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Relational Learning in Psychotherapy Consultation and Supervision

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There are some who would argue that psychotherapy cannot be taught, that therapists are born, not made. Others suggest that therapy is an entirely skill- and theory-based practice that can be taught systematically. As with so many of our binary constructions, neither speaks to the wholeness and complexity of becoming a therapist. Most approaches to teaching psychotherapy, however divergent the core concepts, involve a relationship between a student and a supervisor, a form of relational learning.

RELATIONAL-CULTURAL THERAPY: WORKING WITH CONNECTION AND DISCONNECTION

The relational-cultural model suggests that isolation is the primary source of suffering for people, and it proposes that we grow and heal in connection rather than by becoming more autonomous or separate. Jean Baker Miller and Irene Stiver have outlined the course of this healing in *The Healing Connection* (1997). Other basic tenets of the work were put forth in Jordan and colleagues' *Women's Growth in Connection* (1991),

Women's Growth in Diversity (1997), and in the approximately 100 *Works in Progress* that have been published at the Stone Center since 1981. As noted in Chapter 1, the core processes that are assumed to create change or growth in people are mutual empathy, relational authenticity, and mutual empowerment. Jean Baker Miller has written about the five good things (zest, clarity, increased sense of worth, creativity/productivity, and desire for more connection) that occur in all growth-fostering relationships.

Acute disconnections occur ubiquitously in relationships when one person misunderstands, injures, or violates another person. These injuries need not be intentional, nor need they be permanently damaging. In fact, when the injured person can represent his or her needs and feelings to the other person and feels responded to—as if his or her feelings matter to the other person—he or she is empowered, feels relationally competent, and the relationship is strengthened. In order for relational resilience to develop, the more powerful person must indicate that he or she cares about the feelings and experience of the less powerful person and has an interest in reworking the disconnection. The reworking of disconnections actually strengthens people's connections and affirms their ability to create those connections—to have an effect on others.

Chronic disconnections occur when, in an important ongoing relationship (particularly when it is characterized by unequal power distribution), the less powerful person is not responded to or is unable to represent his or her needs and feelings. The more powerful person may respond with avoidance, denial, shaming, or attack. In such interactions the less powerful person is silenced, feels relationally incompetent (he or she cannot move or affect the other person or the relationship), and feels unable to bring him- or herself authentically into the relationship. The less powerful person moves into what Jean Baker Miller calls “condemned isolation” (Miller & Stiver, 1997); the relationship begins to lose its vitality, mutuality, and depth. This downward spiral leaves the less powerful person feeling vulnerable, ineffective, incompetent, isolated, and possibly endangered. If these interactions are repeated over time with an important and powerful other person (e.g., a parent, older sibling, partner), they will generalize (as relational images) in such a way that all relationships will be experienced as potentially limiting rather than growth fostering.

The work of therapy, largely through mutual empathy, is to help bring the client back into a place of connection where healthy psychological growth can occur once again. Relational images shift, hope develops, and a belief in the positive power of connection emerges; the client feels less isolated. Not only does empathy create better understanding of a person, it also provides an experiential sense of being “joined with,” of moving out of isolation. In order for empathy to create change, however, it

must be mutual. When mutual empathy is present, the client sees, knows, and feels that the therapist is responsive to, and moved by, his or her experience. Mutual empathy provides a sense of relational effectiveness and joining, and it facilitates the development of new relational images in which vulnerability and authenticity become safer prospects, and the person is able to begin to represent more and more of his or her experience in this healing relationship. Eventually all relational images begin to shift, and empathic possibility begins to emerge in other relationships. The use of mutual empathy in therapy challenges many of the more traditional dynamic approaches that emphasize therapist objectivity, neutrality, or nongratification in the therapeutic relationship.

In order for therapists to participate in mutually empathic, healing relationships, they must learn to work with their own responsiveness, their own empathic attunement, as well as their own movement toward disconnection. A therapist's growth is best facilitated in supervision that is itself characterized by mutual empathy and nonjudgmental and nonshaming interactions. In this context supervision can provide similar experiences of change and growth.

MUTUAL EMPATHY IN SUPERVISION AND THERAPY

Many people express uneasiness about how mutual empathy works and how it can be developed in therapists. As noted in Chapter 1, mutual empathy is not about reciprocal empathy (i.e., you empathize with me, and then I'll empathize with you, reciprocally); it is not about the therapist's self-disclosure of personal facts; it is not a denial of the therapist's professional role, which involves ethical and legal standards; it is not a denial of the power differential between therapist and client. It is about real engagement and real responsiveness, not knee-jerk reactivity or total spontaneity. The therapist's responses are guided by a dedication to doing what promotes the healing and well-being of the client. This model of authenticity and engagement involves a delicate, thoughtful process of being real while also being guided by clinical judgment. It is, as Irene Stiver pointed out, finding the "one true thing" (the piece of what is true that can be shared) that can be said to facilitate movement in the relationship and growth in the client. The therapist is guided by principles of the relational-cultural model, anticipatory empathy, and the ethical principles of his or her professional group. Based on an understanding of, and deep respect for, the client and his or her relational resources, together with an appreciation of how mutuality develops, the therapist finds ways to engage the client that allow the client to see how he or she affects the therapist, that his or her feelings matter, and that he or she does not have to

suffer alone. Active understanding of the client's patterns of disconnection and strategies for survival, together with empathy for the suffering experienced due to shame, self-blame, and isolation, serve to help the client feel heard and seen.

WORKING WITH SHAME AND VULNERABILITY

For mutual empathy to develop in therapists, it is essential that supervision be conducted in an atmosphere that is safe, respectful, and based on a model of mutual learning. Too often the supervisor is seen as all knowing (and sometimes acts that way). It is important that the supervisor respect the supervisee's vulnerability in this situation. According this respect means that the supervisor must also work with his or her own vulnerability. Supervisors must be extremely sensitive to possible issues of shame in supervisees, just as therapists must be aware of this potential with clients. Too often, in a field characterized by much opinion that passes for scientific truth, new therapists are ashamed of their uncertainty, the extent to which they do not feel confident about their interventions, and their own human limitations. Although all supervisors have a responsibility to provide thoughtful and corrective feedback, particularly when they feel that a student may be proceeding in an unwise or hurtful direction with a client, it is also incumbent on supervisors to find respectful and empathic ways to offer their critiques. Stories abound of the harsh, shaming responses from supervisors to supervisees. Often supervisees are shamed for having "poor boundaries" if they practice in a more responsive, relational way. Supervisors are obliged to find ways to encourage growth-promoting psychotherapy practice that does not humiliate or shame the students. The lack of immediate validation and the degree of complexity and uncertainty in the healing process make it especially important that we proceed with utmost respect and humility as supervisors, and that the supervisory process itself is collaborative and characterized by "fluid expertise" (Fletcher, 1999).

Shaming can occur unwittingly when supervisors are not attuned to power dynamics in the supervisory relationship or in the larger culture. Some supervisors proceed with little awareness of social forces of stratification and marginalization, as if individuals exist in a vacuum. Supervisees, partly because they are in positions of less power, sometimes are not free to represent their own perspectives (e.g., as a woman, as a person of color, as a lesbian or gay therapist). Supervision should be characterized by fluid expertise. Many supervisors trained in largely intrapsychic models may have difficulty taking into account the cultural, sociopolitical forces that disempower and isolate both clients and supervisees.

Since the relational–cultural model does not depend on a systematic set of techniques, it poses particular problems when we try to teach/supervise. I believe that the therapy relationship is unique, and that there is much to learn in the practice of therapy. In fact, I believe that the learning is lifelong, and that all of us should be in some form of supervision or consultation for our entire careers. I also think we learn about growth-fostering relationships not only in therapy but in all our relationships (and hopefully practice the principles there too). With new therapists, we may have to err a bit on the side of pointing out the differences between the therapeutic relationship and ordinary social relationships. Initial supervisory tasks include the provision of thoughtfulness and respect, “holding” the goal of helping the client change, and guiding the supervisee to step into a professional helping role that is imbued with authentic responsiveness. Reading and talking about principles and theory and looking at clinical dilemmas are an important part of developing competence and confidence. It is important that supervisors share their learning experiences, their hard times as well as their successes. If the supervisee has been trained in a more traditional mode, some rethinking and unlearning must occur, particularly if that mode includes the old “blank screen” approach and those that suggest the therapist’s emotional responsiveness is only a burden for the client.

It is essential that we, as clinicians, maintain the capacity to be present, to connect, to become aware of the forces of disconnection and vulnerability, and to learn *with* our clients. Clearly our own places of disconnection become problematic if we do not work with them. We must (1) be aware of the disconnections, (2) try to figure out their source (in ourselves, the other, or in the dynamics of this particular relationship), (3) move into an inner space of interest and curiosity (rather than defensiveness and withdrawal) around the disconnection, and (4) then share our understandings in a nonshaming way when the time is right. This reflective process suggests the capacity to stay in our vulnerability and to move back into connection, rather than adopting a “one up” or power over position. Working with a kind of relational resilience, we are able to “move,” to respond, rather than become caught in images of what we “should be.” These “ideal self” images are prevalent in life, in general (e.g., “I should be mature, popular, smart, cool,” etc.) and virtually rampant in therapists and supervisors (e.g., “I should have my own problems all worked out,” “I should be connecting and relational at all times,” “I should be completely generous and kind in thought, word, and deed,” etc.). Supervision can reinforce all these images, leading to extensive silencing of the supervisee, or it can provide a place of safety where people can explore and understand how these images function in their therapy work. When supervision reinforces unrealistic images of how a therapist

or supervisor must function, the supervisee often develops a sense of isolation, of being alone with the difficult task of “learning” psychotherapy. Often this atmosphere occurs in a larger teaching context that is shaming, built on “separate self” and “certainty” models of functioning and learning. Although supervision that appears to offer absolute truths and “answers” has an appeal, particularly for beginning students, it often leads to feelings of fraudulence (in both the supervisor and supervisee), to shame for less than “perfect” functioning, and to isolation (a worry that if one were really known or one’s work were truly seen, one would be judged negatively and rejected). The learning of therapy and supervision depends on an attitude of openness and flexibility, an awareness of one’s own patterns of disconnection, and a readiness to stand in uncertainty. I would like to turn now, not to a supervised case, but to a *supervision experience* in which I have been learning and growing, as “consultant.”