

Chapter Four



Individual Supervision and Consultation

Most psychodynamic clinicians would likely say that their early supervision was more critical to their development than their course work and readings. Guest and Beutler (1988) found long ago that initial experiences in supervision remain alive in therapists' minds and are influential for years and even decades afterward. In the supervisory relationship we learn to formulate each patient's dynamics, conceptualize what is going on in the clinical moment, increase our skills at listening and intervening, engage in reverie and notice our internal associations, assimilate professional knowledge, monitor our strengths and vulnerabilities, learn about our blind spots, and adapt our personalities to the art of therapy. Supervisors naturally vary in their skills in addressing these different areas, and the wise supervisee learns to take from each mentor what is most valuable in that person's repertoire.

A premise of this chapter is that most clinicians have a natural human curiosity and a deep wish to keep learning and improving their effectiveness. Most supervisees thus thrive on opportunities to increase their knowledge and develop their clinical skills. This assumption parallels the core psychoanalytic conviction that patients, however conflicted they may be about changing, have an internal drive toward psychological health that makes the difficult work of therapy possible. Psychodynamic consultation attempts to help clinicians enjoy and value a process that supervisors hope they will want to engage in throughout their

professional lives. It is a cardinal analytic belief that the job of a mentor, whether a therapist, consultant, or supervisor, is to remove obstacles from learning and provide psychological nutrition for normal maturational processes.

Although research on therapists' evaluation of their supervision is still relatively sparse (Eubanks et al., 2019; Feinstein, Huhn, & Yager, 2015; O'Donovan & Kavanagh, 2014), a substantial empirical literature is beginning to emerge on the topic that complements existing writing that has been more qualitative and personal (e.g., Rock, 1997). Two recent, coordinated issues of *Training and Education in Professional Psychology* (Callahan & Love, 2019) and the *Journal of Psychotherapy Integration* (Callahan, 2020) have been devoted to accounts of supervisees' experiences of their training. Finally, the voices of the recipients of supervision are joining those of the people entrusted with their clinical education.

I have heard about experiences of supervision that run the gamut from extremely helpful to outright damaging (see Dr. Lamia's brief account in Chapter 1). Empirical studies also attest to this range (e.g., Bambling, 2000; Ellis, 2017; Ellis et al., 2014; Gray, Ladany, Walker, & Ancis, 2001; Henry, Schacht, Strupp, Butler, & Binder, 1993). It is my impression that most psychodynamic therapists recall their formative supervision as a kind of holding environment (Winnicott, 1953) in which they felt respected, supported, and filled with a rich stew of information, theories, problem-solving strategies, expansion of their empathy, new perspectives on their countertransferences, and other nourishing ingredients. At the other end of the spectrum, some remember supervision as torture and are only too glad at the current time to be either unsupervised or working with a handpicked consultant who will not replicate the torments of their training. In this chapter I focus on some elements of effective individual supervision, hoping to increase the instances in which supervision is assimilated more as the former rather than the latter experience.

ESTABLISHING AND MAINTAINING THE SUPERVISORY ALLIANCE

A strong alliance is foundational to effective supervision and also to the identity development of the supervisee as a clinician. Increasingly, the empirical literature, both quantitative (e.g., Geller, Farber, & Schaffer, 2010; Nagell et al., 2014; Watkins, 2011) and qualitative (e.g., Cucco, 2020; Mammen, 2020), supports that long-standing psychoanalytic

lore. The best way I know to create a strong supervisory alliance is to be useful to supervisees, and in the process to be respectful of their emotional intelligence, potential intuitive skill, and good intentions. The following sections discuss some elements involved in the mutual construction of a strong alliance, with an emphasis on the supervisor's role in making this possible.

The Supervisory Contract

In the beginning of any course of supervision or consultation, both parties should clarify what they will be doing together. Different supervisors have different preferences for the presentation of clinical material (e.g., watching videos, reading process notes, or inviting the student's report of what happened). They also have different preferences for whether to follow one patient in depth or to consult on multiple cases as the student feels the need. The training program for which they supervise may also have rules about such issues (e.g., most analytic institutes want advanced candidates to present single cases in depth, one per supervisor; graduate programs generally require that every patient the student sees be talked about regularly with a supervisor even if the work seems to be going well).

One interesting newer approach to supervision is Feinstein's cognitive apprenticeship model (Feinstein, 2020; Feinstein et al., 2015; Feinstein & Yager, 2013). This empirically tested method involves the supervisee's observation of a supervisor's therapy session with a patient, followed by a discussion of the supervisor's orienting conceptualizations and rationales for interventions. Then the trainee works similarly with a patient while receiving supervisory feedback (via Bluetooth connection or the supervisor's presence in the room), both during and after the session. Live supervision is familiar to family therapists but mostly alien to psychoanalysts, who worry about splitting the patient's transference. Despite such concerns, and despite early resistance from supervisors of all orientations, Feinstein and his coauthors found that once their reluctant colleagues tried it, they found live supervision in an apprenticeship format to be effective and gratifying. Patients were mostly cooperative and appreciative of the extra attention, and trainees, although initially apprehensive, reported benefiting from the approach. I am not personally familiar with this way of working, but I am impressed with Feinstein's results.

In the mental health field, we have made significant advances in the area of consent for treatment, but not so much with respect to the

contract for supervision. In most treatment consent forms, the patient signs on to the therapist's arrangements about scheduling, payment, and cancellation policies, as well as to summaries about patient rights, confidentiality and its legal exceptions, and so on. In supervision and consultation, contractual consent is usually verbal rather than written, but some parallel considerations apply. In the first meeting, supervisors need to specify what they will expect, how they like to work, and, if relevant, how they will approach any reporting about their evaluation of the clinician to third parties. The supervisee should make clear what he or she hopes to gain from the experience and should have ample opportunity to ask questions and share concerns. Because supervisees are prone to idealization of their clinical mentors, especially early in their careers, and will need to replace the pedestal eventually with internalizations of realistic professional competence, it can be helpful when supervisors comment to them self-reflectively on their own individual strengths and limitations.

The supervisory contract should be revisable over time, as the supervisee's interests or status changes and also in response to the pair's developing an understanding of what kinds of help a particular therapist needs. In their early meetings, the two parties need to clarify the expectations of each one. Just as, in therapy, it is vital to understand the problem for which the patient came and the kind of help being sought, in supervision, it is important to be on the same page about the general focus and direction of the work. By the time both people have accepted the specifics of their arrangement, the supervisee should be confident that there will be no surprises down the road about supervisory practices and reciprocal responsibilities.

Especially when supervision sessions will not be directly observed, the contract should specify what information the supervisor expects when the less experienced colleague presents a case. Here is my own list of questions for supervisees to address, which can usually be communicated verbally rather than in writing:

- “What is the clinical problem or issue with which you want help?”
- “Who is the patient (age, relationship status, gender and sexual identifications, ethnic/racial/class/religious identifications, current situation, physical presentation, general attitude toward the therapist)?”
- “How long and at what frequency have you seen the patient? How did he or she come to you? What is the person's prior experience with therapy, if any?”

- “What is the problem for which the patient came for help?”
- “When did that problem start, and how does the patient understand why it started then?”
- “What is the short version of the patient’s childhood history? How does he or she describe caregivers, siblings, and other important influences? How reliable and comprehensive does the patient’s account seem to you?”
- “What is the emotional tone of the therapy?”
- “How do you find yourself feeling with the patient?”

Formulating Realistic Therapy Goals for Patients

There is empirical support (e.g., Lehrman-Waterman & Ladany, 2001) for long-standing clinical observations that goal setting promotes a solid supervisory alliance and supervisee satisfaction. Goals for psychodynamic treatments involve both symptom relief and improvement in the areas I have summarized in the previous chapter. Mental health is not unidimensional; for example, high affect tolerance or vitality can coexist with low self-esteem or lack of agency. Patients differ on which vital signs need to be monitored. Whenever possible (though when developmental achievements that the therapist and supervisor are capable of envisaging involve capacities the patient cannot yet imagine, it may not be possible), the client should participate in formulating treatment goals that go beyond symptom reduction. One of the first tasks of the supervisee with any patient will therefore be to articulate treatment goals to which the patient can sign on. Thus, supervisors and supervisees need to share a vision of what would constitute significant progress for each client. This can be trickier than it appears.

For example, there may be implicit or explicit differences between supervisor and supervisee about how serious any patient’s problem is. In my experience, unless a person’s self-presentation clearly accords with the DSM or ICD diagnostic criteria for borderline personality disorder or a psychotic disorder, beginning therapists often fail to recognize severe psychological disturbance. Graduate programs tend to warn students not to overpathologize, but they rarely alert them to the dangers of underpathologizing. Especially if a person is bright, privileged, and competent in many areas, students tend not to pick up right away on how primitive their defenses are, how deeply distrustful they may be, or how internally empty their subjective world is. They tend to identify with

areas in which the client is like them (e.g., smart, socially adept, holding similar values or interests) and unconsciously infer that their level of psychological wellness is also similar. It can be shocking to beginning therapists to realize how many seriously troubled people inhabit the world and how deep is the suffering of those they have signed up to help. One of my younger supervisees once remarked, “Growing up, if I had known how messed up so many people are, I would have spent my childhood being either terrified of what’s out there or guilty about my family’s sanity.”

On the other hand, some supervisees are surprised, and often chagrined, to discover that qualities they have considered “normal” are widely regarded by therapists as pathological. Examples might include assumptions that all married couples fight angrily, that no one likes being alone, that all parents criticize their children unendingly, that everyone is obsessed with physical perfection, that an adolescence without binge drinking is unheard of, and so on. We all generalize about normality from our family of origin and our peer group, and in the Internet age, we can find whole communities of people who share our assumptions and cannot imagine any state of affairs that differs from the one in which they grew up. Such experiences in cyber silos tend to reinforce older learning.

It is painful for supervisees when qualities in themselves that they believed were universal are framed as problematic. Their awareness of such discrepancies between what they have taken for granted and what clinicians generally regard as normal or healthy often arises from their supervisory experience, not so much from intentionally didactic commentary as from matter-of-fact remarks or questions (e.g., “Why do you think your client falls into helpless tears rather than negotiating for what she wants?” or “How do you understand this man’s conviction that apologizing is not ‘masculine?’” or “What has made your client think that being smarter than other people is the ticket to satisfaction in life?”). After noticing their own normalization of problematic phenomena, they have to face anxieties about whether they are healthy enough to be a therapist. In my experience, they usually are, but they nonetheless have to cope with shame about previously unacknowledged limitations.

Returning to the general topic of novice clinicians’ tendencies to see patients as healthier than they are, I have found that students’ prior training in empathic listening and the temperamental and psychological qualities that originally disposed them toward becoming therapists incline them to seek similarity and shrink from seeing others as different in a negative direction. Their tendency to see a patient’s strengths,

at the expense of noticing some troubling weaknesses, has many benefits, including the expectation that they can help, which contributes to patients' hopes for relief from psychological pain. And yet, if students lack a realistic idea of a client's level of psychological organization, they run the risk of pursuing goals that are unattainable in either the near or distant future. Patients can be deeply dismayed by their failure to achieve such goals, and therapists can draw the conclusion that there is something wrong with them as clinicians for not succeeding as they have imagined.

This problem is one of the unintended consequences of the current emphasis on evidence-based treatments. Such therapies are valuable, but they are often empirically tested and validated with the highest-functioning patients in any given symptomatic category. In studies of comparative treatments, researchers generally weed out participants with "comorbidities," who tend to be precisely the more "difficult" or "treatment-resistant" patients that therapists need the most guidance to treat. As a practical matter, mentally healthier individuals are also more cooperative with researchers' agendas and less likely to drop out of a study or miss appointments, and so they are overrepresented in the data that are analyzed in randomized controlled trials.

On the basis of such outcome research, beginning therapists' professors may have definitively told them, among other things, that exposure is a proven treatment for obsessive-compulsive disorders. They are right about that. But they may have gone further to insist that it is the "best practice" or the "treatment of choice" or even that it is unethical to work in any other way with individuals who have obsessions and compulsions. In recent years, I have heard many accounts of such opinions asserted by people whose clinical experience has been minimal. Their confident convictions can leave students helpless when they meet patients with long-standing obsessive-compulsive disorder and many comorbidities, whose personality organization may be at the borderline or psychotic level of severity (Kernberg, 1984).

Both professional lore and common sense suggest that exposure works much better with patients who can understand that their ruminations and rituals are crazy, who can recall a time before they had them, whose family members did not model and reinforce them, and who can appreciate both consciously and unconsciously that the therapist is well intentioned. After graduating from academic programs, therapists must work with many people who would have been excluded from clinical trials, who privately believe they may be in grave danger without their obsessions and compulsions, who cannot remember when they

did not have them, whose caregivers had similar preoccupations, and who fear that a clinician might somehow harm them. Such patients tend to respond to exposure with terror and/or profound resistance. Urging them too soon or too uncritically into exposure paradigms is a setup for the patient's disillusionment about the value of treatment and the therapist's feelings of failure and burnout. This is only one example among many of the consequences of the current disconnect between what can be easily researched and what is clinically relevant.

It is not always easy for a supervisor to convey to newer therapists that they may be misjudging a patient's level of psychological dysfunction. Seasoned mentors frequently encounter resistance to their efforts, however gentle, to point out the depth of a client's difficulties. Often, they are misperceived as regarding treatment as hopeless or as being critical or dismissive of the patient (admittedly, this can sometimes be an accurate perception, but I am talking here about instances when it is not). To the extent that newer therapists identify with any patient, they can feel uncomfortably exposed and apprehensive in the face of the supervisor's focus on the person's more primitive dynamics.

We all have archaic mental processes, but the point needs to be made to supervisees that many patients lack access to more mature adaptations; it is the absence of these adaptations rather than the presence of more primitive operations that suggests more severe psychopathology. It is a delicate balance to try, on one hand, to increase supervisees' capacity to see in themselves the kinds of issues they see in patients (a process that can increase their empathy and respect) and, on the other hand, to note the ways in which such similarities do not indicate that the patient's and therapist's respective difficulties in maintaining their sanity are equivalent. It is important to help clinicians appreciate the universal tendencies that they share with even the craziest patient and at the same time not minimize the patient's level of damage.

I remember a beginning student who was by temperament a gifted empath. She was truly puzzled when I suggested that the man she had begun to treat for an anxiety disorder had some psychotic features, including ideas of reference and terrifying annihilation anxiety. She became uncomfortable when I observed that his political ideas had a paranoid feel and were predicated on the defense of splitting, with no capacity to reflect on his splits. Her political views were similar to his (and so were mine), but she differed radically from her patient in that she was able to understand that her political enemies were not monsters but included individuals who might be well intentioned. She was able, largely because of her mature capacity to tell the truth even to an

authority in an evaluative role, to disclose her worries that I was critical of her politics and insensitive to the issues about which she and her patient cared deeply.

Because of these worries, she had begun to feel a bit unsafe with me, a reaction we were able to see as paralleling her client's deep sense of distrust. Like her, he was very bright; she found it counterintuitive that such intellectual firepower could coexist with emotional fragility and psychotic anxiety. And given her empathic tilt, she experienced his primitive idealization of her as comparable to the reality-based trust she had often felt toward admired others, whereas his idealization had been immediate and based on a primitive merger fantasy that she was in every way a soul mate. He had a history of idealizing and then traumatically devaluing those he had depended on. The therapist eventually realized that making an attachment with this man that was solid enough to keep him out of the hospital was a therapeutic "win," even if he still suffered some anxiety. Her tendency to identify with him was a positive factor in his treatment, in that he thrived in the atmosphere of her egalitarian attitude. But in supervision, she and I had to process the fact that what she and he had in common did not extend to their sharing the same level of overall wellness.

A male supervisee I once worked with was assigned a female patient with "anger management issues" and a history of antisocial behavior. This included having deliberately (and without remorse) tormented her much younger siblings, having reacted with sadistic glee when one of her adolescent rivals was raped, and having sold drugs to friends who were now addicted ("That's their problem"). She behaved in a charming, seductive way with my supervisee—never enough to be accused of "inappropriate" behavior, but enough to make him feel that, despite his knowledge of her checkered background, if she and he were not in the roles of therapist and patient, they could be close friends or lovers. Like the clinician in the previous example, even though his moral faculties were quite intact, my student found himself feeling deeply identified with, and attracted to, this evidently calculating woman.

This man was greatly helped by a combination of group and individual supervision. When he began talking in the group about the beauty, sensitivity, and intelligence of his client, presenting her as regrettably misunderstood by everyone else, his peers began to be visibly uncomfortable. One participant challenged him in a "man-to-man" blunt way, teasing him about how skillfully his patient had fed his narcissism. When he became defensive, the other group members chimed in more tactfully, sharing their curiosity about the fact that although he presented

his patient as lovely, they found themselves not liking her. He was not entirely talked out of his overall formulation (she was misunderstood and he was her lone and righteous champion), but soon his client asked him to lie to the clinic to get her a lower fee, and he began to admit the possibility of an antisocial tinge to her charm.

As further interactions confirmed the group's intuitions, he talked in individual supervision about his feelings of humiliation for having been so gullible. I responded with stories about instances in my own work history when psychopathic individuals have "gotten over" on me. I characterized his vulnerability to her manipulation as the downside of his openness to her experience, a compassionate position and mindset that would generally serve him well as a therapist but that psychopathic patients can be geniuses at exploiting. He and I came to the conclusion that he was projecting his own integrity onto the patient, denying her antisocial traits because they were so disturbing to imagine.

I noted that we are all mammals, with a potential for predatory ruthlessness, and suggested that if he could find that potential in himself, he might be able to see it more easily elsewhere. In dissociating from his own capacity for psychopathy, he might be blinding himself to Machiavellian tendencies in anyone he cared about. Another possible risk of denying one's own antisocial potential is that when psychopathic features cannot be ignored in another person, we tend to see him or her entirely as "other," as monstrous deviations from humanity. We also talked about paying attention to countertransference reactions, which can include being besotted by a client as well as feeling "played," "pinned against the ropes," or chilled and "under the thumb" of a manipulator (Evans, 2011; Meloy, 1988; Mulay, Kelly, & Cain, 2017). Then we talked about the general principles of how to exert therapeutic influence on someone whose psychology was organized around power rather than around love and attachment (McWilliams, 2011).

A converse problem to the tendency of newer supervisees to underpathologize clients is to overpathologize themselves. This response is a psychological parallel to the "medical student syndrome," in which the smallest bodily glitch alarms an aspiring doctor about the possibility of a fatal illness. Avoiding either-or thinking is particularly important when making inferences about a client's level of functioning and consequent realistic treatment goals. Supervisors need to convey that all patients have weaknesses *and* strengths; they can be very psychologically disturbed *and* remarkably resilient; clinicians' dynamics that parallel those of their patients can be both interferences *and* assets to the therapy process.

A mutual assessment of level of severity (Kernberg, 1984; Lingardi & McWilliams, 2017) has critical implications not only for the choice of treatment approach and specification of ultimate goals, but also for what kinds of developments can be noted as evidence of progress (or lack thereof) in an ongoing therapy. Without such an assessment, it is easy to get that inference wrong. One of my supervisees, for example, tended to project his own level of agency onto a female patient who was having difficulty leaving a troubled relationship. His assumption that this should not be hard to do got in the way of his appreciating the import of an instance when his client had, for the first time, told her boyfriend that it hurt her feelings when he criticized her. This was a major move toward self-advocacy on her part, but because of my supervisee's implicit belief that she was capable of his own level of autonomy, he framed it dismissively as a "baby step." His missing the significance of her achievement deprived her of the experience of being witnessed having done something very hard, and it deprived him of realistic evidence of his competence. Another supervisee was appalled when her 7-year-old client yelled "Fuck you!" at her even though this outburst amounted to substantial progress in a child who had been selectively mute for months.

Supervisees need to learn that the rate of treatment progress is hard to predict, no matter how extensive the original assessment. Both anecdotally and empirically (e.g., Seligman, 1995), treatment frequency and length have been associated with therapy effectiveness. We can thus tell trainees with some confidence that what can be expected in short-term or spaced-out treatment will be less than what can be accomplished in longer and more intensive therapies. But beyond that, reasonable expectations for many psychological changes depend on a range of factors, many of which cannot be assessed at the beginning of a treatment, such as the patient's level of motivation once the work starts; or how good the fit will feel to both parties; or whether friends, family members, and the fates will reinforce or undermine positive changes in the client.

In the mid-20th century, much attention was devoted to trying to assess at the outset of treatment whether a given person was "analyzable." Despite earnest efforts, no one ever came up with a foolproof formula for evaluating analyzability (Erle, 1979; Frosch, 2006; Karon, 2002; Peebles-Kleiger, Horwitz, Kleiger, & Waugaman, 2006). Clinical lore abounds about "beginner's zeal," or how newcomers to the field have succeeded with patients that the experienced staff members at their place of work had regarded as untreatable. Supervision requires a subtle balance between supporting the therapeutic ambitions of younger

clinicians and at the same time tempering their pursuit of the impossible, so that they can reasonably appraise their progress with each client.

I want to end this section by commenting on the difference between treatment goals and life goals. Ernst Ticho (1972) originally wrote about this distinction in ways I found helpful as a novice clinician. Treatment goals include areas that are influenceable by work on the self; life goals depend heavily on factors outside one's control. Therapy goals thus might include reducing perfectionism, increasing realistic self-esteem, resolving an internal conflict, making a difficult choice, mourning a painful loss, and so on. Life goals include, for example, finding a partner or spouse, getting a good job, or becoming a parent. They may be attained more easily when therapy goals have met, but they are not themselves treatment goals. Clinicians cannot promise that at the end of the therapy there will be a partner, a job, or a baby; for those aspirations, too much depends on external circumstances. Newer therapists need supervisory help in not signing on to pursue a client's life goals, but instead in reconceptualizing and reframing the clinical task as internally directed work that may increase the probability of achieving such goals.

Promoting Openness and Honesty

After agreeing on the ground rules, therapist and supervisor need to work on creating an atmosphere in which the supervisee can be as forthcoming as possible about his or her work. If the sessions have been videotaped and watched together (or audiotaped and listened to together), the issue of the supervisor's knowing what "really" went on in a session is less problematic for him or her and, simply via exposure, potentially more conducive to the supervisee's eventual comfort in being witnessed. But it also involves more anxiety for the trainee that supervisors need to appreciate. The question of how the supervisee feels about being scrutinized is always worth exploring.

For psychoanalytically oriented practitioners, a core effort underlying both psychotherapy and supervision is the creation of an interpersonal space that allows as much honesty as human beings are capable of with each other (cf. Thompson, 2004). This is a lot easier when a clinician seeks mentorship voluntarily, when the supervisee can choose the consultant, and when there is not an evaluating authority to whom that consultant reports. I address some nuances of the supervisor's responsibility to training programs and the public in Chapters 6 and 7, but I mention the topic here because such situations complicate the possibilities for honesty for both supervisee and supervisor. Often, such

issues cannot be transcended because to the supervisee so much hinges on being positively evaluated. Showing one's limitations feels dangerous. But at least this reality can be named and understood explicitly, and I think it is critical to model frankness by naming that elephant in the consulting room.

Even when supervision is free of the complications of oversight and involuntariness, there are internal and relational dynamics on both sides that complicate efforts to be candid. Supervisees want to learn but also want to be seen as competent therapists, and they may have practical worries about whether the supervisor will refer patients to them or recommend them to colleagues looking to refer clients. They want to improve their knowledge while not appearing too ignorant of what they should already know. For supervisors, the complications arise mostly from concerns not to hurt the supervisee's feelings.

Whatever the challenges to a forthright supervisory relationship may be, here are some ways I have learned to help therapists become more comfortable opening up to me. First, I disclose a lot about my own slow path to learning, emphasizing my misunderstandings and mistakes and what has helped me to improve in whatever area I am seeing a problem in the supervisee. Second, I try to remember to ask frequently if there are any matters the supervisee finds hard to talk about or notices he or she is avoiding. Third, I frequently ask for feedback about how the supervision is going from the perspective of the supervisee.

If the supervisee seems ingratiating or avoidant, I may try to "drill down," as cognitive-behavioral therapists say, on specific areas. For example, have I said anything with which the supervisee has disagreed but did not feel able to tell me? Am I being sensitive enough to issues of culture, race, sexuality, religion, and similar factors in the clinical work? Researchers (e.g., Cabaniss et al., 2001; Ladany, Hill, Corbett, & Nutt, 1996; Mehr, Ladany, & Caskie, 2015; Strømme & Gullestad, 2012; Yourman & Farber, 1996) have consistently found that supervisees withhold important information from supervisors. One thing I am careful *not* to do is to pursue information about the supervisee's background or psychology that is legitimately private and might feel too exposing; for example, I would not ask whether the mentee has ever struggled with an addiction or has a history of sexual abuse. But I do try, as I discuss in the next chapter, to make supervisees feel safe enough to offer information of that sort voluntarily. Doing so can increase self-acceptance, openness to learning, and integration of their emotional experiences with their intellectual understandings.

Finally, as part of the effort to encourage supervisees to consider that they are in a relationship in which they are free to disagree, I ask

them explicitly for criticism of my work as a supervisor. Parenthetically, I am not fond of evaluation forms as an ongoing way of assessing the evolution of the supervisory relationship; these surveys deflect from frank, face-to-face conversations and permit the supervisee's negative feelings to be displaced onto a questionnaire. Such forms have an important place in research and in programs that need to evaluate supervisors systematically, but they are not a substitute for a direct conversation about the supervisor's limitations as the supervisee experiences them. Exemplifying the willingness to be vulnerable and a preference for candor over comfort are key supervisory attitudes for mentees to internalize and generalize to their clinical practice.

Supervisees may have come to their professional calling from backgrounds in which they were the parentified child in their family of origin, and see themselves as having taken on the sensitive family-therapist role originally depicted by Alice Miller (1975) that resonated with so many practitioners and made her book on the "drama of the gifted child" an instant hit in its time. Their automatic default may thus be to try to take care of the supervisor's narcissistic needs at the cost of their own forthrightness. This would be a good dynamic for them to know about and work on. It is hard for people who were raised to support parental self-esteem to question authority. Just as therapists need to learn to ask patients about negative feelings toward themselves, mentors should be able not only to tolerate criticism, but also to invite it.

Supervisors should give supervisees an unambiguous message to the effect that because they are the ones in the room with the patient, they may know more than the supervisor about the possible consequences of alternative ways of dealing with a clinical problem. In a difference of opinion between supervisor and supervisee, unless there is a clear ethical problem with what the treating therapist feels is the right thing to do, I believe that supervisees should be encouraged to try out their own ideas about what is clinically best in any situation. I take this position partly because I think they will not be able to do anything else with authenticity, partly because they are the ones in the physical presence of the patient, receiving all the person's nonverbal communications, and partly because I never really learned anything myself without first trying out what made sense to me and making my own mistakes. But more important, by implementing what seems to them the proper intervention, mentees will either learn from an error or prove the supervisor wrong, either of which will contribute to their growth.

Once when I was leading a discussion for a group of psychologists who provide unremunerated supervision to the students in our program at Rutgers, I asked them why they were willing to contribute their time

pro bono. In addition to their many comments about enjoying our students, they agreed that they learned, even from these novice clinicians, many new ways of relating therapeutically to patients. Without having created an environment in which their students felt free to disagree with them, all those opportunities for the supervisor's own professional enrichment would have been foreclosed. Therapists tend to like having multiple ideas about how to approach any resistant pattern of emotion, cognition, or behavior, because they can easily feel that their usual methods are getting stale and are losing their power to influence their clients. Exposure to the solutions of other therapists, no matter how inexperienced, expands one's clinical repertoire.

ADDRESSING RESISTANCES TO LEARNING

Even though supervision is not therapy, there may be times, especially early in the process, when the supervisor has to address transferences and defenses that get in the way of optimal learning. Some of these resistances are almost universal in supervision. For example, there are some defenses that issue from the depressive dynamics (Hyde, 2009) that I mentioned in Chapter 1. Many clinicians are hard on themselves internally, and they project their self-criticism (their harsh superegos) onto mentors. Expectations of disapproval, an inability to distinguish helpful suggestions from accusations of ineptitude, and shame about ignorance and presumed errors are common.

In the next chapter I discuss ways to make a group supervision setting feel safe enough for participants to be open about their work. Most of those ideas apply equally to individual supervision. But in one-on-one situations, because a supervisee cannot so easily hide or feel support from peers if the supervisor is critical, he or she may feel an even more excruciating sense of exposure and anxiety about disapproval than would pertain in a group. In Chapter 1, I noted that a common defense against fears of being sadistically exposed by a supervisor is the masochistic strategy of attacking oneself preemptively. Thus, many supervisees begin virtually every meeting by confessing one putative error after another, making the implicit plea, "Please don't attack me! I'm already attacking myself, so the job is already done." The supervisee is making the tacit calculation that a mentor who is poised to condemn will back off. If criticism turns out *not* to be the supervisor's intent, the student reasons, nothing has been lost by the strategy of self-attack.

But defensive self-criticism does waste time and energy that could be devoted to learning, and it can be irritating to the mentor, who wants

to support the supervisee and instead feels defensively distanced and misunderstood as a potential bully. My preferred way of dealing with this pattern, as I noted previously, is to name the masochistic defense when I think I am seeing it, to say that I “get it” because I also behaved that way with my early supervisors, and to urge the mentee to take the risk of simply saying what happened without encasing the clinical data in an armor of self-criticism and penitence.

A common defense in early supervisions that do not rely on video or audio records is speaking rather vaguely about general concepts rather than stating what one explicitly said and did. For example, “I expressed support,” or “I mirrored the patient’s feelings.” Just as with clients who speak vaguely (e.g., answering “weird,” or “tense” when the therapist inquires how they feel about something), with supervisees who hide behind abstractions and generalizations, the supervisor may have to keep reiterating, albeit kindly, queries such as “What did you actually say?” or “What is your idea of giving support?” or “Which of the patient’s conflicting feelings did you mirror?” If this resistance is particularly strong, one may have to call it out and decide collaboratively with the supervisee about procedures that will counteract this obscurity, such as audio-recording a session or bringing process notes.

Another familiar dynamic in individual supervision that may be relieved by interpretation involves the potentially conflicting narcissistic needs of supervisor and supervisee. Supervisors want to feel useful; they want to have a sense of having added to the supervisee’s knowledge and skill. They feel good about themselves when they have offered something, taught something, or enhanced something. Supervisees’ narcissistic needs are different. Because of their normal anxiety about being evaluated, their self-esteem depends on hearing the message that they have been a good-enough therapist. Even though they are grateful for practical help, it is easy for them to receive the supervisor’s offerings not as gifts but as exposés of all they should have already known and all their failures to have done the “right thing.” This mismatch of narcissistic needs can also be dealt with straightforwardly, both by naming it and by the supervisor’s taking care not to overwhelm newer clinicians with too many suggestions too soon.

PLAYING WITH ALTERNATIVE SOLUTIONS TO CLINICAL PROBLEMS

In accord with the overall psychoanalytic ethos or sensibility (McWilliams, 2019), psychodynamic supervision supports the autonomy and

potential maturity of the clinician as much as possible. Although there have been psychoanalytic teachers who trained mentees by telling them exactly what to do at each clinical choice point, or relentlessly opined about “standard technique,” most of us adopt an open-minded, curious way of talking with supervisees about their options in any clinical situation. We discuss several alternative solutions to a clinical dilemma, trying to predict the probable outcome of each one given our shared understanding of a patient’s dynamics, current circumstances, and personal strengths and weaknesses. We emphasize that there are different routes to making the unconscious conscious, that the mentee will eventually find what works best for him or her, and that the ultimate goal of supervision is for supervisees to develop a sense of what is most easily integrated into their own unique style.

As they mature clinically, supervisees may voluntarily seek to learn specific dynamic approaches, such as control–mastery therapy (Silberschatz, 2005), transference-focused psychotherapy (Caligor et al., 2018), mentalization-based therapy (Bateman & Fonagy, 2013), the conversational model (Meares, 2012a, 2012b), dynamic deconstructive psychotherapy (Gregory & Remen, 2008), intensive short-term dynamic psychotherapy (Abbass, 2016), or accelerated experiential dynamic psychotherapy (Fosha, 2005). Or they may want to learn emotion-focused psychotherapy (Greenberg, 2014), a close relative of psychoanalysis, or therapies that can be used adjunctively with analytic work, such as EMDR (Shapiro & Forrest, 1997) or somatic treatments (e.g., Levine & Frederick, 1997; Ogden, Pain, & Minton, 2006). At that point, they will be eager to learn a prescribed protocol and will readily enter an implicit contract to be critiqued on how closely they approximate it. But early in their training, or in the absence of their having chosen to learn a focused model, they need more general nurturing of their capacity to be a healing presence and an appreciation of the fact that there are many different ways to arrive at a therapeutic destination.

Consider, for example, a young woman in supervision who has presented the case of a man whose intimate relationships are burdened by his need to be right. Since that tendency appears in the clinical hour (by his insistence, for instance, that he always knows better than the therapist about whatever they are talking about), how should the therapist respond? She could confront the defense by interpreting the fact that he seems to have learned to attach his self-esteem to a putative infallibility, which may be causing some of his interpersonal problems. That response could be right and yet so narcissistically wounding that the confrontation might be rejected out of hand. Would it be better to tease

him gently about the pattern (“You seem to know more than I do about everything!”)? Or should she try to disarm him by smiling and saying something like “I knew you’d be correcting me if I said that!”? Or should she try to go *under* the know-it-all defense to the feelings she thinks it is protecting him against (“I thought I saw a look of pain on your face before you corrected me. What’s that about?”)? Or should she simply absorb this behavior because she feels he is not ready yet to admit to his compulsive, off-putting tendency? Sometimes a supervisee will come up with therapeutic responses that are better than anything the supervisor had been considering.

In clinical situations like this one, I might talk about ways I think I would behave in the session, but with some careful attention to whether my supervisee would find my approach compatible with his or her general stance, and with some reflection on whether my solution would have succeeded or failed. I might note any parallel process phenomena, for example, if my supervisee has an uncharacteristically confident tone that sounds a bit like the patient and affects me the way the patient’s tone affects the supervisee. I would expect that my less experienced colleague and I would discuss together not only the patient’s probable response to an intervention, but also whether the supervisee could authentically make such an intervention. The key psychoanalytic principle of multiple function (Waelder, 1936) suggests that given the “overdetermination” of any problem important enough to bring a patient to treatment, there are many different directions from which one can intervene (Pine, 2020).

I remember once suggesting to a therapist that he say to a self-defeating patient, “There must be something you’re getting out of this tendency to abase yourself.” He responded, “*You* could probably get away with saying that, but if *I* did, I’d feel I was blaming the victim, and she’d be likely to accuse me of mansplaining.” He proposed that instead he could say, “It’s interesting. You seem to be wanting to change this self-destructive pattern, but at the same time, it seems almost automatic. What do you make of that?” Another participant in the consultation group in which this issue came up commented that she might say, “How come I find myself very anxious about your behavior, and yet you seem to have no anxiety at all about it?”

In conversations about the pros and cons of various interventions, it is often valuable for the supervisee to role-play the patient and watch the supervisor struggle over how to respond. Experiencing the client’s tone firsthand is basic to the supervisor’s emerging understanding of what is going on clinically. With the emotions, tone, and prosody that come through in a role play, new possibilities for interaction may emerge not

only for the content of the intervention, but also for the style. A clinician may have all the right words, but if the patient can seize on something in the tone of an observation that feels contemptuous, naïve, or otherwise off base, the “right” words will likely fail to help. Role-playing gives the supervisor a chance to model a tone that might be therapeutic. In the next chapter, I talk at more length about the value of role play in supervision.

One final observation, relevant to colleagues who emphasize intersubjectivity: Not all supervisee errors are countertransferential—a point made at least as early as 1955 by Annie Reich (Sloane, 1957). Less experienced therapists need information and the wisdom of seasoned teachers as much as they need attention to the thoughts and feelings they bring to any clinical situation. They may have misunderstood the client diagnostically, or have been insensitive to some cultural issue they had no reason to know about, or said something that came from unproblematic intentions but encountered a previously unknown traumatic sensitivity in the patient. When mentors take the implicit or explicit position that the main topic for discussion is the student’s subjectivity, they may deprive the clinician of other useful knowledge and, especially with beginning therapists, risk triggering a level of self-consciousness that can interfere with therapeutic effectiveness.

SUPPORTING ETHICAL SENSIBILITIES

Supervisors must hold supervisees accountable for knowing the ethical standards of their profession and the laws that apply to practice (Alonso, 1985). Their specific role is noting when and how these general guidelines apply to here-and-now clinical situations. Not all ethical problems that arise in psychotherapy, however, are resolvable by reference to legal regulations, ethics codes, manuals, or research on relevant topics. As Carol Gilligan’s work (e.g., 1982) has demonstrated, there is more than one kind of moral sensibility, and sometimes alternative perspectives on ethical choices are in tension. Most ethical decisions involve evaluating competing moral claims, not finding the only unambiguously correct position.

Consequently, even seasoned therapists seek consultation with colleagues when trying to figure out the right thing to do in a complicated or particularly worrisome clinical situation, such as a patient’s flirtation with suicidal wishes or a tendency to scapegoat a child. Such consultation is sensible on its own merits given that we all have blind spots that a

colleague can help us look into. It is also good risk management: When clients lodge official complaints against psychotherapists, the regulatory groups and boards responsible for overseeing professional behavior give substantial weight to whether the clinician has consulted with a senior colleague about the issue in question.

Most ethical decisions involve a trade-off, not a clear right versus wrong, and many require a careful weighing of possible consequences by at least two minds. Because there could never be a rulebook covering all possibilities, complicated clinical situations depend on the internal moral gyroscopes of both therapist and supervisor, and these sensibilities evolve with clinical experience. An appreciation that ethical codes and professional rules cannot resolve every ethical problem is an important part of clinical maturation. I go into complex clinical problems more deeply in Chapter 6, which includes an extended example of a dilemma faced by a colleague that illustrates how real-life clinical challenges are sometimes not clearly covered by texts, rules, or protocols. In such situations, at least one supervisory consultation would be vital for any practitioner.

ENCOURAGING THERAPY FOR THE THERAPIST

One of the few areas on which virtually all psychoanalytic therapists agree is the value of psychotherapy for the therapist (see McWilliams, 2004, for the rationale behind this consensus). Analytic training institutes require personal analysis, and most psychodynamically oriented clinical programs strongly encourage personal therapy. Consequently, many of our supervisees have been or are in treatment and fully grasp its value. But psychoanalytic supervisors may also mentor people who do not share this perspective and who feel no inclination to go into therapy unless they are suffering from a diagnosable disorder. Sometimes a newer therapist's undergraduate professor has taken the position that mental health treatments apply only to official DSM categories and are suspect when undertaken with the goal of personal growth. We may believe that some colleagues and potential colleagues could benefit both personally and professionally from their own treatment and yet consider them adequate clinicians. However, we may feel an urgency to get other colleagues to a therapist because their personal dynamics seem to be regularly interfering with their clinical effectiveness.

For example, one early supervisee of mine was deeply identified with the client-centered humanistic tradition. She did well with patients

who blossomed under the care of a comforting, sympathetic clinician. But with clients who were notably personality disordered, defensive, or oppositional, she was quite ineffective. They tended to exploit her generosity, which reinforced their problematic dynamics of entitlement and manipulation. They also tended to quit after a few sessions. When I would encourage her to set reasonable limits with a patient, she would protest that I was being “unempathic.” This objection applied even to her implementing clinic policies, such as charging patients who had made appointments but who had neglected either to show up or to cancel.

This therapist failed to understand that in her zeal to be a paragon of Rogerian empathy, she was unable, because of her own defenses against noticing anything negative in herself, to empathize with patients’ more competitive, hostile, aggressive, and selfish motives. For her, empathy meant identification only with the nicer, needier parts of other people. I had no evidence that she was doing active damage to her clients, but at the same time, she had a disproportionate number of dropouts and was failing to help many of those who needed help the most.

It took me 2 years to talk this supervisee into seeing a therapist. She was highly resistant to the idea, buttressing her position with protestations that she was clinically a “natural,” to whom friends and family members had always come with their problems, and that in her Eastern European community of origin there were ample nonprofessional sources of help if she should need it. She implied, in a voice suffused with sympathetic understanding, that my feeling that therapy would be of value to her might simply reflect a knee-jerk adherence to unproven psychoanalytic dogma (this resistance did make me bristle since for some time there has been considerable empirical evidence that therapy has value for the therapist; see Geller et al., 2005). It took one serious depression and several bad experiences with patients—including one who ended up stiffing her on a huge bill that she had let him accumulate without complaint—before she was willing to consider treatment for herself.

It is dicey to suggest therapy to people like this supervisee, who take such suggestions as a criticism of their overall mental health (which, in this instance, it was, though not to the degree she seemed to fear). The main way I try to reduce resistances to personal treatment is by talking about how valuable my own analytic experiences have been to my clinical work. I make that general point, as most analysts would probably do, but in addition, I look for opportunities to “pursue the particular” (Levenson, 1988), to recount specific times when what I learned in treatment helped me with a difficult clinical situation. Sometimes a conversation about what the supervisee is afraid of is useful, but as it verges on

therapy rather than supervision, I am reluctant to go there. I do, however, raise questions about how clinicians can sincerely value a service that they devalue when it applies to themselves, and how can they be confident in their helpfulness as a clinician if they have not felt the positive consequences of psychotherapy firsthand.

GRATIFICATIONS OF INDIVIDUAL SUPERVISION AND CONSULTATION

Except for situations in which a supervisee or colleague seeking consultation seems to have serious personality pathology or in which there is a fundamental mismatch between supervisor and supervisee, a problem I address in Chapter 9, most experienced therapists I know say that one-on-one supervision can be both more directly rewarding and easier than individual therapy. The satisfactions are similar to those of any teaching role: One witnesses students' increasing confidence and expertise and feels a parental kind of pride in their accomplishments. Unlike their patients, supervisees rarely have the intrusive, primitive dynamics that make clinical work so demanding; also unlike most patients, they often express straightforward appreciation for our help, leaving our self-esteem more intact than it typically is after sessions with clients.

As for being easier, supervisors hear the therapy process at one remove from the affective intensity of the clinical encounter. Consequently, they may have a better sense of perspective and more objectivity than the supervisee can have. This is a situational phenomenon; it occurs irrespective of the therapist's level of clinical sophistication. Recurrent dynamics are more readily seen at a distance, and the patient's progress is more visible as well. Because supervisors tend to hear about each of the supervisee's clients less frequently than the therapist meets with them, they can more easily see the "forest" of the work and are less distracted by the individual trees. Like the visiting grandparent who exclaims, "My, how you've grown!" when the child's parents have witnessed the evolution too gradually to be struck by it, the supervisor can often see clear progress where the supervisee feels only a slog. Speaking of analogies to family life, I have noticed that both psychotherapy and supervision are often implicitly compared to parenthood. There is an old saw to the effect that the main job of parents is to make themselves unnecessary. The same applies to supervision. The gratifications are similar as well, as one's supervisees become independent centers of professional skill and judgment.

CONCLUDING COMMENTS

In this chapter I have elaborated on some general elements of establishing and strengthening the supervisory alliance and conducting individual supervision. I have emphasized the importance of agreeing on the supervisory contract, formulating realistic and individualized goals for each patient, encouraging frank and open discussion, dealing with resistances to learning, engaging in mutual discussion of alternative possibilities for therapeutic intervention, and supporting each supervisee's maturation as an ethical thinker. Finally, I have summarized some of the gratifications of being a supervisor. Most of these considerations apply also to supervision in group settings, which is the topic of the next chapter.

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