Super-vision or space invader?

Two's company and three makes for paranoid tendencies

Carl Bagnini

Dimensions of Psychotherapy, Dimensions of Experience

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Created in the United States of America

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INTRODUCTION

The transference dimension of supervision has been widely discussed in psychoanalytic literature, but attention to the supervisor-supervisee-patient triad has been narrowly

focused on two of the three participants, mainly through the patient's transference to the therapist, and the therapist's countertransference to the patient. Fiscalini (1997) found that the triadic implications of the transference-countertransference between supervisor-supervisee, and supervisee-patient were neglected. Berman (2000) has pointed out that little attention had been paid to how patient-supervisee-supervisor unconscious processes influence the learning of psychotherapy.

Stimmel (1995) refers to the patient-supervisee transference which may parallel the supervisor-supervisee relationship; however, focusing on one parallel process or another leaves out the supervisor's countertransferences to the supervisee and his patient. Traditional supervision studies the unconscious relationship in the supervisee-patient dyad, and then feeds it back to the supervisee to facilitate learning (Teitelbaum 1990). Some supervisors limit their study to supervisee countertransferences to patients: a 'treat' vs. 'train' approach

(Rosbrow 1993). Broader use of interpretive efforts in psychoanalytic supervision merits more investigation (Gorman 2001). To fully research supervision we have to study the entire field of unconscious realities involving the complex triad of patient-supervisee-supervisor. Treat or train is a narrow and false dichotomy. Using the perspective of 'an intersubjective matrix' (Brown and Miller 2002), supervision research can be expanded to triadic influences. This chapter discusses the triadic field of supervision, and a vignette illustrates

its impact on the teaching and learning of psychotherapy.

GROUP PROCESS AND SUPERVISION

My interest in expanding supervision theory stems from many years of teaching psychotherapy from a group affective learning model (Scharff and Scharff 2000) that focuses on the effects of projective identification on the therapist's use of self. In discussions with colleagues who practice group analysis, I further noted the importance of working with

multiple transferences, and how group process concepts are underutilized in supervision. Application of group process can aid in understanding the triad.

For instance, triadic transferences include the subtle or indirect transferences of the patient to the therapist resulting from the supervisor's influence on the treatment relationship. Another example is the impact of the therapy process on the supervisor's inner world.

A ROLE PARADOX FOR THE THERAPIST AND SUPERVISOR

Significant role paradoxes influence the supervisee in the triad. One aspect of the paradox concerns the therapist as 'expert', and the patient as 'learner'. In supervision, however, the supervisor is the 'expert' and the supervisee the 'learner'. Ambiguities are inherent in the shifting from expert to learner. Therapists work with dependency-autonomy issues of patients, and at the same time deal with their subordinate role in the supervision space, which can overlap,

or merge with the role of the patient. The object relations operating in the triad profoundly affect each participant's conscious and unconscious interpretation of their roles.

I propose that the supervisor struggle with a similar paradox and be a 'learner' about the interactive field (Szecsödy 2000). Supervisor and supervisee need to examine how supervision presses into the treatment in ways that interfere with the supervisee's freedom to be alone with

the patient. Dependency in supervisory sessions may foster ‘accommodative’ learning (Szecsödy 1994) rather than ‘assimilative’ learning. Assimilative learning is subtle, as it adds to what is already known. Accommodative learning is superimposed on pre-existing cognitive style and replaces what is known. When the supervisor is geared toward interpreting the case, rather than distinguishing the supervisee’s ideas and theories, rationales and potentials, the result is accommodative learning. The study of

triadic object relations can facilitate assimilative learning.

THE PRESS OF TRIADIC OBJECTS ON THE SUPERVISEE

Whose objects are present during the therapeutic encounter? The therapy dyad includes the objects of the patient and of the therapist in readiness for use by each other. The patient's objects also influence the supervisor's unconscious. What must be added to the menu, as though the cafeteria of objects is not complex enough, are the supervisor's objects. The triad

functions as a circular feedback loop, containing mutual unconscious influences.

A paradox exists in trying to be alone with one's patient (one dyad) in light of the tensions of being scrutinized and evaluated outside the setting. The therapist working with the patient must deal with the 'presence' of the supervisor *in* the analytic setting. Depending on projective processes the supervisor's presence may be experienced as sharp or subtle, kindly or carnivorous. Whose patient

is it? How is the supervisor's influence utilized and therapist creativity promoted? As therapists pursue the requisite knowledge and skills for practice, they attempt to remain personally and uniquely individuals. Supervisees need help with negotiating the authority-dependency supervisory relationship and its reversal in the therapy situation. This intensifies and promotes projective process, blurring boundaries, and leads to a natural paranoid tendency. Supervisees may feel they are on their own, but are they?

I view countertransference analysis as the major tool in egalitarian supervision (Rock 1997), as it can provide the supervisor with a detailed view of triadic mental space. Egalitarian supervision refers to a co-constructed and less authoritarian approach to the learning process. Supervisor self-monitoring through countertransference analysis expands the landscape of supervision by accessing everyone's transferences. When warranted, the supervisor leading a frank discussion of all participants' narcissistic sensitivities

may actually improve the supervisee's confidence.

FROM EGO IDEAL TO PARANOID TENDENCIES

The process of supervision inevitably changes, beginning, for example, with the supervisee's view of the supervisor as ego ideal, and leading to the supervisor as a critical superego figure. There may be instances in which the supervisee expects disappointment or is already in a state of mistrust. The role of learner/less knowledgeable therapist

can foster superego-dominated passivity.

Compliance, in particular, is a negative transference response in supervision, and when not identified, it can promote an inauthentic imitative therapeutic approach. The companion, if not parallel process, is the supervisor's initial appreciation of, and high expectancies that a new supervisee will prove to be a satisfying investment. Initially invested with positive feelings, the supervisee seeks out the supervisor's support and

approval, takes in what the mentor says, whether as theoretical points, clinical insights, transference analysis, or discussions of the frame. Armed with notes and inspiration, the therapist models the therapy after the learned mentor.

Developmentally, some infantile dependencies are natural and adaptive in supervision. Moving up the developmental line there are attendant overlays of childhood needs for nurturing and support, adolescent autonomous strivings against authority,

with suspicions, or ambivalence, and the more adult equality pursuits. The supervisee who occasionally gets stuck at the lower end of the developmental continuum needs an acknowledgement of normative regression. The supervisory process can inhibit the proper surfacing of conflict over autonomy and dependency within the dual roles of therapist and supervisee. Inevitably, there are oscillations between paranoid/schizoid and depressive reactions throughout the treatment (Klein 1946) that surface in the supervision.

UNDERSTANDING ENACTMENTS IN THE TRIAD

Supervisory intervention in a patient crisis requires awareness and judgment in helping the therapist contain the patient. The supervisor can take into account the supervisee's potential for blurring self with other when there are infantile, or pre-oedipal issues involved in treatment. If the supervisor quickly assuages the supervisee's anxieties, instead of taking the multiple transferences into account, supervision will temporarily shore up therapist uncertainty, while

omitting the supervisor's anxieties as mutually useful information.

How else can supervision impair learning? In early treatment there is a crucial period of trial identification with the patient (Casement 1997). This is when the patient is understood from inside their own experience, in order for the therapist to locate important aspects of the transference. Restraint in interpreting is required in this initial period. The supervisee may reflect: How does the patient view the process, the relationship, and me? If the

supervisee studies the patient's issues around dependency needs *and* autonomous strivings, interpretive attempts will be better tailored to both tendencies. What if the autonomy of the supervisee is jeopardized owing to the supervisor's over-identification with the patient's ambivalence or caution? Learning is sacrificed if the supervisor's impatience prevents the supervisee's gradual discovery of the patient's internal world.

Another negative potential is the supervisor who reinterprets the

therapist's interpretations before sufficient time has elapsed for the patient to absorb them. The prescribed approach is for patience in offering reinterpretive comments, allowing the patient to communicate reactions to the supervisee; and if the supervisee does not report the patient's responses, an inquiry can be made as to what is missing in the case reporting.

I now present a vignette to illustrate triadic dimensions of supervision. I offer my understanding of the various transferences, and share my

countertransference to demonstrate its efficacy in grounding the teaching and learning process.

VIGNETTE OF A SUPERVISEE WHO FELT GUILTY

Kathy, 56, in private practice for nine years, sought supervision for a difficult case. Kathy had been seeing Kim, age 17, for one year in weekly analytic psychotherapy and had not been in supervision during that time. Kim was sixteen when she sought help with cutting school and academic underachievement, rebellion at home,

inability to make friends with male peers, feelings of inadequacy, and unwillingness to date. Kathy described Kim as a feisty young woman, a good talker, and full of potential.

Kathy reported a central traumatic situation that provided crucial understanding of Kim's difficulties. During the eighth month of treatment Kim revealed her one-year-older brother had sexually molested her from age ten to age twelve. There was no intercourse and no evidence of intimidation or force. Kathy

encouraged Kim to bring up the incestuous experiences to her parents. Over a period of two months they discussed the consequences of telling her parents. Kim alternated between fear her parents would do nothing and hope they would hear her and understand why she had so many problems. Kathy championed family sessions with mom, dad, and Kim. Two family sessions were held and Kathy actively helped Kim talk about the brother-sister incest. The parents listened, and father responded with sympathy, and a ‘what can you do

now?' attitude. Mother sat slumped and withdrawn, mostly silent, a customary complaint Kim had raised before. Kathy believed Kim's progress in treatment and in life would depend on the parents confronting their son, who was now living away as a college freshman. This did not occur.

Subsequently, Kim changed in physical appearance and communication. Kim's shift consisted of a series of 'I don't knows' as Kathy posed questions that Kim usually raised on her own. Affect was

generally blunted, with shoulder shrugging, and a diminished interest in talking. She wore bland colors, less feminine in style, and she slumped in her chair, making less eye contact. Once she showed an uncustomary irritability by exclaiming, 'You're the therapist, you figure it out.' Kathy believed the basis for Kim's withdrawal and uncooperative attitude was the disappointment with her parents from the family sessions. Kim's response was that she now had her first boyfriend, and he made her feel loved, so what did it matter about

her parents? There was, Kathy thought, both a triumphant feeling behind having her first boyfriend and a contemptuous tone that Kathy believed glossed over the parents' indifference. Kathy related in supervision that she felt anger at Kim's parents for not supporting their daughter and the efforts to bring out the incest experience.

As Kim's sessions continued Kathy felt that having the new boyfriend might mean Kim was ready to wind down the therapy. Without planning to,

Kathy said those very words during a particularly tedious session when Kim was lethargic and uninterested. Kim did not react when Kathy mentioned that summer was coming, and perhaps Kim would want a break, given that her social life and first love were encouraging.

Kim canceled her next session, and in the following session reported there was a strain in the boyfriend-girlfriend relationship. He wanted to date other girls but stay with Kim. Kathy had offered Kim a way to take a break

from therapy but was now confused. Much more had occurred than she had understood. She felt guilty, and decided to seek supervision.

The supervisor's impressions

Kathy was visibly upset as she spoke about the case. She had little insight about Kim's sullen and silent behavior and was therefore not able to interpret. Kathy worried she had lost the patient by suggesting the break in treatment. She had concluded that the patient's problems stemmed fundamentally from the incest, and

focused on that. Kathy did not report how the molestation specifically impaired Kim's functioning, or how the sexual contacts between the siblings became central in her thinking. Kathy overidentified with the sexual component so that family sessions seemed a correct move. Kathy's decision-making process concerned me, especially the choice of brother-sister incest as a 'trauma' to focus on. She used that term in advocating family sessions. I believed the incest was important, but trauma was reductionistic. I thought she had

made an inaccurate assessment of Kim's emotional difficulties and had essentially missed all of the transference issues. This stemmed from unconscious countertransference inducing Kathy to provide direct and unambiguous mothering to contain Kim's many problems. She had reacted to the incest with personal horror rather than with measured thinking.

Had she examined the individual and family psychodynamics more carefully, several hypotheses might

have emerged. Incest can be a flight into sibling pleasure as a defense against neglect and depressive anxieties, and if so, Kathy might work with Kim's recent rejection of Kathy as a projection of rejecting or apathetic parents. Sexual over-stimulation by the parents was another possibility in Kim's childhood, and I wondered whether Kim could have perceived Kathy's zealousness as over-stimulation, if not a promise that Kathy would repair the family deficits. Kathy's countertransference had limited her receptivity and locked her

into a one-dimensional clinical approach by only seeing Kim's problems as caused by the combination of a depressed mother-daughter relationship and incest. I surmised that Kathy was influenced by her earlier work with Kim on the long-term mother-daughter estrangement and that she over-identified with these nurturing deficiencies.

Kathy was burdened by a combination of her own relational vulnerabilities (Rock 1997) and needed a frame for rethinking so she

might discover the personal basis for overzealous application of her conclusions. The two participants in the therapeutic process had been enacting without understanding the implications of transference and countertransference. Kathy, like the mother and daughter, was in a ‘slump’.

My task consisted of how to offer a frame for discovery without humiliating Kathy. The issue in supervision partially paralleled the treatment dilemma, in which Kathy attempted to offer the patient a

wholesale plan for feeling better as her advocate, but there had been a lack of patient self-discovery. Kim was not currently respectful of Kathy. It was clear that Kathy did not comprehend Kim's reactions to her, labeling them as resistance (unanalyzed) with no historical or relational basis. I took a more instruction-oriented approach at first, emphasizing what she had already accomplished with Kim. At that time I did not fully realize I carried triadic transferences related to criticizing, fearing criticism, and disappointments in unreliable

dependency. Building the supervisor-supervisee relationship requires an appreciation of role confusion. The therapist is expected to contain personal fantasies and feelings while with the patient. Supervision (Konig 1995) promotes a different role. The supervisee is called upon to offer ambiguity through the expression of personal feelings and fantasies about the patient to expand self-awareness. This appears to run counter to the therapeutic role in doing treatment, but supervision necessitates a free sharing

of all factors that may affect therapy, including use of self.

I found it important to mention the tensions in the different roles so that Kathy might become comfortable discussing their ambiguities. Trusting me with her feelings about the patient required that she tolerate bad feelings along with good ones, and I felt that this could be accomplished by taking a matter-of-fact approach to role ambiguity as a tool of supervision.

The supervisee initially idealizes the supervisor

Idealization of me occurred early and helped establish rapport. I believed this was due to her desperate need for immediate help, temporarily reducing anxiety all around; but the honeymoon was short, as most are.

My usual style is to raise unconscious transference-countertransference enactments when there is an impasse or rift in the therapist-patient collaboration. I also ask for associations to widen the scope of thinking. While I do not initially know about the supervisee's life, it

often turns out that what is salient there finds its way into supervision. As I get to know the supervisee's personal valences we make a start in self-discovery that I hope will lead to re-connecting with the patient.

I addressed Kathy's unconscious slip in telling Kim to take the summer off, introduced examples of projective identification, starting with Kim's idealized reports of boyfriend bliss, followed by troubled couple relating, and suggested we look for other paired difficulties. Kathy listened to my

references to paired relating and its parallels with the current troubled treatment process. She visibly relaxed, as though a great burden was lifted. Empowered by newfound knowledge to turn the tide in the case, she bypassed feelings associated with inadequacy, or lack of confidence. She did grasp the sequence of dynamic events: Kathy failed to make restitution between Kim and her parents, Kim became sullen and uncooperative, and Kathy rejected her. I pointed to a parallel group process in the failure of the parents to fulfill

Kathy and Kim's desires for restitution, and the unconscious similar feelings of rejection that Kathy and Kim had not discussed. A small glimmer of countertransference awareness accompanied Kathy to her upcoming sessions with Kim.

A learning issue remained on my mind: had I indirectly prevented her from comprehending unconscious processes by filling in the missing 'information' through substitute analysis? If so, would Kathy take a smaller dose of learning from me than

I would have preferred? I took comfort that Kathy used what she could at the time. My helping her in a concrete way, rather than exploring the anxiety areas, was motivated by concern that Kathy recover her therapeutic position.

De-idealization and 'paranoid tendencies'

The process of learning psychotherapy from a supervisor is complicated by the regressive-progressive pulls back and forth across the two boundaries, supervisee-supervisor, and therapist-patient. In

Kathy's situation, examples of paranoid tendencies took the form of incomplete reporting or withholding of case material. On one occasion she announced at the beginning of supervision she had left her notes in the office. At that time I recall responding that her dog hadn't eaten her homework, but close! Another example had to do with partial or selective relating of sessions. The parts left out included moments following an intervention on Kathy's part, with no reference to Kim's responses. Opposite recording gaps focused on

Kim with no references to Kathy. In each situation one of them was left out of Kathy's written work, or in her discussion of the session.

The unconscious withholding of material indicated that Kathy was splitting the relationship between Kim and herself, in favor of a pairing with me that left out a third person. In systems theory a weak dyad usually leads to confiscation of another to promote a triangle. The triangle functions as a defense draining off conflict in the dyad. I felt Kathy was

alternating who was to be included in the dyad. It was either Kim with me, or Kathy and me, but not the two together with me. I felt this as displaced anxieties having to do with conflicted pairings in a triangle. Kathy's defensive case reporting was an example of 'paranoid tendencies'.

Example of triadic transference-countertransference

Learning about the supervisor's influences on the therapist can occur through the patient's transference to

the *supervisor* through the therapist. Several examples of triadic transference-countertransference are in order. One consisted of the patient seeking a boyfriend after the family sessions failed, partly as an age-appropriate developmental step. However, Kim's timing of the relationship was an unconscious flight from disappointments in Kathy. Kim's seeking a boyfriend was not mere coincidence, nor was Kathy's seeking out a male supervisor, to restore hurt parts of her therapeutic self. Kathy's initial idealized dependency in

supervision resembled that of Kim's earlier dependency on Kathy. The second element in the triadic transference-countertransference was that I installed myself between Kathy and her patient, supplying Kathy, so I thought, with the needed linkages for a re-pairing (*repairing*). My countertransference reaction stemmed from my family of origin and my earliest role as the middle child, the only male sandwiched between a younger and an older sister. I often over-functioned in the role of male parental go-between in the family.

The above personal awareness allowed discovery of a third feature of the triadic transference-countertransference. I had been affectively taken over by a powerfully charged triadic projection process that related to Kim's admonition to Kathy: '*You're the therapist, you figure it out*.' Kathy's impasse led her to me to unconsciously bail her out, and, in the role of supervisor-as-over-functioning child, I was taken in by the projective identification. I experienced a slight twinge of painful enlightenment, as the triadic projection process became

clear: the patient needed the therapist, and the therapist needed the supervisor to understand something together that was not previously known, so it might become available in the work. My awareness of my childhood memories shed light on Kathy and her patient's projections. Discovery had taken place for use in future supervision sessions with Kathy. I realized 'paranoid tendencies' were symmetrical with my childhood role as protector, projected as the tendency to over-function as Kathy's and her patient's 'rescuer'.

I decided to discuss with Kathy how the patient was affecting me and the circular process I sensed in the case and in supervision. I did not share my childhood insights when approaching the material in supervision, although they were valuable to me in opening a new supervisory space. In two supervision sessions I asked about idealization, guilt, and identification in the supervision, and raised the parallels in Kim's early treatment relationship. I shared my honest frustration about the patient's withdrawal and how I was

talking a good deal in supervision. My countertransference reenacted Kim and Kathy's impasse. Kathy and I were over-functioning. Kathy was able to think about her early idealization of me, and the patient's idealization of her. She further explained that she had not recognized how she had worked so hard to keep Kim's faith in her. She went on to explain her need to follow my lead, and this did not initially allow for expansive thinking about the relationship from an unconscious standpoint. By being a follower, she was not yet able to work with the

whole experience. Similarly, Kim had withdrawn from the whole experience of the therapy, was less invested in the work, and let Kathy do the talking, withholding important disappointments she felt in Kathy. In later supervision Kathy offered that fear of being a disappointment was a core issue during her childhood and adolescence. She was embarrassed but relieved, paving the way for more openness in her work with Kim and in supervision.

I later learned an important lesson from Kathy, that in early supervision she felt I had spoken with such certainty about the case that she elected to take what was given as 'gospel'. She shared that my teaching had allowed her to put the issue of responsibility for the case in my hands, rather than between us as a collaborative effort. I appreciated the frankness in her depiction. The discussion resulted in fewer directives by me and a more attentive stance by Kathy to what was *not* being said in Kim's sessions. She enquired if Kim

had been reluctant to take on the issue of Kathy's letting her down with the parents. A discussion ensued that brought out Kim's disgust with her parents, as well as her fears of hurting Kathy. Kathy later reported that Kim knew Kathy was pushing the meetings with her parents, and she had passively followed her lead in making the incest the only issue.

Kathy realized that winding down treatment with Kim stemmed from the de-idealization and unconscious disgust Kathy felt for failing Kim,

projected as Kim's not needing to come anymore. Kathy made use of the supervision to de-repress therapeutic blockages and restore her working treatment relationship.

CONCLUSIONS

This chapter expanded psychoanalytic supervision to the study of triadic object relations with emphasis on the supervisor's use of self. The supervision vignette demonstrated triadic transferences in the case and in supervision by illustrating how patient, supervisee,

and supervisor are an interactive field, susceptible to the interpenetration of projective material.

Two questions were raised earlier. Does the supervisor claim any .supervision and can the supervisee remain alone with the patient. Yes and no. Yes, the supervisor has the potential for developing a super-transference or vision of the total situation (Teitelbaum 2001). No, the therapist cannot be truly alone with the patient, any more than the patient and therapist can completely rid

themselves of all of their internal objects.

Supervisors and therapists are subject to having personal issues exposed and their technical skills tested. Humility is a useful ethic in this regard. The supervisor and professional colleague are best served by examining their complex and different roles. The more that role paradoxes are openly discussed the better the dialogue, reducing hierarchical restraints. Subjective forces are also at work in the choices

therapists make in selecting a supervisor. One's feelings, as well as word of mouth in the therapy community about who is good to learn from, govern the choice. Unconscious and conscious fantasies and motives ought to be part of the eventual supervision dialogue. I find that supervisees who freely choose supervisors for help with cases tend to respond favorably to offers that they share their mistakes in a non-judgmental atmosphere. This may not be the case in training institutions,

given the greater evaluative component.

Group process theory can assist in providing requisite knowledge for supervision practice. However, as the panorama of objects to study expands, complexity can add distress for supervisor and therapist. As mentor and mentee discover the internal and external affective landscape, normative paranoid tendencies can initially reduce therapeutic efficacy.

The analysis offered in this study may also prove useful to those

practicing group supervision, an activity with additional levels of richness and complexity. Whether in group or individual supervision, supervisees are well informed to expect complementary relational configurations. As noted, supervision causes regressions (Frawley-O'Dea and Sarnat 2001; Roberts 2001) and progressions in the service of improving analytic skills and empathic responsiveness. The study of triadic mental space offers a more complete canvas on which to base supervisory interventions.

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