PSYCHOTERAPIA 2 (189) 2019
strony: 71–88
DOI: 10.12740/PT/110263

Lech Kalita

A DETAILED DESCRIPTION OF A RELATIONAL-INTEGRATIVE MODEL OF PSYCHOTHERAPY SUPERVISION

Private practice

supervision
integrative approach
relational approach

Summary

Objectives: In this article, a detailed description of a supervision model applied in supervisory work with groups of psychotherapy trainees is presented.

Methods: Results of research in the field of links between supervision and psychotherapy effectiveness are presented; there is a contemporary emphasis on the need for creating and formulating precise descriptions of models of psychotherapy supervision. The presented model is built upon two theoretic foundations: the understanding of interpersonal dynamics is grounded in the relational and intersubjective approach to psychotherapy supervision, while the attitude of pragmatism and evidence-based interventions are linked with an integrative perspective. Thus, the presented approach is described as a relational-integrative model.

Results: The main part of this paper is a detailed description of supervision techniques in the relational-integrative model and examples of practical implementation of these techniques in the work with two groups of psychotherapy trainees.

Conclusions: The formulated description of the supervisory model is an answer to the demand suggested in contemporary literature: the need to explore in more detail techniques of clinical supervisory work. A detailed presentation of methods of supervision and provision of examples of practical implementation allows other clinicians to use these techniques and to verify their empirical foundations.

Introduction

Clinical supervision is generally understood as an educational intervention, in which a more experienced clinician enters into a relationship with a less experienced professional to support the latter's practical abilities and her or his capacities to conceptualize clinical phenomena [1]. A more practical definition can be found in Hess's [2] formulation that the supervision is a human relationship that serves to transform a supervisee's behaviors, feelings, and perceptions in a way that enables him or her to provide more effective services to the patient. The role of supervision in psychotherapy has been widely discussed, e.g. in thorough reviews by Watkins [3, 4], Wheeler [5], and Hess [6] (see also [7 – 9]). Recently, an interesting review of literature on the supervisory relationship has been published in Polish [10]. Polish researchers have also attempted to systematically inquire to the matter of supervisory needs and rules from the perspective of psychotherapists and supervisors [11].

One important challenge for contemporary models of aid is to examine the effectiveness of supervision in different contexts and circumstances. The issue of ambiguous results regarding the relationship between supervision and effectiveness of psychotherapy has been raised by Watkins [4], and Ladany [12] has highlighted the need to address particular dimensions of the supervisory relationship in more detail: she pointed directly to personal style, technique, and the behavior of the supervisor. The presented work is in line with Ladany's [12] suggestion and aims at presenting details of a model of supervision that is implemented in group work with psychotherapy trainees. Thus, the review of up-to-date knowledge about clinical supervision is limited to the absolute minimum, focusing on its relationship with the effectiveness of psychotherapy.

Watkins [4] presents a critical review of research in the area of links between supervision and effectiveness of psychotherapy. His review included analyses conducted between 1981 and 2006 and is supplemented by his own systematic review of articles published between 2006 and 2011. His detailed research shows that in the last 30 years, only 18 such studies were conducted, and of this small number, one third had to be excluded due to the lack of factual focus on the relationship between supervision and effectiveness. Watkins concludes that we still lack strong evidence for links between supervision and therapy effectiveness and encourages further studies. However, he stresses that recent years brought a number of studies with a consistent, promising methodology, most notably research by Bambling et al [13].

Bambling's team [13] focused on establishing how alliance-oriented supervision influences the effectiveness of psychotherapy in 127 patient-therapist pairs. Those pairs were randomly distributed between two groups: only in one of them, the therapist was supervised. Moreover, the supervised group was further divided into two subgroups: in the first subgroup, the supervision was focused on an interpersonal, relational dynamics that facilitates therapeutic alliance; in the second subgroup, the supervision was focused on specific abilities and techniques of establishing therapeutic alliance. Dependent variables included both depressive symptom measures and working alliance measures. In both subgroups of the supervised group, the working alliance was significantly ($p<0.01$) higher ("relationship" subgroup: mean value of 233.9 points in the Working Alliance Inventory; "techniques" subgroup: 225.5 points) than in the unsupervised group (mean value – 191.6 points). Analogously, symptomatic reduction, measured with Beck's depression inventory (the mean value at the beginning of psychotherapy was 33 points in both groups) was significantly ($p<0.01$) higher in the supervised group (average reduction of BDI to 6.3 in the "relationship" subgroup and to 8.6 in the "techniques" subgroup) than in the unsupervised group (average reduction of BDI to 12.2).

The comparison between subgroups showed no significant differences both regarding the quality of alliance and symptom reduction. In the discussion of these findings, the researchers suggest that

supervisory interventions aimed at insight into the relationship and interventions focused on a cognitive and behavioral approach to techniques affect the effectiveness of therapy in a similar manner, both at the dimension of therapeutic alliance and at the dimension of symptom improvement. Perhaps the effectiveness of supervision is based on the general focus on the therapeutic alliance or on the influence of common factors [14]. Thus, it can be said that supervision probably plays an important role in building a working alliance and in symptom reduction in psychotherapy but no specific direction of organizing a supervisory session can be suggested. Bambling and his team speculate that common factors that significantly contribute to psychotherapy effectiveness [14], can also prove to be an important aspect of effective supervision.

The role of common factors in effective supervision, similar to the role of common factors in effective psychotherapy, is also suggested by the results of a study conducted by Weck, Kaufmann, and Witthoft [15]. The researchers focused on topics and processes involved in the supervision of 791 psychotherapy trainees in cognitive-behavioral and psychodynamic training. The most frequent topics included therapists' interventions, working alliance, keeping patients in therapy, and therapeutic goals. The most common technique of supervisory work was case discussion. The authors did not find any significant differences between the supervision of clinical work between the two modalities, i.e. cognitive-behavioral and psychodynamic.

Milne et al. [9] focused on the "synthesis of empirical data" in supervision. On the basis of a systematic review of literature, they created an integrative summary of concepts and models of supervision described in 24 research articles. Basing on qualitative analysis of data presented in the analyzed papers, Milne's team proposed a basic, conceptually integrative, evidence-based model of clinical supervision that included 26 types of supervisory interventions and 28 mechanisms of change. The most frequent supervisory interventions include teaching and advising (present in 75% of studies included in the model), corrective feedback (63% of studies), observation of sessions or analyses of session recordings/notes (42%), goal setting (38%), and data-gathering and clarifying (38%). Among the 28 identified mechanisms of change, as many as 82% belong to the "cycle of learning from experience" described in Kolb's model [16]. This cycle includes the phases of direct experiencing (in this instance – the therapist's experience of psychotherapy with her or his patient), reflective observation (analyzing experience), abstract conceptualization (deriving conclusions from experience) and, finally, active experimenting (implementing conclusions into real life).

Detailed presentation of a relational-integrative supervisory model: theoretic context

On the background of cited research data, I propose a detailed description of a supervision model for a group of psychotherapy trainees. The model was implemented in a research project conducted

continuously since 2016 and has been described elsewhere [17]. This model includes both a relational aspect of the working alliance and a dimension of goals and tasks [13]. In compliance with a proven role of common factors in psychotherapy [14] and a very probable role of common factors in supervision [13, 15] the supervisory techniques in the presented model are based to a large degree on an integrative perspective, in which the supervision is seen as a space of collaborative search for most helpful ways of supporting the development of a therapeutic process with the broadest choice of measures possible on base of contemporary knowledge, patients' needs, therapists' abilities, and the supervisor's abilities. In this perspective, clinical supervision can be defined, after Hess [2], as a human relationship that serves to transform behaviors, feelings, and perceptions of a supervisee in a way that allows her or him to offer a more effective treatment to the patient. Supervisory work on a relational aspect (interpersonal dynamics) of a therapeutic alliance in this model can be traced to experiences of relational an intersubjective approaches in psychotherapy – *i.e.* perspectives precisely focused on exploration of subtle relational phenomena and on describing the contribution of both participants of a therapeutic encounter to the quality of a working alliance (see *e.g.* [18, 19]). The presented model of supervision aims to bridge these two perspectives (integrative and relational) as complementary and non-conflictual.

Brown [20] argues that the integrative or contextual concept of common factors can be combined with particular therapeutic approaches, defined by specific techniques. Zarbo et al. [21] stress that integrative approach to psychotherapy is not equal with eclective stance; in such terms, a relational-integrative model of supervision requires that the supervisor is both familiar with the relational paradigm and has knowledge in other concepts of schools of psychotherapy.

In their thorough book on supervision, Frawley O'Dea and Sarnat [22] describe a number of distinct models, based on different approaches to the three fundamental dimensions: the supervisor's authority, the supervisor's focus, and the supervisor's role in the relationship. In the relational model, the supervisor's authority is not a given and is not referred to her or his expertise or knowledge in theories and techniques but to a developed ability to understand relational dynamics (including acting out behaviors) in therapeutic and supervisory dyads. In this aspect, the supervisor is more of a participant in the supervisory relationship, in which both parties influence each other. The supervisor's area of focus is broad, as the supervisor attends to relational issues in the therapist-patient couple and in the supervisor-supervisee couple. The field of supervised phenomena includes also somatic sensations, affects, and dreams. The way of the supervisor's participation in the relationship also includes the exploration of unconscious engagement in the therapeutic relationship and the supervisory relationship. The supervisor participates in various ways, e.g. by giving information about the supervisee's feelings or by containing them but always tries to remain aware of the relational situation and to include the supervisory

relationship in the picture. Such an approach to learning via supervision emphasizes the role of a lived experience ([22, p. 41], see also the cycle of "learning from experience" by Kolb [16]).

An important aspect of the relational approach to supervision is the inclusion of a parallel process: a situation in which the patient unconsciously communicates his or her experience, feelings, or conflicts to the therapist, who, in turn, unconsciously communicates this material to the supervisor [23]. From this perspective, the parallel process can be used to 1) explore the patient-therapist dynamics; 2) explore the therapist's internal dynamics ; 3) explore the therapist-supervisor dynamics. Each of these areas can facilitate the development of the therapeutic process, as well as the supervisory process [23, p. 297]. A neurobiological foundation of the idea of the parallel process can be found in research on mirror neurons [24, 25].

Norcross and Popple [26] have formulated some clear-cut rules on which an integrative approach to psychotherapy supervision is based. The primary aim of integrative supervision is to support the supervisee in an integrative approach to clinical work – in order to heighten her or his effectiveness. To reach this aim, the supervisor can encourage the supervisee to identify situations in which a referral to another professional can be beneficial (which sometimes happens to be the best intervention in the case of inexperienced therapists) or to apply integrative methods of clinical work (which is commonly beneficial in the case of more experienced therapists).

The main tasks of the supervisor in the integrative perspective are promoting an attitude of respect to empirical data; assessment of the patient's functioning on the basis of characteristics not only related to the diagnosis; inclusion of variables such as the patient's reactivity, culture, preferences, coping styles; facilitating and monitoring the therapeutic relationship, especially regarding common goals; addressing frustration and consternation in the supervisory relationship. One of the most important aspects of this supervisory stance is a pragmatic attitude and unceasing observation: what works and what does not work? Such evaluation should simultaneously encompass the patient's functioning, the development of the therapeutic process and the development of the supervisory process. In the integrative approach, the supervisor interchangeably assumes roles of a lecturer, a teacher, a consultant, a colleague, a controller, a supporter, a mentor, and a quasi-therapist [26].

In line with Ladany's [12] suggestion to engage in a deeper exploration of the various practical dimensions of supervisory relationships, especially styles, techniques, and behaviors of the supervisors, what follows is a detailed description of a relational-integrative model of supervision.

Presentation of the relational-integrative model: techniques

This list is not intended as a full catalogue of every intervention possible to undertake in a relational-integrative model but serves as a review of the most crucial techniques and behaviors.

A. Case description

The supervisor encourages his or her supervisees to prepare a description of a presented case. The possibility to read notes before the supervisory sessions gives the supervisor additional time to formulate hypotheses and saves time during the supervisory session. The supervisees describe facts from the patient's life, his or her family background, problems she or he stated at the beginning of therapy, and the history of the therapeutic process. The supervisees are also encouraged to describe their ways of understanding the patient.

B. Defining the problem and the goal

Every process of supervision should include an attempt to define the problem and the goal of work. (Does the supervisee need to ground her or his conceptual understanding? Does she or he experience difficulties in building an empathetic relationship with the patient? Does she or he observe recurring difficulties? Does she or he need to work on some particular technique?) These questions are restated in every session. (What does the supervisee need t o d a y in her or his work with the patient?) The precise defining of the goal of a supervisory meeting serves to improve the cooperation between supervisee and supervisor but also promotes a particular way of thinking, with a clear-cut focus on the awareness of goals of every therapy.

C. Formulating hypotheses

Together with the supervisee, the supervisor engages in formulating hypotheses regarding the patient's psychopathology and the understanding of a given moment in the development of the therapeutic relationship. The supervisor takes an inclusive stance: she or he accepts the multitude of possible perspectives of understanding human behaviors, emotions, and motivations. She or he does not force her/his own hypotheses nor she does she/he try to lead the supervisee in directions consistent with her/his own understanding – but she or he demands to motivate each hypothesis to build a convincing picture of the patient's psychic functioning. This approach facilitates a therapist's ability to convey their understanding in a more understandable way and promotes a culture of a careful, systematic formulation of hypotheses, as contrasted with an intuitive approach to work. The ability to formulate clear-cut and substantiated hypotheses regarding psychic functioning is a necessary condition for the inclusion of regressive experiences in attempts to understand the patient.

D. Parallel process

The exploration of a parallel process, *i.e.* of an unconscious transmission of relation patterns of a patient-therapist couple to a supervisee-supervisor couple, should include the unavoidable speculative nature of such a construct and the supervisor should explicitly state this in their conversation with the supervisee. At the same time, the concept of the parallel process can be included in various hypotheses formulated about the patient. In the exploration of this area, the dominant role is played by regressive

experiences, which are the primary channel of communicating unconscious experience. Thus, supervision will also include exploration of the supervisees' impression of being with their patients: how do they feel on a somatic level? do they experience fantasies or associations unrelated with overt material of the session? how do they experience non-verbal communication with their patients? Conclusions regarding the parallel process, derived from exploring regressive phenomena, can be seen as valid (though still speculative) only if they can be clearly linked with a broader outlook on the patient's psychic functioning.

E. Exploration of relational phenomena

An invariant dimension of the supervisory process in the attempt to explore relational phenomena, to link them with therapeutic goals, and to ground them in a broader understanding of each patient. The relational perspective allows including the participation of both patient and therapist in playing out relational patterns. Thus, it is an approach less focused on analyzing transference, which is standard in some schools of psychodynamic or psychoanalytic thinking, and more oriented towards defining a relationship dynamic created together by patient and therapist during the therapeutic session, and towards estimating each participant's contribution into playing out a particular pattern. The supervisory process can be seen in a similar way: not to treat every experience in supervision as an influence of a parallel process, but to include both parties (therapist and supervisor) in a mutually created supervisory relationship, and then – to estimate what each party brings into the dynamics.

F. Theoretic conceptualizations

It happens that attempts to formulate hypotheses about a patient's functioning require reference to particular theoretic concepts. The supervisor sometimes presents theories about psychopathology, psychic functioning, or therapeutic stance. The priority is always set on the practical link between the presented theory and clinical material, to prevent academic case discussions and to remain focused on more consistent and probable hypotheses that the therapist should be able to convey to the patient in a systematized way. The supervisor should explicitly point to the areas of his or her theoretical proficiency and might encourage supervisees to share their theoretical perspectives. Wherever possible, the supervisor should back theory with empirical research and point to the fact that some theoretical formulation has been proven by research.

G. Suggestions regarding working technique

In some cases (when needed by the supervisees), hypotheses regarding the patient's functioning can be supported by concrete propositions of applying a particular technique. Sometimes the supervisor suggests a general direction, at other times she or he can share exemplary statement she or he would formulate in the therapist's place. The supervisor should explicitly state that this is not the best possible approach to working technique but an example of her or his own way of talking to the patient. The main

aim of this intervention is to promote the ability to translate clinical hypotheses into the language of a direct dialogue with the patient. The supervisor encourages the supervisees to propose their own interventions. Sometimes supervisees might ask the supervisor direct questions about ethical issues or basic aspects of the therapeutic frame; in such cases, the supervisor should answer directly and explain the rationale for her or his answer (*e.g.* point to the ethical code or to a particular fundamental ethical rule).

H. Sharing the supervisor's clinical experience

In some instances, the supervisor makes direct reference to his or her clinical work. One reason for such an intervention is to highlight the value of learning from experience: the supervisor shows that surviving difficult clinical situations in their work with a particular patient gives more freedom to attend to similar situations in work with other patients. The supervisor needs to stress that every therapeutic process and every patient-therapist couple are different and every analogy has limited, supportive value. The other reason to share clinical experience is the need to support the supervisees in tolerating frustrations and failures. The supervisor sometimes gives examples of his or her own therapeutic failures or insufficient understanding to encourage the therapists to tolerate the stance of humility and acceptance of unavoidable errors and misunderstandings – without losing the attitude of professional responsibility. This might help therapists in accepting their own mistakes in a less severe way.

I. Supervision of supervision

The supervisor's catalogue of techniques includes also supervision of the supervisory process in which she or he is involved. Openness towards further perspectives of parallel exploring patient-therapist and therapist-supervisor relationships introduces an additional dimension of understanding and helps the supervisor in understanding his or her own attitudes in supervision and in defining his/her own role in relationships with supervisees.

An exemplary description of relational-integrative supervision in one-year-long group supervision with psychotherapy trainees

The group of trainees consisted of:

T1: A trainee in psychoanalytic psychotherapy

T2: A trainee in Gestalt psychotherapy

T3: A trainee in psychodynamic psychotherapy

T4: A trainee in systemic psychotherapy

T5: A trainee in integrative psychotherapy

The group work clearly included four distinctive phases characterized with particular relational phenomena and by particular pragmatic needs of supervisees. Those phases corresponded with general

phases of development of a group process – according to the scheme: orientation → conflict → cooperation and consistency → goal-oriented activity (see *e.g.* [27], [28], [29]). In this paper, I mention the phases but I will concentrate on phenomena connected with the process of supervision and the development of supervisees.

Phase I

In the first phase of the supervisory work, the group was dominated by relational phenomena typical for newly founded groups: the participants co-created an atmosphere of mutual suspicion and persecution. The gathering of trainees representing differing therapeutic modalities resulted in the expectation of critic from both the supervisor and other participants. Due to the understanding of a relational aspect of the group process, the supervisor was attempting to openly encourage the participants to share their thoughts about the presented material in a theoretically neutral way, avoiding any jargon typical for each perspective. As there were 2 participants representing the psychodynamic/psychoanalytic perspective, the supervisor exemplified unnecessary "psychoanalytic jargon" and translated it into a common language for all participants. For example, the concept of "paranoidal anxieties" was translated into the need to build basic trust. The supervisor also stressed that the attempt to create a common language might sacrifice some clinical nuances but allows a more fluent exchange of thoughts. In the beginning, the supervisory sessions required a lot of activity on the supervisor's side, as the participants tended to hide in background and were hesitant to share their own understanding or hypotheses about the patient's functioning. The psychodynamic therapists (T1 and T3) started to share their thoughts with a bit more daring attitude and the supervisor attempted to actively include T2, T4, and T5 in their exchanges by asking them to contribute their own understanding. The relational dimension of the group dynamic was in some way parallel to the relational dynamics of therapeutic processes led by the trainees; as the group of trainees engaged in the search for a "common language in supervision", each therapist engaged in a similar search for "common language" with their patients, while both parties (in both relationships) experienced heightened anxiety and suspicion. The supervisor made note of his own anxiety in face of massive expectations from the trainees and accepted this feeling as an unavoidable playing out of a relational pattern typical for the first phase of human contact.

On the integrative or pragmatic dimension of the supervisory model, the first phase of group work can be described as a time of the most intensive focus on formulating a goal of psychotherapy accepted by all involved parties. The supervisor might have irritated the participants by his ever-repeated question about goals they have negotiated with each patient but this was a very conscious attempt to promote a culture of the precise formulation of a direction and area of work. The first phase of group work was also the most technique-oriented phase. The participants asked about various details about therapy settings

and about ways of conducting initial sessions. The supervisor tried to address these questions directly, emphasizing that his answers are in most cases just one possible perspective, not the only one.

Phase II

On the relational dimension, the second phase of the supervisory group work brought lessening of relationships founded on suspicion and mistrust and the introduction of rivalry. When the participants started to share their thoughts in a more direct way and when they all had already shown some parts of their clinical work, they started to engage in conflicts related with the attempt to build their confidence on devaluating other perspectives. The supervisor decided to intervene directly and quickly to this relational dynamic: he pointed out the moments of unnecessary antagonisms and suggested that "alien" ways of working can be translated into a common language. For example, in this phase of work, T2 – the Gestalt therapist, presented her work which included the "empty chair" technique. The other participants considered her technique "odd" and started to talk about possible abuse by the therapist. The supervisor intervened and explained that T2 is conducting her therapeutic tasks by the means she had learned to use in her therapeutic training; then, he proposed that the other participants could try to describe the technique of an empty chair by their own therapeutic modalities. The supervisor also explained that in his view, T2's intervention was helpful and he perceived it as an attempt to concretely support her patient who was experiencing difficulties in benefiting from an abstract conversation about mental representations of significant persons. T4 noted that in systemic work, she makes similar use of the presence of various family members. Her statement was far more benign than the earlier accusations. The other participants connected on a similar note and the relational scheme of rivalry was transformed into a more cooperative one. The supervisor's interventions in this phase were focused on resolving similar problems.

On the integrative dimension of the supervision, this phase of work required the most intellectual effort from the supervisor, as rivalry and tension between the participants demanded that hypotheses about the patient's functioning had to be simultaneously translated to various "languages" and then integrated into a common thought acceptable by all participants. The pragmatic approach to the therapeutic processes required the support of the therapists in building a context for understanding their patients' difficulties – so that they would be more able to formulate interventions aimed at goals defined in phase I.

Also, on the boundary between the relational and pragmatic perspective, some parallel phenomena occurred: therapists and patients experienced tensions similar to the described group conflicts, which were revolving around ways of understanding the patients' problems.

Phase III

The third phase started somewhere around the second part of the trainees' one-year-long program. In the relational dimension, this phase proved to be the most pleasant and creative one. Thanks to the

former moderating of relational schemes of persecution and mistrust and subsequent rivalry, the group entered a phase of cooperation, mutual recognition, technical and theoretic pluralism, and deep engagement in their work with patients. The trainees had accepted their differing stances and made advantage of the multi-perspective approach to enrich their clinical understanding. To provide an example – the integrative therapist, T5, presented her work with a patient who struggled with the tendency to reproduce a destructive relational pattern in intimate relationships and asked T1, the psychoanalytic therapist, to help her understand the concept of transgenerational transmission. T1 presented an elaborate theoretic thought, which was supplemented in a few points by T3. Then, T2 said that this conversation did not directly involve her patient, but she would benefit by having been introduced to theories she did not know. T5 asked T2 to share how the transgenerational transmission is understood from the Gestalt perspective and T2, being able to hold her own identity, explained that she had focused on the direct quality of contact in the session and can elaborate on this aspect. The group listened to T2's comment carefully and decided it was a valuable contribution to understanding the patient.

The relational dimension did not require the supervisor's heightened activity. The supervisor gently supported the developing processes of cooperation and respect, often stayed low profile and allowed the trainees to give support to each other. The supervisor decided to intervene in the closing part of supervisory sessions to realize the pragmatic dimension of supervision.

From the perspective of an integrative, pragmatic model of supervision, the main point of focus in this phase was the matter of supporting the working alliance and developing ways of using an empathetic understanding to address the fundamental problems of patients (the goals of therapy). Most of the trainee-led psychotherapies developed positively but they had the tendency to drift away from the main problem, thus, the trainees needed some guidance in narrowing their work to the previously negotiated goals.

Phase IV

In the last phase of the supervisory work, the relational dimension was dominated by feelings of gratitude and satisfaction, punctuated by the sadness linked with the closing of the shared work without fulfilling all therapeutic ambitions. In this phase, similarities between the group process in supervision and individual therapeutic processes became obvious also for the trainees. The therapists were able to discuss relational themes with their patients and stressed that they benefit from being able to discuss their own separation feelings during supervisory sessions. They were able to draw a clear boundary between their own and their patients' feelings – they used awareness of their own relational experiences in service of better emotional attunement. In this phase (as in all the former phases), the supervisor addressed relational phenomena in group supervision processes without formulating pseudo-therapeutic comments

regarding the therapists' experience but used these phenomena to demonstrate the parallel process or to ground themes from therapeutic processes in lived experience. For example, when T4 said she would miss the other trainees' voices and that in just a few weeks she would have to cope with potential new patients on her own, the supervisor did not suggest that the group or the therapist herself should address her painful feelings, like possible difficulties in accepting her own responsibility intrinsic to independence (the supervisory relationship did not give him the right to such comments) but used this relational phenomenon to point to possible difficulties of their patients in accepting responsibility and independence. In other words, the supervisor used T4's feeling as a point of reference to attune to patients' feelings.

In the integrative dimension, the last phase of group work was focused mainly on evaluating the soon-to-be-finished therapeutic processes. This evaluation was both quantitative (patients were filling symptoms-related forms) and qualitative, by means of discussing what was successful and what was unsuccessful in each therapeutic process. The supervisor discussed helpful and effective attitudes and interventions and speculated about possible reasons for failures and shortcomings. The trainees pointed to the particular importance of feedback summarizing a year's work: in reference to the led therapeutic processes, the supervisor formulated comments in which he summarized the most helpful aspect of each trainee's individual style and tried to point out potential threats included in their individual styles. The trainees stressed that singling out and directly addressing their own individual style of work, which they were largely unaware of, was an important element of supporting their professional identities.

During the discussion of most important changes in their clinical work, T1 pointed out that she had started to use theory in a less intellectual way and tried to make her language, in which she communicated with her patients, more simple; T4 said she had started to pay more attention to giving her patients more responsibility for their improvement; T2 highlighted that she had learned to use her emotions in a more systematic and careful way; T3 pointed that she had become more able to look for balance between support and insight; and T5 realized she had gained more proficiency in establishing an adequate distance to patients, which includes both being close to their feelings and keeping a professional boundary intact.

An exemplary supervisory session in the relative-integrative model

To illustrate the supervisory work in a most direct fashion, I will conclude by presenting an example of a supervisory session, which comes from working with a further group of trainees. This group of psychotherapists included the following persons:

T6: A trainee in psychoanalytic psychotherapy

T7: A trainee in systemic therapy

T8: A trainee in psychoanalytic psychotherapy

T9: A trainee in cognitive-behavioral therapy

T10: A trainee in integrative psychotherapy

T10 presented the case:

The patient Natalia lives with her mother, step-father, and two younger sisters. The mother's family lives in her nearest neighborhood (grandmother, mother's brother). The patient has just started her 3rd year of university studies, financed by her mother's brother. When she was 4, her parents broke up; since then she hadn't had any contact with her biological father, with an exception of a single phone call on her 18th birthday – when she told her father she didn't want to have anything in common with him. She knows where her father lives (nearby her house). She can't talk about her father with her family, as this leads to something she calls "hysterical attacks" presented by her mother.

She was seeking therapy due to depressive episodes. She is in pharmacological treatment.

As her therapeutic goal, she has defined the need to work through the trauma related to the abandonment by her father. She added she wanted to improve her ability to concentrate; she would like to be more self-aware.

In the last two months, she started to drop out of her sessions. She always gives a justification for her absence (meeting with a friend, obligation to attend college classes, job interview).

***P:** — Good afternoon.*

***T**: — Good afternoon.*

***P**: — Last week I was here, and it was dark. No one was there. Only after a while, I remembered that you had cancelled the session.*

***T**: — What did you feel when no one was here?*

***P**: — Relief, I guess. Yes, it was relief that the therapy will not happen. It costs me very much to be here.*

***T**: — You find it very hard to be in therapy. Can you tell me anything more about this?*

***P**: — When I'm here, it is fine. I start to talk and it is fine, but before I start, I wonder if this makes any sense. I feel that I cannot be helped. I was at the psychiatrist's and I have new pills, but they don't work at all. I don't have any energy. I have started to doubt if I should continue my studies [she describes how in crisis intervention classes she took all cases to herself and lived out her problems anew].*

***T**: — Is there something else?*

***P**: — Lately, I had a quarrel with my friend...* [She tells a story about a quarrel with a friend who left for a 2 weeks trip] *I feel that this relationship doesn't make any sense anyway.*

***T**: — Do you feel the same about us?*

***P**:* [silence]

***T**: — Our sessions were cancelled for 2 weeks due to my absence.*

***P**: — Maybe there is something about this... But I know I can't be angry, everyone has the right to take some time off. It was me who was mistaken and thought the meeting would take place.*

***T**: — You felt abandoned.*

***P**:* [silence] *— I don't know, I had such destructive thoughts – to neglect the home assignment at the university. I got angry at myself but I was not able to write the assignment. 20 minutes passed. 3 days later I tried again. I felt hopeless, normal people just sit and write. If it was not for Bartek, I would have written nothing.*

***T**: — I will refer to our meetings again. On our first session, you were talking about very difficult issues, like you wanted to tell... To write everything at once…*

***P**: — It is true in a way. I want to feel better immediately but this is not the case and I'm angry. I feel deflated. I even experience suicidal thoughts again, I think about cutting myself. I won't do anything, I know this is not a solution but sometimes I just can't stand it. I don't have any energy.* [She tells about quitting the gym and neglecting her appearance].

***T**: — It's like you are in a closed circle, without any strength left but you demand 100% effectiveness from yourself and you are angry at yourself that you can't do it.*

***P**: — This anger also leaves me weak. It is like this. I guess I'm having depression.*

***T**: — What does this mean to you?*

***P**: — Not much, really, no one will understand, anyway. I told my grandma about the pills and she told me to put myself together. I want someone to lead me, to tell me what's right and what's wrong. I feel that this therapy, and that my whole life – it's like being in a dark room, making movements with my arms, like this* [she demonstrates] *but I can't see anything.*

***T**: — You need to turn on the light.*

***P**: — Yes, yes, I need someone to turn on the light.*

***T**: — Can you turn on the light?*

***P**: — Ha ha... I don't know where the switch is.*

***T**: — We can look for it. But for now, we have to finish.*

The following discussion ensued in the supervision group:

Supervisor: — Let's begin. Maybe you can tell us something more about the current situation with Natalia and about the session.

T10: — Well, not much to add to what I have written down. Maybe it was a bit better after our last supervision but then this present crisis unfolded. My patient keeps on finding reasons to miss her

sessions and I'm worried she might drop out from therapy. I'm not sure if it's a matter of motivation or if the therapy is too difficult for her. I suppose it's the latter but I don't really know. In fact, I don't know what to think, I would like to hear your comments. [Turning to the group] What do you think?

S: — [In brackets, in italics, I put unspoken thoughts of the supervisor that crossed his mind during this supervisory session.] [*I decide to keep silent, wait and see how the situation unfolds. I note that the therapist addresses the group directly in asking for support. I think that perhaps the patient is really determined to reach for help if I take into account the problematic course of her therapy and the fact that she could have dropped out earlier*].

T6: — I thought that maybe this patient reacts to something related to the therapeutic process. I'm wondering: what makes her so uncomfortable when she's with you, what troubles her? Maybe she's seeing you too rarely? And then she hates you like she hates her biological father?

S: — [*This does not convince me but I think that it is important that T6 is trying to support T10 with her own understanding and that she quickly offers her comment, without prolonged silence. I decide to keep on observing the situation*].

T10: — I don't know if she hates me. But indeed, sometimes I feel quite tormented or uncomfortable when I'm with her. I don't know what I could possibly say to her, how I could help her. And I even noticed that when the patient was absent, I felt a bit of relief, similar to the one that the patient was talking about in our session.

S: — [*I think that the feeling of helplessness that T10 notices is the dominating experience of her patient, but I still refrain from commenting and wait*].

T8: — Yes, so I suppose that maybe you should use your feelings and on this basis try to say something to the patient. She seems to be lost in her feelings and if you made use of countertransference and told her that it is her who is feeling tormented and that she feels relieved when she can be absent from the meeting – this would help her find herself. I think you should comment in transference-countertransference.

S: — [*On the one hand, this comments sounds a bit scolding but what is in the foreground is the fact that T8 attempts to support T10 and offers his own point of view. T10 is not offended and listens carefully. I'm happy with the group work and I think that maybe Natalia needs a similar experience of being listened to by someone who is clearly attempting to support her; without this experience, she feels alone in the dark room*].

T10: — I don't know... I don't know. I guess I'm a bit afraid of telling her such things; I don't want to scare her away. I'm wondering if I can say anything at all. I don't want to make her drop out by an inadequate comment.

T7: — Such a huge... mass of helplessness. Who will turn the light on?

S: — [*I felt that this might be one of the crucial problems in the current therapeutic situation. On the one hand, there is the patient, desperately looking for an object in the wake of a paralyzing fear of nothingness, and on the other hand, there is the therapist who cares for the patient but who is too afraid not to hurt the patient. The silence after T7's comment seemed to correspond with the tense atmosphere in T10's sessions as I imagine it. This made me think about being lost in a dark room. I formulate a thought about the need of more active involvement on T10's part but as for this moment, I decide to invite T9 into the discussion, as I feel that she is left out and perhaps a bit overwhelmed by the "psychoanalytic discourse" of T6 and T8. I feel that my intervention might support both T9's comfort in the group and in some way might help the group experience something I want to describe subsequently*].

S: — And how about you? What do you think?

T9: — Me? I think that this patient is sinking into depression. She doesn't care about her appearance; she withdraws from her life just like she withdraws from therapy. That's why I would try something to make her more alive: maybe I would try to sit with her and write a list of possible activities or to plan the day – something to stop her from falling into this state.

[*At this point, I decide to give a comment in which I attempt to gather the group's thoughts, my own thoughts, and reflections about the parallel process*.]

S: — It seems to me that you are using different languages and propose interventions that are based on diverse, individual styles but you are all trying to address the patient's problem in a similar way, which I perceive as helpful. At first, I want to stress that in my opinion, the patient describes her state quite clearly at the beginning and at the end of the session. She finishes with an image of being lost in a dark room but she also begins by saying that it was dark and empty when she came to see T10 last time. I think that this is not only a real account of going to a cancelled session but also a description of the patient's internal world. If the patient is sinking in a depressive experience, as T9 suggests, these images would be much grounded in such an experience: a feeling of being desperately stuck in a world where you are left alone. Thus, I feel that all of your propositions are worthwhile because in each case you are trying to emphasize that the therapist is present and is willing to help the patient. That the therapist can actively hold the patient's hand, in a metaphorical manner; to ensure the patient that she is not alone, even though this is what she dreads the most. Whether we achieve this goal by a comment in which we show clearly that we are thinking about the patient and her history, as T6 suggest; or by using our feelings to work in transference, as T8 suggests; or by a metaphorical comment about putting the light on, as T7 suggest; or by mutual, concrete work on making the patient's day more active, as T9 suggests – this decision is less important than the general direction of highlighting the therapist's presence and care for her patient. I think that if you want to prevent a drop-out, it would be good to use your own style and your own language to reach for the patient, to show her that you are actively engaging in attempts to

understand her and that she is actually not alone in the dark room. If the patient feels such a presence, you can return to more typical work revolving around conveying your understanding of the patient's experience; but now, perhaps, Natalia needs to feel that there is someone who is willing to support her.

[*I feel that this intervention was well received not only by T10 but also by the rest of the group, especially by T9, who might have feared that her proposition is to "shallow" for the other participants. The atmosphere becomes clearly more relaxed.*]

T10: — Thank you, I feel better prepared for my next session... I think I don't worry so much that I will hurt Natalia and make her drop out.

T6: [smiling] — And now we know that it is the therapist who should turn the light on...

Summary

In this article, a detailed description of a supervision model applied in supervisory work with groups of psychotherapy trainees is presented. This model is built upon two theoretic foundations: the understanding of interpersonal dynamics is grounded in a relational and intersubjective approach to psychotherapy supervision, while the attitude of pragmatism and evidence-based interventions are linked with an integrative perspective. Thus, the presented approach is described as a relational-integrative model. Results of research in the field of links between supervision and psychotherapy effectiveness are presented; there is a contemporary emphasis on the need for creating and formulating precise descriptions of models of psychotherapy supervision. The main part of this paper was a detailed description of supervision techniques in the relational-integrative model and examples of practical implementation of these techniques in work with two groups of psychotherapy trainees.

References

1. Watkins C. Toward a Tripartite Vision of Supervision for Psychoanalysis and Psychoanalytic Psychotherapies: Alliance, Transference–Countertransference Configuration, and Real Relationship. Psychoanal. Rev. 2011; 98. 557-590.
2. Hess AK. Psychotherapy supervision: theory, research, and practice. New Jersey: Wiley; 1980.
3. Watkins C. Psychotherapy Supervision in the 21st Century: Some Pressing Needs and Impressing Possibilities, Clin. Supervisor, 1998; 7(2): 93–10.
4. Watkins C. Does Psychotherapy Supervision Contribute to Patient Outcomes? Considering Thirty Years of Research, Clin. Supervisor, 2011; 30:2, 235-256.
5. Wheeler S, Richards K. The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. Couns. Psychother. Res. 2007; 7:1, 54-65.
6. Hess AK. Psychotherapy supervision: A conceptual review. In: A. K. Hess, K. D. Hess, & T. H. Hess (ed.), Psychotherapy supervision: Theory, research, and practice. New Jersey: Wiley; 2008, pp. 3-22.
7. Kilminster S, Jolly B. Effective supervision in clinical practice settings: a literature review. Med. Educ. 2000; 34; (10): 781–881.
8. Schlessinger N. Supervision of psychotherapy. A critical review of the literaturę. Arch. Gen. Psychiatry 1966; 15(2):129–134.

9. Milne D. How does clinical supervision work? Using a „best evidence synthesis" approach to construct a basic model of supervision. Clin. Supervisor, 2008; 27, 2: 170–190.
10. Jelonkiewicz I. Co dzieje się w relacji superwizyjnej? Psychoter. 2018; 4(187): 69–80.
11. Bomba J, Bierzyński K. Potrzeby i zasady stosowania superwizji psychoterapii. Psychoter. 2015; 2(173), 5-14.
12. Ladany N, Mori Y, Mehr KE. Effective and ineffective supervision. Couns. Psychologist, 2013; 41(1), 28-47.
13. Bambling M, King R, Raue P, Schweitzer R, Lambert W. Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression, Psychother. Res. 2006; 16(3), 317–331.
14. Wampold B. How important are the common factors in psychotherapy? An update. World Psychiatry, 2015; 14(3): 270–277.
15. Weck F. Topics and techniques in clinical supervision in psychotherapy training. Cogn. Beh. Therapist, 2017; 10: e3.
16. Kolb DA. Experiential learning. Upper Saddle River, NJ: Prentice-Hall; 1984.
17. Kalita L, Chrzan-Dętkoś M. Program stażowy jako skuteczne i opłacalne narzędzie zwiększania dostępności psychoterapii, Psychoter. 2018, 3(186): 39–53.
18. DeYoung P. Relational psychotherapy. A primer. London: Routledge; 2003.
19. Ringstorm A. Meeting Mitchell's Challenge: A Comparison of Relational Psychoanalysis and Intersubjective Systems Theory. Psychoanalytic Dialogues, 2010; 20. 196–218.
20. Brown J. Specific Techniques Vs. Common Factors? Psychotherapy Integration and its Role in Ethical Practice. Am. J. Psychother. 2015, 69(3): 301–316.
21. Zarbo C. Integrative psychotherapy Works. Front Psychol, 2015; 6: 20–21.
22. Frawley-O'Dea M., Sarnat JE. The Supervisory Relationship: A Contemporary Psychodynamic Approach. Guilford Press, New York; 2001.
23. Mendelsohn R. Parallel Process and Projective Identification in Psychoanalytic Supervision. Psychoanal. Rev. 2012; 99. 297–314.
24. Gallese V, Goldman A. Mirror neurons and the simulation theory of mind-reading. Trends Cogn. Sci. 1998; 2: 493–501.
25. Meissner W. Toward a Neuropsychological Reconstruction of Projective Identification. J. Am. Psychoanal. Assoc. 2009; 57(1): 95–129.
26. Norcross J, Popple L. Supervision essentials for integrative psychotherapy (clinical supervision essentials). American Psychological Association; 2016.
27. Tuckman W. Developmental sequence in small groups. Psychological Bulletin, 1965; 63 (6): 384–399.
28. Corey M, Corey S. Grupy. Metody grupowej pomocy psychologicznej. Instytut Psychologii zdrowia; 2008.
29. Jedliński K, ed. Trening interpersonalny. Wydawnictwo WAB; 2011.

E-mail address: l.kalita@psyche.med.pl