Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXIV, n. 2, 2023
doi:10.4081/rp.2023.742

FOCUS 2: PSYCHOANALYTIC SUPERVISION

Supervisory relationships

*Sandra Buechler**

Abstract. – Experience as a trainee and as a supervisor has taught me how anxious novice clinicians can be. Early in our careers, we may have a broad knowledge of theory, but still lack confidence in our ability to help patients. How can supervisors address this issue? This paper focuses on helping novice clinicians develop what I call an 'internal chorus.' This inner object provides a resource to cope with the clinician's most vulnerable moments with patients. An illustration of an 'internal chorus' is provided.

Key words: supervision; training; education; therapist; clinician.

Supervision of novice clinicians

Over the course of my career, I supervised in many contexts: inpatient psychiatric hospitals, youth guidance clinics, adult outpatient treatment centers, psychology graduate school programs, psychoanalytic institutes, and private supervision. When I think back over these varied experiences, one moment comes to mind. I was the director of an outpatient community clinic that served as a training facility for doctoral students in psychology. The students saw patients under close supervision. For many, it was their first clinical experience.

One of my supervisees was a young man who was adept at theory but had no experience doing treatment. Reluctant to ask for help, nevertheless he knocked on my door shortly before his first patient was due to arrive. Looking anxious he managed to ask, 'Dr. Buechler, when the patient comes, what do I do?'

There was a very intelligent and highly motivated young man, eager to 'do the right thing', wanting to navigate his first clinical experience without asking for help but suffering from anxiety and uncertainty. As the moment of his patient's arrival grew near, he felt painfully unprepared. Suddenly he

*William Alanson White Institute, New York, N.Y. 10023 USA.
E-mail: sbuechler2@msn.com

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realized that the theories he had studied had not told him the one thing he crucially needed to know. He needed to know what to do when the patient appeared for the session.

I have revisited this moment many times, using it to try to stay in touch with the beginning therapist's uncertainties. I think it is easy for experienced supervisors to forget what those initial clinical encounters can be like. What supervisors offer may be valuable, but not sufficiently appreciative of the inexperienced clinician's anxiety. The novice clinician may feel extremely responsible for the outcome of the treatment yet confused by theories that advocate differing therapeutic stances. For some, the situation can recruit previous feelings of feeling unprepared to face difficult moments in their personal lives. Some have reported imagining that there were therapeutic techniques or approaches that all other clinicians knew, but they, alone, had failed to learn. Feelings of shame and anxiety, as well as guilt, can accompany these thoughts. Many feel their incompetence will be exposed, and their unfortunate patients will suffer for it.

As a young clinician myself, I can remember years of feeling ill-equipped for doing my job, while still needing to look competent. I felt it was important not to reveal these feelings, even to my supervisors. Fortunately, it is more common, now, for supervisors to be aware of the potential shame and guilt of neophyte clinicians. But, of course, supervisors are not always empathic and sometimes add to the supervisee's feelings of inadequacy. This can be inadvertent, when, for example, the supervisor suggests how they would have responded differently to the patient. This can be a well-intentioned effort to teach but, partially depending on the tone in which it is said, it can actually increase the supervisee's sense of incompetence, in comparison with the seasoned supervisor.

I have written about these issues many times, often using examples from my own clinical and supervisory experiences. In particular, my book Still Practicing: The Heartaches and Joys of a Clinical Career (Buechler, 2012) deals with sources of shame and sorrow at each phase of a clinical career. In the first two chapters, I address some ways training programs may (through overt actions and omissions of potentially helpful guidance) add to the insecurity of the novice.

Of necessity, supervision of relatively inexperienced clinicians must address basic treatment issues, such as creating a viable frame, initiating therapy, maintaining ethical boundaries, exploring the patient's history, co-creating treatment goals, and dealing with the financial aspects of the work. While early in their careers most feel free to openly ask questions about these basics, I have found that many very experienced clinicians still have questions about them but may feel reluctant to bring them up, feeling ashamed that they still need help in these areas. For some, the need to look like they 'know what they are doing' exerts pressure that

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doesn't ever really end. Supervisors can sometimes be helpful by sharing that these issues can be challenging, even for the most experienced clinician.

But, for the most part, as therapists gain experience, they come to supervisors with fewer questions about the fundamentals. Rather, they want help with treatments that feel 'stuck' or with patients who suffer seemingly endless crises, or with their own troubling negative 'countertransferential' feelings toward certain patients, or their impulses to violate ethical boundaries, or their uncertainty as to whether or not a treatment has reached the limit of its effectiveness, or whether an 'enactment' is potentially therapeutically useful or a signal that the treatment should terminate and the patient should seek help elsewhere. Of course, much supervision is undertaken as part of a training program and has a less specific focus. Trainees may simply want to develop their way of working, or what I would call their 'signature style'. Some clinicians may come to institute or private supervision asking for help with a certain kind of treatment dilemma, such as a fear of losing patients, or difficulty working with patients who present in a particular way. Some want help increasing their practices and some, of more advanced years, ask for help with the challenges of retiring. Throughout my career, and in much of my writing, I have suggested supervisory approaches to the dilemmas clinicians and their patients frequently encounter. One of my books (Buechler, 2019), Psychoanalytic Approaches to Problems in Living: Addressing Life's Challenges in Clinical Practice, is focused on helping clinicians treat people who are facing particularly problematic aspects of life.

Of course, every supervisory relationship is unique, with its own set of strengths and challenges. But, in the remainder of this paper, I suggest some fundamental difficulties that often limit supervision's usefulness as well as some sources of its potential benefits. While, as already mentioned, I think the context of the supervision and the degree of the supervisee's clinical experience significantly affect its aims, I also believe that there are aspects of the supervisory relationship that transcend these specifics. I will argue that productive supervisions have commonalities. While these qualities may be hard to define, I think it is worth trying. In sum, what makes a supervision growth enhancing?

Characteristics of helpful supervisory relationships

Let me begin with a personal example of an effort I made, years ago, to understand just how my first psychoanalytic supervisor helped me enormously. In my (Buechler, 2017) book, Psychoanalytic Reflections: Training and Practice, I published a 'letter' I wrote to this supervisor, years after the supervision ended, trying to express my gratitude. I put the word 'letter' in

quotes because it was not a letter in the usual sense, in that I wrote it after he died. So, alas, it was never actually sent to him. I still regret that I didn't write and send it to him while he was still alive.

The letter was my effort to understand the effect of this supervision on my work at the time, and my subsequent career. The supervisor was Ralph Crowley, M.D., and our work began in the first year of my psychoanalytic training at the William Alanson White Institute in New York City. As I will explain, I think Dr. Crowley's positive impact was a product of what he said, how he said it, what he did, and, perhaps most importantly, what he did not do.

I should mention that I chose Dr. Crawley as my first analytic supervisor largely because he had worked with Harry Stack Sullivan, M.D. I was intensely interested in Sullivan's thinking, and I believed that my best chance to learn about the Sullivanian approach would be with someone who had been under the supervision of Sullivan. Dr. Crowley was known to be an acolyte of Sullivan's and I also liked Dr. Crowley's direct, blunt expressive style.

One of the first things that impressed me in this supervision was Dr. Crawley's evident investment in our work. Very often, I would find articles he had copied waiting for me when I came to the supervision session. I don't think I can overemphasize how important this was. To me, it said that my development mattered. It was worth his effort. In retrospect, I believe that this simple but profound gift of investment in me encouraged me to feel optimistic about my future as an analyst.

Perhaps Dr. Crowley's greatest impact was in the consonance between his words and his actions. In other words, he really practiced what he preached. How he treated me reflected the same values that he conveyed in his suggestions for my work with my patients. He was straightforward with me, at the same time as he was advocating my being straightforward with my patient. He used simple, non-jargon language with me, just as he suggested I do in my work as an analyst. He balanced pointing out my strengths with honest reflections on the areas I needed to develop further, just as he recommended to do with my patient. He tried to be clear without any unnecessary harshness. In how he spoke to me I learned that one can be both truthful and kind. Tact and truth can coexist. In retrospect, I credit Dr. Crowley for opening my mind to non-binary thinking. He palpably cared about the impact his words would have on me. He did not avoid saying things I might find disturbing, but he said them with evident concern for my feelings. This had significant effects on me as a clinician and as a human being. I held this as a model for my therapeutic work as well as my supervision of other clinicians. But, just as importantly, Dr. Crowley was teaching me the importance of integrity by example. I think of integrity as a kind of wholeness or consonance between one's stated values and one's actions.

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When integrity is not present, when, for example, the supervisor preaches empathy but treats the supervisee non-empathically, the impact can be quite damaging. At best, in a sense, it is confusing. At worst, I think it can cause the supervisee to feel hopelessly inadequate and inept, unable to learn in the supervision, but also unable to understand why.

Another benefit of this experience took many years to occur. My book, Clinical Values: Emotions that Guide Psychoanalytic Treatment (Buechler, 2004) included a chapter on integrity. My supervision with Dr. Crowley had not only taught me about the importance of consonance between words and actions. More broadly, it helped to engender my focus on the values (curiosity, hope, courage, integrity, emotional balance) that can productively undergird treatment and supervision, regardless of the clinician's theoretical allegiances.

In my experiences as a supervisee and as a supervisor, growth is often enhanced when both participants are willing to share their thoughts as they occur. When a supervisor thinks out loud, the supervisee gets to hear not only the contents of those thoughts but also their sequence. This can be immensely valuable. When supervisors share only their conclusions, supervisees are often left dumbfounded, puzzled as to how the supervisor arrived at these formulations, but afraid to ask questions, lest they reveal the supervisee's limitations. But when supervisors share their thoughts as they are formulating them, they model a process that can help those in training have the courage it takes to keep the treatments they conduct alive and creative.

This brings me to the role of shame in delimiting growth in supervision. Both supervisors and supervisees can experience demoralizing shame and, perhaps even more frequently, the fear of shame. Shame, or a sense of being insufficient, inadequate, a failure, can delimit the curiosity necessary to learning. The fear of shame can inhibit the creativity of both participants in treatment and in supervision. Elsewhere (Buechler, 2008) I have written about the shame accompanied by anxiety that is, in my judgment, the most debilitating form of shame. I called it the 'impossible necessary'. This is the helpless feeling that something absolutely necessary to do is beyond one's capabilities. One feels profoundly insufficient and, at the same time, intensely vulnerable. I speculate that experiencing the 'impossible necessary' brings us back to the utter helplessness we all faced as infants.

For example, both supervisors and supervisees can feel it is absolutely vital to comprehend something that they simply can't grasp. Let's say the supervisee's patients keep leaving treatment precipitously and/or prematurely. Both participants might feel it is essential that they understand why this is happening, in order to change it. But, what if they can't?

Shame may be evoked in supervision in numerous ways. Without meaning to, supervisors may implicitly evoke the supervisee's shame by focusing on 'countertransference' feelings, defenses, blind spots, and so on. In my

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book (Buechler, 2012), I differentiated the shaming experiences in training that come from acts of commission *versus* acts of omission. Briefly, teachers and supervisors can elicit shame in their tone, wording, focus, and, even, their body language. But, perhaps even more commonly, in what is omitted, in failing to equip clinicians as well as possible, they also foster shame. Adequate preparation can include discussing the relationship between theory and practice, conceptualizing the phases of treatment, describing some possible uses of 'countertransference' feelings and enactments, exploring various ways of formulating a treatment's goals, discussing how treatment can be informed by the awareness of the patient's cultural background, sharing ideas about how aging might affect the clinician's work, attitudes about the 'practical' side of treatment, including fee setting, and so many other issues. Perhaps most meaningful to me, personally, is the open exploration of what it is like to treat people who are encountering many of life's greatest challenges. Over the span of a career, clinicians and their patients are likely to face severe illnesses, devastating losses, humiliations, frustrating obstacles, profound regrets, confounding contradictions, paralyzing ambivalence, enraging conflicts, and everything else that challenges human beings. At some point, every therapist encounters a patient who is going through that clinician's own worst nightmare. My own belief is that in these times we need a strong foundation of love for doing treatment, commitment to the work, and confidence in ourselves as clinical instruments. Supervisors can foster the clinician's ongoing work on building this foundation.

Much of my thinking about supervision includes the idea that training should provide the learner with an 'internal chorus' of helpful voices, to turn to in challenging moments in sessions. This inner object is not modeled after any one supervisor or teacher but, rather, is an amalgam of all those who have provided helpful guidance. For example, when the clinician is feeling especially lost and lonely, a phrase from a past supervisor, an idea taken from reading, or an experience with one's own analyst, may help to contain the painful feelings. Becoming part of the supervisee's 'internal chorus' means, to me, that the supervision has lasting significance. Aside from assuaging the clinician's potential loneliness, this internal object provides a resource that fosters resilience. Clinicians need to be able to 'bounce back' during and after troubling sessions, and over the course of days, weeks, years of practice. The 'internal chorus' is a source of the strength to do so. In supervision, we can help the trainee develop the emotional resilience to bear the many losses that are inevitable in practice. Eventually, clinicians lose every patient they ever treat. This can be taxing emotionally. Sometimes supervisors can be helpful by openly sharing what these experiences have been like for them.

My own 'internal chorus' includes some I never met, such as H.S. Sullivan, Frieda Fromm-Reichmann, and Erich Fromm, as well as many of

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my supervisors, teachers, and personal analysts. Perhaps it goes without saying that Ralph Crowley, my first analytic supervisor, often plays a prominent role. When I feel ‘stuck,’ or painfully lonely, I remember a phrase or idea they gave me, and I feel better able to cope. For example, when I became locked into a particular viewpoint, my training analyst often asked: ‘What else could be true?’. I hear that phrase often and, no matter what is happening, it makes me smile.

In my view, the best, most growth-enhancing supervision has something in common with the art of sculpture. Sculptors ‘find’ the sculpture in the stone. That is, rather than impose a design on the sculpture, they mine the stone and bring forth its potential shape. So, it is with psychoanalytic supervision. In truly educative supervision both participants search for the qualities, talents, proclivities, personal strengths, life experiences, theoretical expertise, and any other aspects of the supervisee that, taken together, can inform their clinical style. Good supervisors and their supervisees ‘find’ the clinician in the trainee. Together they formulate what I would call the trainee’s ‘signature style’. The development of this therapeutic identity is a lifelong process begun, hopefully, in the earliest phases of training.

I believe that the goal of all education is to ‘educe,’ that is, to bring forth the learner’s potential. Doing treatment is a formidable task. It takes everything the clinician has: all our hope, perseverance, patience, stamina, courage, integrity, curiosity, playfulness, love, kindness, honesty, wisdom, and knowledge. The best supervision helps the supervisee access these qualities and learn to apply them to their clinical work.

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Conflict of interests: the author declares no potential conflict of interests.

Ethics approval and consent to participate: not required.

Received: 29 November 2022.
Accepted: 2 May 2023.

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Ricerca Psicoanalitica 2023; XXXIV:742
doi:10.4081/rp.2023.742

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