A “Two-Person” Supervision

Pr. Hanoch Yerushalmi, Ph.D.

Department of Community Mental Health, University of Haifa, Israel

Email address: [hyerush1@univ.haifa.ac.il](mailto:hyerush1@univ.haifa.ac.il)

Tel: 972-54-6999657

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Abstract

Psychodynamic therapy and psychodynamic supervision are two professional encounters, which have different characteristics and goals, but share many similarities. The way in which supervision is conducted does not always reflect changes in clinical analytic theory and practice regarding the therapeutic action and the therapeutic goals. This article discusses how some crucial changes in psychodynamic theory and practice should be reflected and represented in supervision. The proposal is made that supervision needs to leave room for an ongoing, dynamic discussion of the field created between supervisor and supervisee, including their mutual enactments, the supervisor's authority and the power relations between the two participants. Contrary to the useful dynamics in therapy, supervisors are advised to allow only cautious and transient changing regressive states in supervision.

Key words: Supervision, mutual enactments, power structure, regressive states

Psychodynamic therapy and psychodynamic supervision are two professional encounters, which have different characteristics and goals, but have many similarities in the way the discourse between their participants is conducted. In recent years, following wide scale changes in clinical analytic theory and practice and in the beliefs and perceptions regarding the essence of therapeutic action and the therapeutic goals, the thinking behind psychodynamic psychotherapy supervision is also undergoing changes. Nevertheless, the implications of these changes regarding the way in which the supervision is conducted are sometimes unclear to supervisors and supervisees alike. This article discusses how changes in psychodynamic theory can be reflected in supervision, assuming that the way in which the supervision is conducted cannot be separated from the management of the therapeutic sessions, which are brought to supervision for discussion and processing.

Adapting supervision to these changes in clinical theory is essential, because in most cases, the supervisors serve as role models with whom the supervisees identify, a process that clearly involves some very important learning. Applying action principles and beliefs from within the supervisors' clinical approach and their inclusion in the way the supervision is managed and in the messages conveyed to the supervisees will enable the latter to internalize these responses when forming their clinical identity. In this article, I will point to several central developments in clinical psychology, whose essence is the transition to two-person psychology, and which have become widely accepted in clinical circles. The article will clarify how supervisors apply these principles in supervision. First, I will address the perception of the therapeutic encounter as an encounter between two subjects and the implications of this perception for the supervision relationship; later, I will turn to the question that has received extensive focus in relational psychoanalysis regarding the source of authority and expertise of the contemporary therapist, as well as the question of defining the authority and expertise of the supervisor in psychotherapy. Following this, I will present the contribution of "enactment" to the therapeutic perception and its implications for the perception of supervision from the relational perspective. Finally, I will draw attention to an important difference between the supervision and therapeutic relationships; essentially, the caution needed when creating conditions that may trigger regression.

**The Intersubjective Encounter**

**The Perception of Therapy as an Intersubjective Encounter**

Many writers today define therapy as an encounter between two people with different subjectivity: they organize their self-experience differently and differ in their self-definitions and in their perceptions of self and of the world around them. They also differ in the values, beliefs and motivations that they relate to human actions and communication. This notwithstanding, and in spite of these differences, they attempt to hold a genuine, intimate dialogue. Only a dialogue such as this can nurture a safe atmosphere in which the patient's personal experiences and latent emotions and distress can be genuinely explored. Such a dialogue enables both partners in the therapeutic dyad to have the openness, honesty and tranquility needed to examine the patients' mental life and to create a deep change within them (Stern, 1985; Atwood & Stolorow, 1993; Orange, Atwood, & Stolorow, 1997; Coburn, 2002). Therefore, therapists today strive to create therapeutic designs that will enable a true, authentic encounter between their own subjective system and that of the patient, while examining the individual contribution of each to the formation and development of this encounter.

In every two-person intersubjective encounter, the participants have mutual influence. According to this new two-person psychology concept, each participant attempts to influence the other on many levels (Aron, 2003; Bromberg, 2012; Green, 2004; Hirsch, 2002). Mutual influences on the other's perception of reality, on the meanings that the other ascribes to events in the world, etc., occur continuously, both overtly and covertly, through a struggle and sometimes through ongoing negotiation (Pizer, 1992). Whether or not we admit this, or wish this to be the case, our interlocutor in the interaction brings about changes within us, and vice versa. In recent decades, many clinicians have understood the need to consider the bilateral flow of influences, and have begun to recognize that therapeutic action is far more reciprocal than was previously thought.

Ogden (2004) contributed to the understanding of the intersubjective encounter created in the psychodynamic therapy by defining the concept of the "analytic third." This concept relates to the new entity created in the therapist-patient encounter, which is a kind of subjective third and has a life of its own. Davies (2004) and Aron (2006) explained that the analytic third is not a static achievement of therapist and patient, but is variable and in constant metamorphosis. This is a psychological space in which the two participants sense their similarities and differences at different moments. At times, they feel as though they are merging with each other and at others, they are distanced and separate. These interpersonal experiences strengthen the relationship between the partners in the dyad and contribute to its development. This concept helps to understand the uniqueness of each therapist-patient encounter and the importance of examining the field between them. Indeed, the field or space between therapist and patient has become an object of investigation in dynamic therapy.

As mentioned above, this theoretical perception assumes that we are constantly striving to influence and shape our environment and to have effective experiences and to experience agency, while simultaneously striving to be influenced by others in the environment, through identifying with their roles and thus developing our personalities (Slavin & Kriegman, 1998). Slavin and Kriegman wrote that through ongoing attentive exploration, patients can always sense how they can influence us, the therapists, how they penetrate our identity and how they can identify our conflicts, and "force" us into places where we find it hard to be. According to Slavin and Kriegman, we frequently go with them to these places and in the process, experience a genuine change. They added that we do this because the relationship with the patients demands it and because they are worthy of it.

If that is the case, although patients turn to therapists in search of influence and change, a deep relationship and genuine dialogue will be created in therapy only if the patients succeed in effecting change in the therapists themselves—even if the relationship is asymmetrical. Indeed, many therapists today believe that true development in therapy is impossible if the mutuality principle is not realized in the therapeutic relationship. In other words, just like their patients, the therapists' values, beliefs and deep emotions will also be authentically influenced, to an extent. This is a new belief that is very different from therapists' accepted longstanding beliefs, and changes the previous balance and expectations from the therapeutic dyad.

These theoretical and clinical changes contributed to the understanding that therapists' biases and deep interests as well as the extent to which they are influenced by their patients (including being carried along and deviating from planned therapeutic goals) are part of the therapeutic reality. Each therapeutic reality is a unique human environment, which is different from the one that would have been created with a different therapist and in different circumstances. In this environment, specific parts of each participant's personality come forth in response to messages received from their interlocutor at a given time. This leads to the self-evident conclusion that the patient's transference is always shaped by a unique relational environment, which must be understood and interpreted in the context of a specific therapeutic relationship (Atwood & Stolorow, 1997; Orange & Stolorow, 1998).

**The Perception of Supervision as an Intersubjective Encounter**

Although the changes in clinical theory were slow to influence theoretical approaches to supervision (Ganzer & Ornstein, 2004; Schamess, 2006), writers began to investigate how supervisors and supervisees create a supervision space between them and to examine the components influencing the creation and development of this space. For many years, dynamic psychotherapy supervision was perceived as an encounter between supervisor and supervisee, aimed at helping supervisees work through therapeutic processes that they had experienced, to help them establish themselves as therapists and to create the optimal conditions for their professional growth. However, in recent years, the perception of supervision has expanded, and today, it is clear that, without an intimate and authentic dialogue between supervisor and supervisee, the supervision relationship will not be a significant factor in the supervisees' professional and personal development (Brown & Miller, 2002; Jaffe, 2000).

Throughout the supervision, supervisors and supervisees negotiate issues such as the perception of the therapeutic relationship (between supervisees and their patients), the perception of the supervision relationship, therapeutic values, the supervision framework, the division of powers between them, etc. This negotiation takes place on different levels—overtly and covertly, declaratively and verbally, as well as through nonverbal expression. In addition, the unique nature of the supervision relationship influences the way in which the supervisees combine concealment with honest and open disclosure of their experiences during therapy, which they have brought to supervision.

If that is the case, supervision, which expresses current therapeutic principles, focuses on the development of the supervision relationship created with each supervisee, with each individual's unique characteristics and faults, as well as on the experience of "togetherness" created within the encounter. Such reflective observation includes evaluation regarding the supervisors' contribution in supervision, as well as an examination of the supervision environment created in every unique supervisor-supervisee relationship.

**The Source of Expertise and Authority in Relational Psychotherapy**

**The Expertise and Authority of the Therapist**

In the past, therapists believed their role to be the observation of their object—the patient, in a "clean," and objective way and to examine the supervisees' biases and self-deceptions (Mitchell, 1995). Other therapeutic approaches claimed that the therapist's role was to examine the patient's subjectivity, in a skilled and perceptive manner, through sensitivity, involvement and "lending" themselves to fulfill this task (Roiphe, 1995). Therapists' authority was attributed to several factors: to their knowledge of human nature and therapeutic processes as well as their ability to observe the patient without involving their own issues and conflicts and their ability to prevent personal biases from influencing their judgment. It was believed that therapists with suitable training and experience had the ability to observe the patients—the objects of their observation—from an external rather than an involved stance. Such a stance was perceived as securing the therapist's ability to arrive at well-founded clinical facts and findings.

Recently, relational therapists have developed new beliefs regarding analytic therapy processes. According to these beliefs, therapists and patients assess each other throughout the process, to an equal degree, while constantly making assumptions to explain their interlocutor's actions and messages. This being the case, therapists need to observe and investigate the field between themselves and their patients—an investigation that is not perceived as external and objective. The therapist, as observer, is perceived as an integral part of the observation. According to this approach, the therapists' observations reflect the atmosphere and the quality of interpersonal and intersubjective relationships in the therapy and the internal dramas of both participants in the therapeutic dyad. Interpretive explanations for the transference-countertransference reality and the resulting insights (which, as already mentioned, are always specific to the therapeutic dyad that created them and to its unique encounter) are not imparted by one person to another in the therapy. Rather, they are co-constructed by both participants in the dyad, through ongoing complex negotiation, which takes place on different levels of interpersonal communication. Therapeutic insights are always specific to the therapeutic dyad that co-constructed them and to the unique encounter between the participants. Finally, the therapist certainly has greater theoretical and research knowledge than the patient, but no less important is the knowledge originating with the patient—the lived experience; it is the patients who experience their life events and who are present in the interpersonal encounters (Frayn, 1993; Goldberg, 1998; Lyons-Ruth, 2006; Mills, 2005; Orange, 2002; Shane, 2006; Benjamin, 1997: Shapiro, 2002).

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Even though relational therapists are not expected to interpret the patients' manifestations of transference as having a fixed and given meaning (since the transference-countertransference matrix is always unique to a specific therapeutic relationship), it is clear that managing relational therapy demands considerable skill and the ability to understand interpersonal and intersubjective processes. In addition, for therapists to be able to suggest changes in patients' perceptions for acquiring new insights into their lives, they clearly need to represent professional authority. How, therefore, can we define these therapists' expertise according to the current relational approach, if they cannot assume the traditional roles of the therapist? If, according to this approach, their roles have changed, what is the significance of this change regarding the authority that they can attribute to themselves? I believe that a reasonable definition of their expertise, which is the source of their authority, is as follows: *knowledge of the advancement and reflective observation of intersubjective systems***.** In other words: knowledge about the management and development of relationships in which therapists are capable of participating in an emotionally engaged manner, while simultaneously performing reflective observation of what is happening to them and to their patients in the therapeutic space.

This expertise includes developed relational ability, from which patients can internalize something during the therapy and can use it at other opportunities and in other relationships in their lives. Through this internalization, patients broaden their implicit relational knowledge, which enables them to find new ways of "being with others." That is to say, managing, developing and enriching their ability for more mutual and harmonious relationships (Stern et al., 1998).

This new definition of the therapists' expertise and authority redefines the way in which they influence the therapeutic process and the patients themselves. According to classical perceptions, the therapists' influence on the patients was primarily through interpretive intervention, which reorganized the patients' mental life. Traditionally, the therapists' interventions with patients worked to undermine the patients' constructions regarding their external and internal reality of life. According to this perception, the deconstruction led patients to replace these constructions with alternatives that were apparently more suitable and more objective. According to Schafer (1992), in the attempt to deconstruct, dismantle and estrange their patients' perceptions and constructions, therapists pointed to discrepancies, contradictions and conflicts in patients' statements and emotions, causing them embarrassment, guilt and anxiety. Following these reactions, the patients tended to distance themselves from their old perceptions and truths and gradually adopted the clearer and more consistent alternative insights of their therapists. In the relational therapy approach, we understand today that new truths need to be created by the therapist and patient together (Gediman, 2006).

**The Expertise and Authority of the Supervisor**

Similar to the change in the perception of the therapist's expertise and authority in psychotherapy was the change in the perception of the supervision relationship. In the past, supervisors' professional authority was perceived as derived from knowledge considered to be objective and external to each specific encounter with the patient. Supervision was perceived as assisting supervisees to escape from the barriers that prevent them from identifying the patient's transference and resistances (Crowell, 2007; Gee, 1996; Hanoch, 2006). To increase the objective dimension of supervision, supervisors were required to identify and neutralize their countertransference toward their supervisees' manifestations of transference toward them, to prevent biases in their own perception of their supervisees.

The current perception of all knowledge as relational and as based on a specific point of view has revolutionized the perceptions of supervision, and similarly, the perception of supervisors' and psychotherapists' authority. Although supervisors, in general, have greater theoretical, research and clinical knowledge than supervisees, the latter have experiential knowledge due to actual participation in the therapy—and this knowledge is no less important than the supervisors' knowledge. Through their presence in therapeutic interactions and through playing an important and significant role as participant observers, the supervisees have first-hand knowledge of what happened in the therapy. Just as therapists are no longer perceived as objective observers and as authorized to interpret their patients' mind, neither should supervisors be seen as omnipotent observers, whose role is to enlighten their supervisees (Rock 1997). Moreover, it is very clear to us today that supervisors have just as many biases as supervisees: they, too, are influenced by their unique personal organization of experiences, which colors and influences the meanings that they ascribe to events in the world, as well as their perceptions and judgments regarding the actions of their supervisees in therapy.

Supervisors, who are interested in representing the significant changes that occurred in the perception of the therapeutic action and its accompanying values, are therefore required to pay attention to their created supervision design. First, the constructions that are formulated in supervision and that relate to the supervisees' therapy should be jointly constructed by supervisor and supervisee, and should be achievable in an ongoing process of mutual negotiation (Yerushalmi, 1999). Although the supervisors' contributions can provide external, reflective and organizing observation, it should be remembered that the supervisors also carry their own biases. Even more important, they lack the knowledge derived from experience, as they were not present in the therapeutic interaction when the transference-countertransference events occurred. Therefore, their suggestions for the construction of the therapeutic events and the development of the therapeutic relationship can be presented only in an initial form, as a basis for negotiation between supervisor and supervisee, through clear understanding that the relevant knowledge in their possession is only one of several types of knowledge. Such a stance must lead to much greater cooperation between the two, to construct their understandings and to formulate their knowledge regarding the patients' mental life (Frawley-O’Dea & Sarnat, 2001).

I suggest that therapists are experts in creating intersubjective systems and in utilizing reflection to examine them (as claimed above), then supervisors are experts in examining these types of systems as they are reconstructed in supervision, and in processing them retrospectively. Reconstruction of a therapeutic interaction in supervision can sometimes be performed through the supervisee's partial, temporary, careful entry into regressive situations, or through a narrative told in supervision that is as experiential and authentic as possible. Another way of reflectively observing the therapeutic interaction in supervision is through identifying and locating unique and spontaneous situations and time points, effecting a genuine change in the therapeutic relationship. That is to say, authentic moments that either enhanced or undermined the therapist-patient relationship and changed the development of the therapy. Such identification will enable important understanding of why patients and even therapists develop similar intersubjective systems in their lives.

**Mutual Enactments**

**Mutual Enactments in Therapy**

One of the concepts that has had tremendous influence on the character and the shaping of the relational approach in psychoanalysis is mutual enactments. Mutual enactments are genuine events and actions taking place within a dialogue between two people, coerced by the therapeutic partner. Both participants in the dialogue sense that the actions that they are urged to perform are the result of their interlocutor's behavior (Ginot, 2001). Enactments always include nonverbal and covert messages, which might be implied not in the declarative content of words, but in the way that they are expressed, through gestures and conspicuous emotional reactions. Enactments are perceived as being forced on those operating them by their interlocutor, and as expressing the interlocutor's needs, desires and fantasies, which fulfill a role in his or her unconscious internal drama (McLaughlin, 1991). Cassorla (2001) explained that each participant is bound by these unconscious behaviors and actions, which convey his or her interlocutor's transferential fantasies, hopes and true or imaginary perceptions..

The source of people's unconscious need to cause their interlocutor to actualize their own internal drama through an enactment is in the parts of the mind that are disassociated from one's central being and awareness—'self states' or 'self-versions' that include specific organization styles of experiences, emotions and unique self-other perceptions, which appear only in certain intersubjective contexts (Aron, 1996; Messer & Warren, 1995; Rangell, 1985). Different writers from the relational approach have suggested that all people have disassociated self-states, which do not receive direct verbal expression, and are pushed far from the center of awareness. These infiltrating self-states are covertly and indirectly expressed through enactments, thereby influencing every person's most meaningful interactions.

The concept of mutual enactments has become very important in the relational approach, as it expresses the principle of mutuality in the therapeutic relationship and the joint creation of an interpersonal reality. Mutual enactments always constitute an expression of a transference-countertransference matrix, and include a certain reconstruction of past relationships that have become fixed in the person's memory. These "relational memories" appear repeatedly in the form of enactments, whose motive is unknown to the person, and which occur in the interaction with significant others, instead of appearing in the form of clear, conscious memories. Their repeated appearance enables their processing and formulation (A. Freud, 1968). Relationship schemata, which frequently led to harm and frustration in the past, are reconstructed through longing for a more satisfactory response to one's needs by significant others in the present.

Sometimes, an enactment is expressed only through the desire or the need to act and the person is prevented from its realization because of moral inhibitions or perceiving this enactment as inappropriate to the present interpersonal reality. Sometimes this refers to relatively refined aspects of behavior, which are more difficult to discern, but a drama sometimes breaks out when people are pushed to act severely and even violently toward each other. Such a drama may lead to a crisis in the therapy, as both participants in the dyad are unaware of the sources that cause them to act against each other, and merely have to cope with a stormy and frightening interpersonal experience. In such a case, it is essential to identify the unconscious motives that enacted this storm of emotions, not only for important understanding of the person's mental life, but also to be released from a destructive entrapment in the therapy itself. Mutual enactments are derived from unconscious sources in the two interlocutors, and they can often, therefore, be identified, recognized and understood only after they have occurred (Renik, 1993).

An enactment can also lead to very positive outcomes regarding the development of the therapeutic relationship and the understanding of unconscious personal processes. This is achieved when therapists and patients succeed in meeting each other's developmental needs and in regulating the other's arousal states. In such a case, therapists and patients will experience a huge leap forward in the therapeutic relationship and will undergo an important corrective experience regarding problematic and painful enactment circles from previous life periods. A mutual enactment can sometimes be a difficult experience because it precisely reconstructs painful and frustrating past relationships, and therefore, involves an experience of regression and compulsive repetition of previous suffering.

**Mutual Enactments in Supervision**

The supervision encounter, like any meaningful encounter, includes mutual enactments in which both participants cause their interlocutors to act in ways that reconstruct relationship schemata from their past. Although the supervision content involves reconstructing stories from the supervisee's therapy sessions and giving them new meaning, both supervisor and supervisee, who are constantly interenacting, are in a very vulnerable position (Brightman, 1985). Some of these enactments have their source in the internal world of supervisor and supervisee, and to the traces of memory buried within each, and others have their source in processes that occurred in the therapy itself and were reconstructed in supervision in a parallel process (Frawley-O'Dea, 2003).

It is important to mention that the only way to impart the essence of mutual enactments is through experiential illustration of these concepts, in the here and now of the relationship. When such enactments occur in the supervision interaction, they can be examined, and their sources can be reflected upon and understood. Examining enactments and counter-enactments in supervision can teach the supervisor and supervisee about covert, undeclared and nonverbal messages that move between them and that will assist in clarifying the system of mutual influence, thereby enhancing the supervision relationship. Moreover, discussion of both parties' enactments will enable the supervisors and supervisees to focus on the supervision relationship and not on the supervisee alone, with his or her individual ways of coping with difficulties.

As mentioned, in mutual enactments in supervision, past relationships and dissociated self-states receive expression in a parallel process. They reconstruct in supervision the supervisees' therapeutic relationship schemata with their patients (Frawley-O’Dea & Sarnat, 2001). As this might be the case, the enactments in supervision can serve as an important source for understanding therapeutic processes and stances taken by participants in the therapist-patient interaction. Supervisors can serve as a living, constructive and nurturing example of how to cope with the mutual enactments that arise in supervision, which the supervisees can then apply in therapy. Through identifying with the supervisor's coping method, the supervisee can internalize forms of observation and reflection, as well as processing and organizing those significant interpersonal and intersubjective events, which come under the category of mutual enactments.

This type of focusing in the supervision relationship itself and in its formative interpersonal and intersubjective processes is in keeping with the current perceptions in relational psychoanalysis, which emphasize dealing with a field that was created between two people and less with the intrapersonal aspect. This expresses the perception of the supervision as an ecological system, as an emotional and intellectual environment, in which the supervisees' choices and clinical decisions are constructed and shaped and where their professional identity is formed.

**Conclusion and Reservations: Beyond the Similarity Between the Supervision Environment and Therapy**

In this article, it was claimed that the values of the intersubjective approach cannot be internalized if the supervision that deals with the supervisees' therapy does not contain intersubjective action principles and values. Hence, every significant relationship, including the supervision itself, should be observed as an intersubjective system—regarding also the stances taken by supervisors, as well as their perceptions and the messages that they convey to their supervisees. Supervision that is influenced by the intersubjective approach, therefore, includes the supervisor's reflective stance alongside full participation in the mutual enactment between supervisor and supervisee. Supervision needs to leave room for an ongoing, dynamic discussion of the supervisor's authority and the power relations between supervisor and supervisee (Schwartz, 2008). It is claimed that the application of these enactment principles in the supervision management will introduce important means of observation and intervention, to enhance supervision relationships and accelerate the supervisees' personal and professional growth.

The application of principles and perceptions from the therapeutic world in the supervision interaction draws, among other things, on the similarity between these two professional situations. They are both based on empathy and introspection, on examining the field that was created between the participants in the encounter and on the role division between helper and helped. Nevertheless, I will indicate one essential difference between therapy and supervision. In the context of regressive states, it is inappropriate and even harmful to make use in supervision of some of the action principles that are suitable in therapy. A clear distinction must be made between the place, the role and the significance of regression in supervision and in therapy.

Some of the parameters that define psychotherapy often encourage regression in patients. Thus, for example, when ambiguity prevails in the therapy room, the anonymity of the therapist and his or her neutral stance evoke regression to prior self-states and to childish styles of experience organization. In addition, therapists' interventions often encourage patients not to fight against emotional stances, as the attempt to control them generally leaves them inflexible and reserved; rather, they should allow themselves to rely on and trust in their therapists. The therapeutic space enables them to observe, to process and to "digest" the regressive states that are evoked by these factors.

Temporary entry into such regressive states enables contact with repressed and dissociated material, as part of the optimal therapeutic action, and creates a connection with experiences, memories and dissociated self-components. Bollas described this as follows:

A psychoanalytic session is an inevitable regression to the early orders of existence, not because the analyst acts like a mother or a father, nor even because the patient acts infant or childlike, but because those psychic structures that typify these orders and constitute the very core of mental functioning are amplified in a psychoanalysis. (1996, p. 16)

Supervision of psychotherapy contains components similar to therapy regarding this issue also, and, not infrequently, supervisees are tempted to enter into regressive states (Baudry, 1993; Doehrman, 1976;Frijling-Schreuder, 1970). Indeed, supervisors in the role of mentor in the supervisees' professional and personal life elicit early desires, in the latter, for parental figures that influenced their development in the past. Nevertheless, it is important to understand the different roles of regression in supervision and in therapy. Transient and changing regressive states in supervision might often put supervisees in touch with themselves and lead them to important insights regarding the patient's mental states and the therapeutic process. However, in the absence of a predefined space to work with this regression, which is agreed upon by the participants in the professional encounter, destructive outcomes might follow regarding the supervision relationship and the optimal experiences of supervisees in their training as therapists.

When supervisors presume that the supervisees have a personal choice and the ability to make a mature, if not always conscious, decision as to whether and to what extent they might enter regressive states, they might overlook the potential risks of the situation. They might, in an unintentional and unconsidered manner, elicit the supervisees' hidden longing for intimate, symbiotic relationships, which might determine their path. An atmosphere of security, tranquility and optimal authority, which characterizes supervision, might stimulate that same longing, which is usually kept under control. In certain cases, these types of regressive states in situations of supervision might lead to dependence in supervisees, who then lack an appropriate space (such as in therapy) to process and grow from this dependence (Yerushalmi, 2012). In other cases, the entry into regressive states might cause supervisees to behave or react impulsively or in an insufficiently controlled manner, which may arouse guilt and shame later on. Uncontrolled or extremely limited entry into regressive states might blur the sometimes unclear boundary between personal, intimate supervision and in-depth personal therapy. Therefore, in light of all the above, a clear reservation must be made—that the contribution of regression to supervision is expressed only under conditions of considerable caution and strict control.

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