touch with our feelings and desires. Our physical health may be compromised in many ways by emotional and relationship issues.

Dynamic psychotherapy is designed to help the client get in touch with her or his unconscious memories, feelings, and desires that are not readily available to the conscious mind. Therapy is designed to help clients of all ages understand how their unconscious feelings and thoughts affect the ways they act, react, think, feel, and relate. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Each client, by expressing her or his story in whatever ways possible to someone who knows how to listen and to give new meanings back, has the opportunity to learn about herself or himself in a new way.

Dynamic psychotherapy can provide a safe place for people of whatever age to discover for themselves their own truths. It provides a unique opportunity to re-experience personal history in a new relationship, to see it in a new way, and to make connections between past and current conflicts that illuminate the way one relates to oneself and to others.

Clients are encouraged to talk about thoughts and feelings that come up about therapy or about the therapist. These feelings are important because elements of one's earliest affections and hostilities toward parents and siblings are often shifted onto the therapist and the process of therapy. This phenomenon, known as "transference," offers a rich source of understanding, for it offers the possibility for people to re-experience and re-work important feelings arising from the past with the maturity they possess in the present.

Dynamic psychotherapy is usually not a short-term therapy as it takes time to explore the complex layers of feeling and experience that make up a person's own unique relationship history. People find that their therapy easily can extend for several years but there is no prescribed length of treatment. Only the people closely involved have a sense of when personal goals have been met. When the client feels she or he has accomplished the desired goals, then a termination date can be set.

Dynamic psychotherapy aims to help people experience life more deeply, enjoy more satisfying relationships, resolve painful conflicts, and better integrate all the parts of their personalities. Perhaps its greatest potential gift is the essential freedom to change and to continue to grow in relationships.

Informed Consent Regarding Case Conference Seminars and/or Individual Psychotherapy Tutorials as Distinguished from Case Consultation and Supervision

Name: _____

Home Address: _____

Work Address: _____

Home Phone: _____ Work Phone: _____

Fax_____E-Mail_____

I understand that consultation group fees are $_____ for each 90-minute session unless otherwise arranged. I further understand that I will be responsible for paying the fee before the end of each month whether or not I can attend the sessions. The fee is subject to change occasionally.

I understand that the group is *ongoing* and meets continually except for previously announced vacations and holidays of the therapist. Should I discontinue or change groups I will give notice of at least four sessions so that group members have an opportunity to deal with the termination.

Individual tutorial fees are $_____ per 45-minute session unless otherwise arranged. If ongoing regular group or individual time is reserved, I understand that I am responsible for regularly scheduled time whether or not I am able to keep the appointment.

I understand that occasionally sessions may be recorded for research, teaching, and publication purposes with the permission of the presenter and without the right to

financial remuneration. I agree to disguise at all times the identity of the client as much as possible. Tapes will be kept locked in a safe and later destroyed or given to the presenter.

I understand I may be asked to help edit the transcript of my work and that I have the right to refuse to have the material utilized for research, teaching, and publication purposes.

I have read the above description of the case conference seminar and individual tutorials as contrasted with case consultation and supervision and understand their educational purposes. I agree to abide by the ethical codes of my profession and to adhere as closely as possible to the guidelines set out herein regarding the seminar and tutorial experiences. Since participants may share personal as well as professional information that is private, I understand that all communications may be claimed as privileged and confidential and agree to abide by all ethical and legal considerations of confidentiality.

Signature	Date	License Number/ Expiration Date
Malpractice Carrier (attach face sheet)	Policy Number	Expiration Date
Supervisor's Name and Signature	Date	License Number/ Expiration Date

Note: Please attach face sheet of current Malpractice Insurance

Appendix C:

Employment Agreement for Trainees

This is an agreement entered into between _____

(licensed psychotherapist) and _____

psychotherapy trainee).

This employment agreement supplements the state laws regarding the employment of trainees and the ethics requirements of the various professions concerned. Those laws include absolute adherence to the ethical codes of each profession. The trainee will hereinafter be referred to as "employee" and the licensed psychotherapist as "employer."

1. Laws and Ethics. Employee agrees to study carefully the ethics codes of the American Psychological Association and, if training in another discipline, the codes of that discipline. Any questions will be addressed to the employer. Employee agrees absolutely to abide by all laws and ethical codes governing clinical practice while under supervision of the employer. Employee agrees to discuss immediately with employer any and all questions about or possible infractions of those codes, or questionable situations that create potential risks and/or liabilities for the employee and/or employer. Failure to do so constitutes a breach of this agreement.

Employee assumes sole personal and financial responsibility and liability for any problems and/or claims resulting from an infraction of the laws and applicable ethics codes and further indemnities the employer against any and all claims of whatever type resulting from employee's legal or ethical infractions. Any and all legal and/or outside consultation expenses resulting from or necessitated by claims of alleged infractions or the investigation thereof are to be borne by the employee. If the time spent by the employer exceeds ten hours in dealing with such claims he will be reimbursed by the employee at $_____/hour since infractions or other activities that might lead to allegations are beyond the scope of employment and not a part of this employment agreement. All professional services are to be rendered on the employer's regular work site unless otherwise agreed upon in writing. Upon discussion of possible infractions the employer reserves the right to insist on outside clinical, ethical, and/or legal consultation at the employee's expense and/or to terminate this agreement immediately. Legal and ethical infractions by employee may be reported to her or his training institution and/or to the relevant licensing boards and ethics committees. All dual relationships with clients, ex-clients, or friends, or relatives of clients, or ex-clients that are exploitative and/or damaging, especially business, social, and sexual ones, are forbidden by law and will result in immediate termination and possible reporting to authorities. Employee agrees to maintain membership in the appropriate state professional association both to remain updated on professional issues and to have ready access to legal counsel.

2. Financial Arrangements. Employee will be treated as an "employee" under IRS laws and employer will maintain payroll records in accordance with all state and federal tax and employment laws.

Operating expenses for hiring an assistant or intern in this particular private practice setting have been determined to be approximately $_____ monthly, which includes use of office space, light clerical work, bookkeeping and accounting, and consideration for expenses involved in overseeing the work of the trainees, file management, and emergency consultation. Employee must arrange for and/or assume financial responsibility for his/her own telephone, voice mail, beeper services, and malpractice liability insurance.

Because expenses are high in private practice, the percent paid on gross receipts up to the amount of $_____ in a calendar month to the employee will only be ____% of fees collected for services rendered. The employee will be paid _____% of all fees collected in a calendar month over that figure. Any agreed-upon supplementary hours are to be paid at the rate of $_____. Should any change in this arrangement be deemed necessary or desirable, both parties will agree and put in writing the altered terms.

Should the gross monthly income drop below the first figure above for three consecutive calendar months or average below that figure for any six-month period, the employer may need to renegotiate the arrangements, or ask for a termination for financial reasons.

All client checks must be made to the employer and the date on the check or the date actually turned into the bookkeeper (whichever is later) will determine the month to which the check is credited. All fees are to be turned in daily if possible but definitely before the weekend. Cash payments will be receipted and signed by employer. Pay periods will be roughly twice a month as arranged with the financial manager. The

employee will be responsible for accurately filling out insurance forms and other bills, having the supervisor sign them, and, if appropriate, pursuing them to collection. Collection agencies or other forced collection procedures will not be used unless authorized by employer, so the employee needs to be prepared for losses of all fees not collected at the time of service.

Trainee will use informed consents in the book, *Facing the Challenge of Liability in Psychotherapy* and other forms provided by the employer in order to ensure uniformity in the practice.

3. Malpractice Insurance Coverage. The employee is responsible for working with the employer's financial manager and arranging for malpractice coverage and administrative law protection equivalent to that which the employer carries. This can be arranged under the employer's existing policy or under a separate policy so long as the financial manager deems it to be essentially equivalent. Employee must bear the cost of this insurance directly and provide the employer ongoing proof of coverage.

4. Supervision. The employer agrees to provide one hour of face-to-face individual supervision (a standard 45-minute session) and two hours of group supervision (a standard 90-minute session) weekly. The employee must arrange to accommodate the time schedule of the employer. Extra time can be scheduled by consulting the employer's calendar several days in advance. Emergency after-hours and weekend consultation supervision coverage will be arranged according to need. If more ongoing time is deemed necessary by the employer, the financial overhead agreement will need to be revised.

5. Files and Records. All confidential files and records are and shall remain the property of the employer. The employee shall have the right to copy any and all parts of the records for his or her professional use at his or her expense. At the outset employee is responsible for providing complete copies of professional and personal files of any client brought into the practice. All laws and ethics regarding record maintenance are to be strictly maintained by both parties, with special reference to:

a. Information in writing must be given to all clients that employee is not licensed but working under the supervision of the employer and that all fees are to be paid to the employer.

b. Use of Client Information Questionnaire and Informed Consent contracts as well as supervisor's other standard file documents as required and approved by employer is necessary.

c. Original files are never to leave the employer's office under any circumstances. Copies are subject to all precautions to ensure their confidentiality. In the event materials for letter writing or evaluations need to be taken from the office, only copies may be removed and they must be kept stored in a large self-addressed, stamped envelope marked clearly, "Confidential Medical Records, Drop in Any Mailbox."

6. Termination of Employment. Either party has the right to terminate this agreement without cause upon thirty days' written notice delivered in person or by a certified agent to the other. The supervisor may terminate the contract immediately in the event of a breach in law or ethics.

This employment agreement, along with the laws, state regulations, ethics codes, and limitations of both parties' malpractice insurance, constitutes the entire agreement between employer and employee. No other informal or verbal agreements shall exist unless and until they are put into writing and signed by both parties. No unethical, illegal, or illicit agreements are authorized by this agreement. Should any activity, practice, or habit be discovered by either party that in any way violates law or ethics or otherwise casts a shadow upon this agreement, it is the obligation of either party to bring the matter up for immediate discussion and clarification.

Certification

I hereby certify that I have accurately and truthfully represented myself with regard to the requisite training, education, and legal (licensing) status in the attached curriculum vitae which I have signed and dated. I hereby agree to abide by the above provisions for employment.

_____

Employee Date

_____

Employer Date

Attach, sign, and date:

1. Curriculum vitae

2. References forms

3. Malpractice Face Sheet

Personal References for Employment as a Psychotherapy Trainee

You have my permission to contact the following people for references about my character, background, qualifications, and work. A photocopy of this page is an equally valid permission.

Reference: _____

_____

_____

Reference: _____

_____

_____

Reference: _____

_____

_____

Trainee Signature: Date:

_____

Print Full Name: Birth Date

_____

Appendix D:

How Psychotherapy "Hooks Into The Flesh"[399]

The French anthropologist Claude Lévi-Strauss[400] in a chapter titled "The Effectiveness of Symbols," undertakes a penetrating definition of the psychoanalytic task, revealing from an anthropological and sociological viewpoint the necessarily dual nature of the psychotherapeutic endeavor.[401]

Lévi-Strauss reviews the first available South American magicoreligious text, an eighteen-page incantation obtained by the Cuna Indian, Guillermo Haya, from an elderly informant of his tribe. The purpose of the song is to facilitate unusually difficult childbirth. Its use is unusual since native women of Central and South America have easier deliveries than women of Western societies. The intervention of the shaman is thus rare and occurs only in the extreme case of failure to deliver and at the request of the midwife.

The song begins with the midwife's confusion over the pregnant woman's failure to deliver and describes her visit to the shaman and the latter's arrival in the hut of the laboring woman, with his fumigations of burnt cocoa-nibs, his invocations, and the making of nuchu, sacred figures or images carved from various prescribed kinds of wood that lend them their effectiveness. The carved *nuchu* represent tutelary spirits who become the shaman's assistants. He leads the *nuchu* to the abode of *Muu* (inside the woman's body). M*uu* is the goddess of fertility and is responsible for the formation of the

fetus. Difficult childbirths occur when *Muu* has exceeded her functions and captured the *purba* or soul of the mother. The incantation thus expresses a quest for the lost soul of the mother, which will be restored after overcoming many obstacles. The shaman's saga will take the woman through a victory over wild beasts and finally through a great contest waged by the shaman and his tutelary spirits against *Muu* and her daughters. Once *Muu* has been defeated, the whereabouts of the soul of the ailing woman can be discovered and freed so the delivery can take place. The song ends with precautions that must be taken so that *Muu* cannot pursue her victors (an event that would result in infertility). The fight is not waged against Muu herself, who is indispensable to procreation, but against her abuses of power. After the epic saga, *Muu* asks the shaman when he will come to visit again, indicating the perennial nature of psychic conflict that can be expected to interfere with childbirth.

Lévi-Strauss comments that in order to perform his function the shaman is, by cultural belief, assigned supernatural power to see the cause of the illness, to know the whereabouts of the vital forces, and to use *nuchu* spirits who are endowed with exceptional powers to move invisibly and clairvoyantly in the service of humans.

On the surface the song appears rather commonplace among shamanistic cures. The sick woman suffers because she has lost her spiritual double, which constitutes her vital strength. In traveling to the supernatural world and in being aided by assistants in snatching the woman's double from a malevolent spirit and restoring it to its owner, the shaman effects the cure. The exceptional aspect of this song, making it of interest to anthropologists and psychoanalysts alike, is that '"*Muu's* way' and the abode of *Muu* are not, to the native mind, simply a mythical itinerary and dwelling-place. They represent,

literally, the vagina and uterus of the pregnant woman, which are to be explored by the shaman and *nuchu* and in whose depths they will wage their victorious combat" (p. 188). In his quest to capture her soul, the shaman also captures other spirits, which govern the vitality of her other body parts (heart, bones, teeth, hair, nails, and feet). Not unlike the invasive attention of the psychoanalyst, no body part is left unattended to.

Muu, as instigator of the disorder, has captured the special "souls" of the various organs, thus destroying the cooperation and integrity of the main soul, the woman's double who must be set free. "In a difficult delivery the 'soul' of the uterus has led astray all the 'souls' belonging to other parts of the body. Once these souls are liberated, the soul of the uterus can and must resume its cooperation" (p. 190). It is clear that the song seeks to delineate the emotional content of the physiological disturbance to the mind of the sick woman. To reach *Muu*, the shaman and his assistants must find "*Muu's* way," the road of *Muu*. At the peak moment when the shaman has finished his carvings, spirits rise up at the shaman's exhortation:

> The (sick) woman lies in the hammock in front of you.
>
> Her white tissue lies in her lap, her white tissues move softly. The (sick) woman's body lies weak.
>
> When they light up (along) *Muu's* way, it runs over with exudations and like blood.
>
> Her exudations drip down below the hammock all like blood, all red.
>
> The inner white tissue extends to the bosom of the earth.
>
> Into the middle of the woman's white tissue a human being descends.
>
> [Holmer and Wassen, cited in Lévi-Strauss, p. 190]

"*Muu's* way," darkened and covered with blood, is unquestionably the vagina and the dark whirlpool the uterus where *Muu* dwells.

Lévi-Strauss comments that this text claims a special place among shaman cures. One standard type of cure involves an organ that is manipulated or sucked until a thorn, crystal, or feather appears, a representation of the removal of the malevolent force. Another type of cure revolves around a sham battle waged in a hut and then outside against harmful spirits. In these cures it remains for us to understand exactly how the psychological aspect "hooks into" the physiological. But the current song constitutes a purely psychological treatment. For the shaman does not touch the body and administers no remedy. "Nevertheless it involves, directly and explicitly, the pathological condition and its locus. In our view, the song constitutes a psychological manipulation of the sick organ, and it is precisely from this manipulation that a cure is expected" (p. 192).

Lévi-Strauss observes that the situation is contrived to induce pain in a sick woman through developing a psychological awareness of the smallest details of all of her internal tissues. Using mythological images the pain-induced situation becomes the symbolic setting for the experience of conflict. "A transition will thus be made from the most prosaic reality, to myth, from the physical universe to the psychological universe, from the external world to the internal body" (p. 193). The mythological saga being enacted in the body attains sensory and hallucinatory vividness through the many elements of ritual-smell, sound, tactile stimulation, rhythm, and repetition.

What follows in breathless (hypnotic) rhythm and rhyme are more and more rapid oscillations between mythical and physiological themes "as if to abolish in the mind of

the sick woman the distinction which separates them, and to make it impossible to differentiate their respective attributes" (p. 193). Spirits and events follow one another as the woman's total focus becomes the birth apparatus and the cosmic battle being waged there by the invasion of the shaman and his spiritual helpers who bring illuminating light into the birth canal. The presence of wild animals increases the pains that are thus personified and described to the woman. Uncle Alligator moves about with bulging eyes, crouching and wriggling his tail. He moves his glistening flippers that drag on everything. The Octopus arrives with sticky tentacles alternately opening and closing, contracting and expanding passageways. The black tiger, the red animal, the two colored animals are all tied with an iron chain that rasps and clanks against everything. Their tongues are hanging out, saliva dripping, saliva foaming, with flourishing tails and claws tearing at everything.

According to Lévi-Strauss the cure consists in making explicit a situation originally existing on an emotional level and in rendering acceptable to the mind pains that the body otherwise refuses to tolerate. The shaman with the aid of this myth encourages the woman to accept the incoherent and arbitrary pains, reintegrating them into a whole where everything is coordinated and meaningful. He points out that our physicians tell a similar story to us but not in terms of monsters and spirits but rather in terms we believe like germs, microbes, and so forth. "The shaman provides the sick woman with a language, by means of which unexpressed, and otherwise inexpressible, psychic states can be immediately expressed" (p. 198). The transition to the verbal system makes it possible to undergo in an ordered and intelligible form an experience that would otherwise be chaotic and inexpressible. The myth and its hypnotic power enable the

woman to release and reorganize the physiological processes that have become disordered in the woman's sickness.

Lévi-Strauss[402] explicitly contextualizes this shamanistic cure as psychoanalytic in nature. The purpose is to bring to a conscious level conflicts and resistances that have remained unconscious, with resulting symptom formation. The conflicts and resistances are resolved not because of knowledge, real or alleged, but because this knowledge makes possible a specific experience, in the course of which conflicts materialize in an order and on a level permitting their free development and leading to their resolution. This vital experience is called abreaction in psychoanalysis. We know that its precondition is the unprovoked intervention of the analyst, who appears in the conflicts of the client through a double transference mechanism as (1) a flesh-and-blood protagonist and (2) in relation to whom the client can restore and clarify an initial (historical) situation which has remained unexpressed or unformulated....

> The shaman plays the same dual role as the psychoanalyst. A prerequisite role—that of listener for the psychoanalyst and of orator for the shaman—establishes a direct relationship with the patient's conscious and an indirect relationship with his unconscious. This is the function of the incantation proper. But the shaman does more than utter the incantation; he is its hero, for it is he who, at the head of a supernatural battalion of spirits, penetrates the endangered organs and frees the captive soul. (pp. 198-199)

The shaman, like the psychoanalyst, is thus enabled by the dual relationship to become (1) the transference object induced vividly in the patient's mind, and (2) the real

protagonist of the conflict, which is experienced by the patient as on the border between the physical world and the psychical world. In this dual situation in which pain is deliberately induced by the practitioner, the psychoanalytic client eliminates individual myths by facing the reality of the person of the analyst. And the native woman overcomes an organic disorder by identifying with a mythically transmuted shaman.

Lévi-Strauss notes that the shamarita cure is a counterpart to psychoanalytic cure. Both induce an experience through appeal to myth. The psychoanalytic patient constructs a myth with elements drawn from his or her personal past. The shamanist patient receives from the outside a social myth. In either case the treating person fosters the emergence of a storyline that cures by giving language to experience. The effectiveness of symbols guarantees the parallel development in the process of myth and action.

Lévi-Strauss provides a fascinating argument that aligns the shamanism of ages past with the modern activities of psychoanalysis and psychotherapy. His arguments go considerably beyond Freud and into areas being explored in psychoanalysis and psychotherapy today, in which an inductive property of symbols permits formerly homologous structures built out of different materials at different levels of life—organizational processes, unconscious agency, and rational thought—to be understood as profoundly related to one another. Lévi-Strauss points out that the individual vocabulary of the cure is significant only to the extent that the unconscious structures it according to its laws and thus transforms it into language. Whether the myth is a personal re-creation or one borrowed from tradition matters little; the essential structure of language and the unconscious is the locus of the power of the symbol. Any myth

represents a quest for the remembrance of things past and the ways those remembrances are structured in the unconscious. "The modem version of shamanistic technique called psychoanalysis thus derives its specific characteristics from the fact that in industrial civilization there is no longer any room for mythical time, except within man himself" (pp. 203-204).

Notes

[1] (Norcross, 2002)

[2] (Hedges, 1992)

[3] (Hedges, 1992)

[4] (Stern, 2010)

[5] (Schindelheim, 1995 p.155)

[6] (Schindelheim, 1995 p.165)

[7] (Schindelheim, 1995 p.165)

[8] (Schindelheim, 1995 p.160)

[9] (Slavin, 1998)

[10] (Slavin, 1998)

[11] (Slavin, 1998)

[12] (Freud 1910, 1915).

[13] (Heiman,1950)

[14] (Sheppard, B. 2000; Davoine, F. and Gaudillière, J. 2004)

[15] (Ogden, 2004)

[16] (Jung, 1946).

[17] (Allphin, 2005 pp 98-113)

[18](Allphin, 2005 p.101)

[19] (Allphin, 2005 p. 105)

[20] (Allphin, 2005 pp. 106-107)

[21] (Allphin, 2005 pp. 109-110)

[22] (Allphin, 2005 pp. 109-110)

[23] (Allphin, 2005 pp. 112)

[24] (Allphin, 2005 pp. 112-113)

[25] (Ekstein, 1984)

[26] (Greenson, 1967, 1978)

[27] (Beck and Dozois, 2011 p.401)

[28] Attributed to Alexander Pope, "*An Essay on Man, Epistle 1*", 1733.

[29] Cited in Stern, D. B. (2005), p. v.

[30] Schore, Siegal, Porges, etc.

[31] See (Siegal, 1999; Siegal, 2007; Cozolino, 2002; Cozolino, 2006; Schore, 1994; Schore, 2007; Porges, 2004)

[32](Edelman and Tononi, 2000, p. 144.)

[33] (Edelman and Tononi, 2000, p. 144.)

[34] Neuroscientist Joseph LeDoux in The Synaptic Self and The Emotional Brain maintains that we are each responsible from long before birth for constructing a self, a sense of personal agency, that is essentially made up of how our flow of neurotransmitters come to influence migrations of neuron connections in response to our early relationship strivings. Our "synaptic selves" are the direct genetic heritage of our limbic and neocortical brains that develop in response to our early social-emotional contexts.

[35] (Mesulam, 2000)

[36] (Pearce, 2002; Pearce 2007)

[37] (Schore, 2004; Schore 2007)

[38] (Pearce, 2002 pp. 70-2)

[39] (Pearce, 2002 p.74)

[40] A good overview of recent infant research upon which these comments are based is Beebe, B. and Lachman, F. (2002). *Infant Research and Adult Treatment: Co-constructing Interactions*. Hillsdale: NJ Analytic Press.

[41] (Fonagy et.al., 2002 p. 157)

[42](Beebe and Lachman, Op. cit., p.13)

[43] (Schore, 1999; Schore 2003)

[44] Daniel Stern, 1977, pp 87-88, cited in Beebe and Lachman (2002), p. 97.

[45] (Stern, D. B. 2010)

[46]Tronick, E. as cited in Beebe and Lachman (2003)

[47] Jessica Benjamin, as cited in Beebe and Lachman 2003 p. 160.

[48] Jessica Benjamin, as cited in Beebe and Lachman 2003 p. 184, (emphasis added)

[49] (Darwin, 1872, 1965)

[50] (Hedges, 2012b)

[51] (Leary, 2005 p.417)

[52] (Rowland, 1996)

[53] (Tummala-Narra, 2004)

[54] (Tummala-Narra, 2004 p.306)

[55] (Tummala-Narra, 2004 p. 307)

[56] see LeDoux 1996, 2002; Edelman 1993, 2006, 2000 (with Tononi); Damasio 1994, 1999, 2003; Pert 1997; Lewis, Amini, and Lannon, 2000; Cozolino 2002; and Siegal, D. J. 1999, 2007.

[57] Maher and Tetreault define positionality as suggesting "that rather than being composed of any fixed 'essence' or individual identity, we all develop amid networks of relationships that themselves can be explored, analyzed, and changed, as long as people understand that they are not simply individuals, but differentially placed members of an unequal social order" (1996, p. 163).

[58] (Hartman, 2002)

[59] (N. Rand in Abraham and Tarok 1994, pp. 166-167)

[60] (Marrone, 1998 pp. 135-139)

[61] (hooks, 1995)

[62] (hooks, 1995 pp 143-144)

[63] (Volkan, 2004)

[64] (Hedges, 1983)

[65] (Stolorow, Brandchaft, and Atwood, 1987 p. ix)

[66] (Stolorow and Atwood, 1992 p. 3)

[67] (Stolorow and Atwood, 1992 p. 18)

[68] (Trevarthen, 1980)

[69] (Stern, D. N. 1985, 2004)

[70] (Benjamin, 1988)

[71] (Benjamin, 1988 pp. 15-20)

[72] (Benjamin, 1988 p. 23)

[73] (Benjamin, 1988 p. 30)

[74] (Benjamin, J. 1995, p. 126)

[75] (Stern, D. N. 2004)

[76] (Stern, D. N. 2004 p. xiii)

[77] (Stern, D. N. 2004 p. xiii, italics added)

[78] (Stern, D. N. 2004 pp 219-220)

[79] (Stern, D. N. 2004)

[80] (Stern, D. N. 2004 pp 219-220)

[81] (Stern, D. N. 2004 pp 78-79)

[82] (Stern, D. N. 2004 p. 81)

[83] (de Beauvoir, 1952,1989)

[84] (Freud, S. 1905)

[85] (Hedges, 2011)

[86] *Hating in the First Person Plural* edited by Donald Moss. New York: Other Press, 2002

[87] (Tummala-Narra, 2004)

[88] (Tummala-Narra, 2004 p. 301)

[89] (Tummala-Narra, 2004 p. 302)

[90] (Tummala-Narra, 2004 p. 308)

[91] (Tummala-Narra, 2004 p. 308)

[92] (Stimmel, 1995)

[93] (Stimmel, 1995 p. 609)

[94] (Stimmel, 1995 p. 613-614)

[95] (Stimmel, 1995 p. 614)

[96] (Stimmel, 1995 p. 614-615)

[97] (Stimmel, 1995 p. 616)

[98] (Hedges, 2012c)

[99] (Greenspan & Shanker, 2004)

[100] (Greenspan & Shanker, 2004 p. 53)

[101] (Fonagy et. al, 2002)

[102] (Freud, S. 1914 p 150)

[103] (Gediman & Wolkenfeld, 1980)

[104] (Searles, 1955, 1965 pp.157-176, 172-173)

[105] (Ekstein & Wallerstein, 1958 p. 237)

[106] (Doehrman, 1976)

[107] (Hunt, 2001)

[108] (Lesser, 1984)

[109] (Stimmel, 1995, p. 609.)

[110] (Grey and Fiscalini, 1987)

[111] (Berman, 2000 p. 280)

[112] (Frawley-O'Dea and Sarnat, 2001 pp. 172-174)

[113] (Frawley-O'Dea and Sarnat, 2001 pp. 190-191)

[114] (Caligor, 1981)

[115] (Caligor, 1981 p. 4)

[116] (Caligor, 1981 p. 4)

[117] (Caligor, 1981 p. 6)

[118] (Caligor, 1981 p. 25)

[119] (Gediman and Wolkenfeld, 1980)

[120] (Freud, S. 1910, 1915)

[121] For a brief history of the emergence of the countertransference as a working tool to Hedges' assertion that it is "the royal road" to understanding the internalized symbiosis see Hedges, L. E. (1992). Interpreting the Countertransference.

[122] Formulations of Robert Stolorow, Christopher Bollas, and Donnell Stern respectively.

[123] (Norcross, 2002)

[124] (Frawley-O'Dea and Sarnat, 2001)

[125] (Frawley-O'Dea and Sarnat, 2001 p. 141)

[126] (Frawley-O'Dea and Sarnat, 2001 p. 141)

[127] (Frawley-O'Dea and Sarnat, 2001)

[128] (Frawley-O'Dea and Sarnat, 2001 p. 142)

[129] (Frawley-O'Dea and Sarnat, 2001)

[130] (Frawley-O'Dea and Sarnat, 2001 p. 117)

[131] (Frawley-O'Dea and Sarnat, 2001 p. 118)

[132] (Frawley-O'Dea and Sarnat, 2001 p. 121)

[133] (Frawley-O'Dea and Sarnat, 2001 p. 122)

[134] (Sarnat, 1992)

[135] (Sarnat, 1992 p. 397)

[136] (Sarnat, 1992 p. 397)

[137] (Sarnat, 1992 p. 397)

[138] (Sarnat, 1992 p. 398)

[139] (Sarnat, 1992 p. 398)

[140] (Sarnat, 1992 p. 398)

[141] (Sarnat, 1992 p. 398)

[142] (Sarnat, 1992 p. 400)

[143] (Sarnat, 1992 p. 400)

[144] (Freud, S. 1912, 1958 p. 115)

[145] (Isakower, 1992)

[146] (Jacobs, 1991 p. 120)

[147] (Ogden, 1994b)

[148] (D.B. Stern, 2010)

[149] Routledge, in press.

[150] (Fliess, 1942)

[151] (Klein, 1946)

[152] (Heimann, 1950)

[153] (Racker, 1968)

[154] (Kohut, 1959)

[155] (Modell, 1984)

[156] (Gill, 1994)

[157] (Casement, 1993 p. 393)

[158] (Renik, 1993)

[159] (Beebe, et. al, 2005)

[160] (Schore, 2003a; Schore, 2003b)

[161] (Casement, 1985 p. 31)

[162] (Teitelbaum, 2001 p. 46)

[163] (Casement, 1993 pp. 392-393)

[164] (Jung, 1921 para. 12)

[165] Cited in (Gee, 1996 p. 546)

[166] Bion, W.R. 1963 cited in (Gee, 1996)

[167] Aronson, S. (2000). Analytic Supervision: All Work And No Play?. *Contemp. Psychoanal., 36*:121-132, (p. 131). [Citations of Blos, P. (1979), *The Adolescent Passage*. New York: International Universities Press; Erikson, E. H. (1956). The Problem of Ego Identity. *J. Amer. Psychoanal. Assn. 4*:56-121; Freud, S. (1914), Remembering, repeating and working through. *Standard Edition, 12*:147-156; Winnicott, D. (1971), *Playing and Reality*. London: Tavistock; Levenson, E. A. (1982). Follow the Fox—An Inquiry Into the Vicissitudes of Psychoanalytic Supervision. *Contemp. Psychoanal. 18*:1-15; Bromberg, P. M. (1996). *Standing in the Spaces: The Multiplicity Of Self*.]

[168] (Stern, 2010 p. 111)

[169] (Gilligan, 2002)

[170] (Jung, 1968*)*

[171] (Bion, 1965)

[172] (Lakoff and Johnson, 1980)

[173] (Schafer, 1976)

[174] (Campbell, 1973)

[175] (Spence, 1982)

[176] Ernest Kris has formulated “regression in the service of the ego” to apply to all creative processes including creative learning such as that which can be accomplished in the supervisory situation.

[177] (Greenson, 1978)

[178] (Fleming and Benedek, 1964 p. 80)

[179] (Ekstein & Wallerstein, 1956)

[180] (Teitelbaum, 1990 p. 245)

[181] (Teitelbaum, 2001 p. 10)

[182] (Fiscalini, 1985 p. 593)

[183] (Fiscalini, 1985 pp. 606-607)

[184] (Fiscalini, 1985)

[185] (Fiscalini, 1985)

[186] (Hunt, 2001 p. 167)

[187] (Searles, 1965 p. 585)

[188] (Searles, 1965 p. 586)

[189] (Yerushalmi, 1999 pp. 426-427)

[190] (Stern, D.B. 1997)

[191] (Kohut, 1971)

[192] (Freud, S. 1924)

[193] (Schore, 1968)

[194] (Schore, 2003 pp. 17-18)

[195] (Porges, 2004)

[196] (Porges, 2004 p. 22)

[197] (Schore, 2007)

[198] (Porges, 2004)

[199] (Hedges, 2012a)

[200] (Hedges, 2012a)

[201] See Appendix for an account of "how the symbol hooks into the body."

[202] (Levenson, 1982 p. 1)

[203] (Lacan, 1938)

[204] See Bromberg, P. M. (1993). Shadow and Substance: A Relational Perspective on Clinical Process. In Mitchell & Aron. (1999). *Relational Psychoanalysis: The Emergence of a Tradition*. Hillsdale, NJ: The Analytic Press; Stern, D. B. (1992). Commentary on Constructivism in Clinical Psychoanalysis. *Therapeutic Dialogues 2*: 331-363 ; Stern D. B. (1997). *Unformulated Experience: From Dissociation to Imagination in Psychoanalysis*. Hillsdale, NJ: The Analytic Press; and Stern D. B. (2009). *Partners in Thought*. Hillsdale, NJ: The Analytic Press.

[205] (Fisher, 1992; Fisher, 2004)

[206] (Fisher, 2004, p. 74)

[207] (Fisher, 2004 p. 78)

[208] (Kris, 1952)

[209] (Ferenczi, 1932)

[210] (Balint, 1952)

[211] (Kohut, 1984)

[212] For an illuminating and scholarly treatment of this subject see Robert Van Sweden's excellent book, Regression to Dependence, New Jersey: Jason Aronson, 1995.

[213] (Langs, 1997)

[214] (Langs, 1997 p. 124-125)

[215] (Slavin, 2006)

[216] (Hedges, 2012a)

[217] (Hedges, 1992)

[218] (Teitelbaum, 1990 p. 257)

[219] (Teitelbaum, 1990 p. 257)

[220] (Teitelbaum, 2001 p. 12-13)

[221] (Fiscalini, 1985 p. 591)

[222] (Fiscalini, 1985 p. 591)

[223] (Fiscalini, 1985 pp 592-599)

[224] (Caligor, Bromberg, and Meltzer, 1984 p. xvi)

[225] (Strean, 1991 p. 412)

[226] (Grinberg, 1970 pp. 376-79)

[227] (Corbett, 1995 pp. 73-74)

[228] (Wilke, 1995 pp. 206-210)

[229] (Martin, Mayerson, Olsen, and Wiberg, 1978 pp. 421-423)

[230] (Speicher, 1995 pp. 199-200)

[231] (Lebovici, 1970 p. 392)

[232] (Fiscalini, 1985)

[233] (Fiscalini, 1985 p. 593)

[234] (Fiscalini, 1985 p. 595)

[235] (Fiscalini, 1985 p. 597)

[236] (Fiscalini, 1985 p. 597)

[237] (Yorke, 2005 p. 34)

[238] (Yorke, 2005 p. 34 italics added)

[239] (Bion, 1965)

[240] (Bion, 1965 p. 35 italics added)

[241] (Bion, 1965)

[242] (Kugler, 1995 p. 20)

[243] (Kugler, 1995 p. 20)

[244] (Moore, 1995 p. 55-56)

[245] (Corbett, 1995 p. 63)

[246] (Astor, 1995 pp. 215-228)

[247] (Teitelbaum, 1990 p. 242-245)

[248] (Jacobs, David, and Meyer, 1995 pp. 32-33)

[249] (Martino, 2001)

[250] (Martino, 2001 p. 112)

[251] (Martino, 2001)

[252] (Martino, 2001 p. 115)

[253] (Martino, 2001 p. 115)

[254] (Martino, 2001 p. 116)

[255] (Brown and Miller, 2002)

[256] (Berman, 2000 pp. 275-279)

[257] (Brown and Miller, 2002)

[258] (Brown and Miller, 2002 p. 817)

[259] (Brown and Miller, 2002 p. 817-818)

[260] (Brown and Miller, 2002 p. 819)

[261] (Fiscalini, 1985)

[262] (Fiscalini, 1985 p. 68)

[263] (Sugg, 1995 pp. 849-853)

[264] (Levenson, 1982 p.4)

[265] (Levenson, 1982 pp. 5-6)

[266] (Levenson, 1982 p. 6)

[267] (Levenson, 1982)

[268] (Levenson, 1982 p. 7)

[269] (Aronson, 2000 p. 130)

[270] (Levenson, 1982 p. 13)

[271] (Teitelbaum, 2001 pp. 4-5)

[272] (Yerushalmi, 1999 pp. 419-426)

[273] (Frawley-O'Dea and Sarnat, 2001)

[274] (Frawley-O'Dea and Sarnat, 2001 p. 51)

[275] (Frawley-O'Dea and Sarnat, 2001 p. 41)

[276] (Frawley-O'Dea, 2003 pp. 359-360)

[277] (Frawley-O'Dea, 2003 pp. 363-364)

[278] (Moncayo, 2006 p. 541)

[279] (Moncayo, 2006 p. 527)

[280] (Moncayo, 2006 p. 528)

[281] (Teitelbaum, 1990 p. 244)

[282] (Teitelbaum, 1990 p. 245)

[283] (Bromberg, 1984 pp. 38-39)

[284] (Aronson, 2000 p.129)

[285] (Gee, 1996 p. 540)

[286] (Strean, 1991)

[287] (Strean, 1991 p. 409)

[288] (Strean, 1991 p. 410)

[289] (Strean, 1991)

[290] (Caligor, 1981 pp. 4-5)

[291] (Frawley-O'Dea and Sarnat, 2001 p. 202)

[292] (Sachs and Shapiro, 1976 p. 394)

[293] (Sachs and Shapiro, 1976 p. 408)

[294] (Sachs and Shapiro, 1976 pp. 408-409)

[295] (Bromberg, 1984)

[296] (Epstein, 1986 pp. 396-397)

[297] (Frawley-O'Dea and Sarnat, 2001 p. 207)

[298] (Frawley-O'Dea and Sarnat, 2001 pp. 201-218)

[299] (Kohut, 1959)

[300] (Sullivan, 1959).

[301] (Hedges, 1992)

[302] (Mahler, 1968)

[303] I will later on go into the nature of this work.

[304] (Ferenczi, 1932)

[305] (Reich, 1945)

[306] (Sullivan, 1953)

[307] (Ogden 1994, 2002)

[308] (Stolorow et al.1987, 1992, 1994, 2002)

[309] (Spezzano, 1993)

[310] (Oremland, 1991)

[311] (Renik 1993, 1995)

[312] (Grotstein, 2000)

[313] (Orange,1995)

[314] These features of the self–and–other relatedness are elaborated in detail in my book *Interpreting the Countertransference* (1992).

[315] (Hedges, 1983, 1992, 1996, 2006)

[316] (Maroda, 1999; Spence 2011)

[317] (Johnson, 1991)

[318] (Stark, 1994, 1997)

[319] (Stern, D. B. 2009 p. 8)

[320] (Stern, D.B. 2010)

[321] (Friedman, 1988)

[322] Listening Perspective IV is defined in detail with case examples given in Hedges' 1983, 2006. Further definitions are available with case illustrations in Hedges 1996 and 2011.

[323] (Kohut 1971, 1977, 1984)

[324] (Winnicott, 1971)

[325] Listening Perspective III is defined in detail with case examples in Hedges' 1983. Further definition and case illustrations are given in Hedges 1996 and Hedges 2011.

[326] Listening Perspective II is defined with case illustrations in Hedges 1983 and Hedges 1992. Further definitions and case illustrations of how it manifests in countertransference and sexuality are given with case illustrations in Hedges 1996 and 2011.

[327] I have given preliminary definition and illustrations to Listening Perspective I in Hedges 1983 and 1992. I have given further elaboration and case illustrations in Hedges 1994a,c, 1996, 2000b, 2006, and 2011.

[328] (Mahler, 1968)

[329] Margaret Mahler (1968) is explicitly clear that she is borrowing the term symbiosis from biology as a metaphor to describe the subjective experience of attachment or bonding. She goes to great pains to make clear that actual symbiosis as a social/biological phenomenon is not what she is observing.

[330] (Freud, S.1915)

[331] (Freud, A. 1936)

[332] (Klein, 1952, 1957)

[333] (Hedges, 1983)

[334] (Hedges, 1992, 1996)

[335] see also Bollas, 1987

[336] (Kohut, 1971)

[337] (Freud, S. 1924)

[338] (Hedges, 1992, 1996)

[339] (Hedges, 1983)

[340] (Khan, 1963)

[341] (Hedges, 1983, 1992, 1996)

[342] (Bowlby, 1969) (Schore, 1994, 2003) (Siegel, 1999) (Beebe and Lachman, 2002)

[343] (Hedges, 1994 a, c) (Grotstein, 1994)

[344] (Johnson, 1991) (Stark, 1994, 1997) (Shapiro, 1995) (Maroda, 1999) (Grotstein, 2000)

[345] (Fraiberg, 1982)

[346] (Tustin, 1984, 1986)

[347] (Stern, 1985) (Schore, 1994, 2003) (Siegel, 1999) (Beebe and Lachman, 2002)

[348] (Edelman, 1993) (Damasio, 1994, 1999, 2003) (LeDoux, 1996, 2002; Pert, 1997) (Edelman and Tononi, 2000) (Schore, 2004a,b) (Porges, 2004)

[349] (Hedges, 1994a, b, c, 2000b) (Van Sweden, 1995)

[350] (Edelman, 1993) (Damasio, 1994, 1999, 2003) (LeDoux, 1996, 2002) (Pert, 1997) (Edelman and Tononi, 2000) (Schore, 2004a,b) (Porges, 2004)

[351] (Bromberg,1998)

[352] (Stern, D. B. 2010)

[353] (Sullivan, 1953)

[354] (Hedges, 1994c)

[355] This phenomenon is illustrated earlier in this book as a “relational thought experiment.”

[356] (Hedges, 2000a, b)

[357] (Bromberg, 1998)

[358] (Stern, D. B. 1997, 2010)

[359] (Kohut, 1984)

[360] (Kohut, 1984 p.8)

[361] (Johnson, 1991) (Hunter, 1994) (Stark, 1994, 1997) (Shapiro, 1995) (Van Sweden, 1995) (Aron, 1996) (Mitchell, 1998) (Maroda, 1999) (Grotstein, 2000)

[362] In deference to the treat-teach controversy in supervision, it should be noted here that the supervisory relationship is envisioned in this book as one in which the supervisee and occasionally the supervisor may have need to drop into one of these early modes of experiencing in order to grasp some aspect of experience being communicated nonverbally by the client. However, with few extremely rare exceptions would it be seen as appropriate to sustain such investigation in the supervisory situation but rather to transfer it to a therapeutic situation for either the therapist or the supervisor reading such regression.

[363] (Hedges, 1994c, 2000b)

[364] (Hedges et al., 1997; Hedges, 2000b)

[365] (Tustin, 1984)

[366] (Blanck and Blanck, 1979)

[367] The power of “therapeutic symbiosis” and individuation by both client and therapist has been elaborated considerably by Harold Searles

[368] Kohut’s original term is Selfobject (1971)

[369] (Kohut, 1982)

[370] (Kohut, 1984)

[371] see Hedges 1992, 2003, and 2013e for fuller statements of the paradigm shift

[372] Mitchell and Aron 1999

[373] Benjamin 2013

[374] see Schore 2012 on affect regulation and Porges 2004 on polyvegal theory and neuroception

[375] see D. N. Stern 1985, 2004

[376] see Fonagy, et. al. 2002

[377] Hedges 2005, 2013c,e

[378] D. B. Stern, in press

[379] for examples see Grotstein, 1994, 2000 ; Hedges 1994a,c, 2000, 2005, and 2013e; Kalsched 20 , in press; Bromberg 1998, and D. B. Stern 2010 , in press

[380] D. B. Stern 2010

[381] As a supervisory aid to understanding the work of Robert Langs regarding the frame, this appendix is reprinted from Hedges, L. (1983). *Listening Perspectives in Psychotherapy* Northvale, NJ: Jason Aronsoon. p. 285-291

[382] (Langs, 1973, 1978, 1980, 1981)

[383] (Strachey, 1934)

[384] (Langs, 1976)

[385] (Bion, 1962, 1963)

[386] (Modell, 1976)

[387] (Langs, 1976 p. 252)

[388] (Langs, 1976 p. 70)

[389] (Baranger and Baranger, 1966)

[390] The reader is referred to Langs's *The Listening Process* (1978) for a detailed account of these ideas, particularly Appendix B. Further elaboration of his ideas is contained in Psychotherapy: A Basic Text (1982).

[391] (Langs, 1976, p. 217)

[392] (Langs, 1978,1980,1982)

[393] (Bion, 1962)

[394] (Modell, 1976)

[395] (Bion, 1962)

[396] (Eissler, 1953)

[397] (Giovacchini ,1979a)

[398] (Langs, 1980)

[399] This essay was first published in *The California Therapist* 1949 and reprinted in Hedges *Remembering, Repeating and Working Through Childhood Trauma* in 1994. It is reprinted here as an anthropological-psychological insight into why the expression of personal ideas and feelings in crucial to the success of both the psychotherapeutic and the supervisory relationship.

[400] (Lévi-Strauss, 1963, 1949)

[401] (Lévi-Strauss, 1963, 1949)

[402] (Lévi-Strauss, 1949)

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About Lawrence Hedges' Other Books

Terrifying Transferences: Aftershocks of Childhood Trauma

There is a level of stark terror known to one degree or another by all human beings. It silently haunts our lives and occasionally surfaces in therapy. It is this deep-seated fear--often manifest in dreams or fantasies of dismemberment, mutilation, torture, abuse, insanity, rape, or death--that grips us with the terror of being lost forever in time and space or controlled by hostile forces stronger than ourselves. Whether the terror is felt by the client or by the therapist, it has a disorienting, fragmenting, crippling power. How we can look directly into the face of such terror, hold steady, and safely work it through is the subject of *Terrifying Transferences*. Contributing therapists: Linda Barnhurst, John Carter, Shirley Cox, Jolyn Davidson, Virginia Hunter, Michael Reyes, Audrey Seaton-Bacon, Sean Stewart, Gayle Trenberth, and Cynthia Wygal.

Listening Perspectives in Psychotherapy

In a fresh and innovative format Hedges organizes an exhaustive overview of contemporary psychoanalytic and object relations theory and clinical practice. "In studying the Listening Perspectives of therapists, the author has identified himself with the idea that one must sometimes change the Listening Perspective and also the interpreting, responding perspective." –Rudolf Ekstein, Ph.D. Contributing therapists: Mary Cook, Susan Courtney, Charles Coverdale, Arlene Dorius, David Garland, Charles Margach, Jenna Riley, and Mary E. Walker. Now available in a Twentieth Anniversary edition, the book has become a classic in the field.

Working the Organizing Experience

Hedges defines in a clear and impelling manner the most fundamental and treacherous transference phenomena, the emotional experiences retained from the first few

months of life. Hedges describes the infant's attempts to reach out and form organizing connections to the interpersonal environment and how those attempts may have been ignored, thwarted, and/or rejected. He demonstrates how people live out these primitive transferences in everyday significant relationships and in the psychotherapy relationship. James Grotstein contributes a critical history of psychotherapy with primitive transferences and a case study is contributed by Frances Tustin.

Interpreting the Countertransference

Hedges boldly studies countertransference as a critical tool for therapeutic understanding. "Hedges clearly and beautifully delineates the components and forms of countertransference and explicates the technique of carefully proffered countertransference informed interventions…[He takes the view] that all countertransferences, no matter how much they belong to the analyst, are unconsciously evoked by the patient."--James Grotstein, M.D. Contributing therapists: Anthony Brailow, Karen K. Redding, and Howard Rogers.

In Search of the Lost Mother of Infancy

"Organizing transferences" in psychotherapy constitute a living memory of a person's earliest relatedness experiences and failures. Infant research and psychotherapeutic studies from the past two decades makes it now possible to define for therapeutic analysis the manifestations of early contact traumas. A history and summary of the Listening Perspective approach to psychotherapy introduces the book. Contributing therapists: Bill Cone, Cecile Dillon, Francie Marais, Sandra Russell, Sabrina Salayz, Jacki Singer, Sean Stewart, Ruth Wimsatt, and Marina Young.

Strategic Emotional Involvement

Following an overview of contemporary approaches to studying countertransference responsiveness, therapists tell moving stories of how their work came to involve them deeply, emotionally, and not always safely with clients. These comprehensive, intense, and honest reports are the first of their kind ever to be collected and

published. Contributing therapists: Anthony Brailow, Suzanne Buchanan, Charles Coverdale, Carolyn Crawford, Jolyn Davidson, Jacqueline Gillespie, Ronald Hirz, Virginia Hunter, Gayle Trenberth, and Sally Turner-Miller.

Therapists At Risk: Perils of the Intimacy of the Therapeutic Relationship

Lawrence E. Hedges, Robert Hilton, and Virginia Wink Hilton, long-time trainers of psychotherapists, join hands with attorney O. Brandt Caudill in this tour de force, which explores the multitude of personal, ethical, and legal risks involved in achieving rewarding transformative connections in psychotherapy today. Relational intimacy is explored through such issues as touching, dualities in relationship, interfacing boundaries, sexuality, countertransference, recovered memories, primitive transferences, false accusations against therapists, and the critical importance of peer support and consultation. The authors clarify the many dynamic issues involved, suggest useful ways of managing the inherent dangers, and work to restore our confidence in and natural enjoyment of the psychotherapeutic process.

Remembering, Repeating, and Working Through Childhood Trauma: The Psychodynamics of Recovered Memories, Multiple Personality, Ritual Abuse, Incest, Molest, and Abduction

Infantile focal as well as strain trauma leave deep psychological scars that show up as symptoms and memories later in life. In psychotherapy people seek to process early experiences that lack ordinary pictorial and narrational representations through a variety of forms of transference and dissociative remembering such as multiple personality, dual relating, archetypal adventures, and false accusations against therapists or other emotionally significant people. “Lawrence Hedges makes a powerful and compelling argument for why traumatic memories recovered during psychotherapy need to be taken seriously. He shows us how and why these memories must be dealt with in thoughtful and responsible ways and not simply uncritically believed and used as tools for destruction.”---Elizabeth F. Loftus, Ph.D.

Facing the Challenge of Liability in Psychotherapy: Practicing Defensively

In this litigious age, all psychotherapists must protect themselves against the possibility of legal action; malpractice insurance is insufficient and does not begin to address the complexity and the enormity of this critical problem. In this book, Lawrence E. Hedges urges clinicians to practice defensively and provides a course of action that equips them to do so. After working with over a hundred psychotherapists and attorneys who have fought unwarranted legal and ethical complaints from clients, he has made the fruits of his work available to all therapists. In addition to identifying those patients prone to presenting legal problems, Dr. Hedges provides a series of consent forms (on the accompanying disk), a compelling rationale for using them, and a means of easily introducing them into clinical practice. This book is a wake-up call, a practical, clinically sound response to a frightening reality, and an absolute necessity for all therapists in practice today. Now available in a revised and updated edition.

Sex in Psychotherapy: Sexuality, Passion, Love, and Desire in the Therapeutic Encounter

This book takes a psychodynamic approach to understanding recent technological and theoretical shifts in the field of psychotherapy. Hedges provides an expert overview and analysis of a wide variety of new perspectives on sex, sexuality, gender, and identity; new theories about sex's role in therapy; and new discoveries about the human brain and how it works. Therapists will value Hedges' unique insights into the role of sexuality in therapy, which are grounded in the author's studies of neurology, the history of sexuality, transference, resistance, and countertransference. Clinicians will also appreciate his provocative analyses of influential perspectives on sex, gender, and identity, and his lucid, concrete advice on the practice of therapeutic listening. This is an explosive work of tremendous imagination and scholarship. Hedges speaks the uncomfortable truth that psychotherapy today often reinforces the very paradigms that keep patients stuck in self-defeating, frustrating behavior. He sees sexuality as a vehicle for both therapists and patients to challenge what they think they know about the nature of self and intimacy. This book is a must-read for anyone interested in understanding 21st century human beings—or in better understanding themselves and their sexuality.

Overcoming Our Relationship Fears

We are all aware that chronic tension saps our energy and contributes to such modern maladies as high blood pressure and tension headaches, but few of us realize that this is caused by muscle constrictions that started as relationship fears in early childhood and live on in our minds and bodies. *Overcoming Our Relationship Fears* is a user-friendly roadmap for healing our relationships by dealing with our childhood fear reflexes. It is replete with relationship stories to illustrate each fear and how we individually express them. Dr. Hedges shows how to use our own built-in "Aliveness Monitor" to gauge our body's reaction to daily interactions and how they trigger our fears. Exercises in the book will help us release these life-threatening constrictions and reclaim our aliveness with ourselves and others.

Overcoming Our Relationship Fears: WORKBOOK

Developed to accompany Hedges' Overcoming Relationship Fears, this workbook contains a general introduction to the seven relationship fears that are a part of normal human development along with a series of exercises for individuals and couples who wish to learn to how to release their Body-Mind-Relationship fear reflexes. An Aliveness Journal is provided for charting the way these fears manifest in relationships and body maps to chart their location in each person's body

Cross-Cultural Encounters: Bridging Worlds of Difference

This book is addressed to everyone who regularly encounters people from other cultural, ethnic, socioeconomic, linguistic, and ability groups. Its special focus, however, is aimed at counselors, therapists, and educators since their daily work so often involves highly personal cross-cultural interactive encounters. The running theme throughout the book is the importance of cultivating an attitude of tentative and curious humility and openness in the face of other cultural orientations. I owe a great debt to the many students, clients, and friends with diverse backgrounds who over the years have taught me how embedded I am in my own cultural biases. And who have helped me find ways of momentarily transcending those biases in order to bridge to an inspiring and illuminating intimate personal connection.

Making Love Last: Creating and Maintaining Intimacy in Long-term Relationships

We have long known that physical and emotional intimacy diminish during the course of long-term relationships. This book deals with the questions, "Why romance fades over time?" And "What can we do about it?" Relational psychologists, neuropsychologists, and anthropologists have devoted the last two decades to the study of these questions with never before available research tools. It is now clear that we are genetically predisposed to search out intersubjective intimacy from birth but that cultural systems of child rearing seriously limit our possibilities for rewarding interpersonal relationships. Anthropological and neurological data suggests that over time we have been essentially a serially monogamous species with an extraordinary capacity for carving out new destinies for ourselves. How can we come to grips with our genetic and neurological heritage while simultaneously transcending our relational history in order to create and sustain exciting romance and nurturing love in long-term relationships? Making Love Last surveys research and theory suggesting that indeed we have the capacity and the means of achieving the lasting love we long for in our committed relationships.

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