PSYCHOTERAPIA 1 (176) 2016
strony 59-75

Barbara Józefik[1, 2], Krzysztof Szwajca[1, 3], Marta Agata Szwajca[1]

THE ISSUE OF BORDERS IN THE SUPERVISION PROCESS

[1] Department of Child and Adolescent Psychiatry, Jagiellonian University Medical College
[2] Laboratory of Psychology and Systemic Psychotherapy
[3] Krakow Institute of Psychotherapy of SIEMACHA Association

Summary

The article presents a discussion of supervisors, representatives of various theoretical perspectives that took place within the Supervisor Conference on October 4th 2013 in Bochnia. Various depictions of the supervisory relationship were the point of consideration, with particular emphasis on the issue of boundaries between supervision and supervisee's therapy. Supervision is one of the basic forms of teaching psychotherapy, and it is the most personal one. It revolves around the relationship between the supervisee and the supervisor. The intensity of this process with high mutual exposure and emotional nature with its inevitable asymmetries and inequalities makes this relationship complex and unique. The feelings experienced by the supervisee in the process of therapy are a response to what the patient brings, but also reflect the psychotherapist's personal experience. Clarifying what is personal and what is relational, which is an important objective of supervision, may reveal very private, intimate themes. Hence an important question comes up: how to maintain a proper boundary between what should be the subject of reflection in supervision and what is appropriate in a psychotherapeutic relationship. The question was answered in a panel discussion involving supervisors representing the main psychotherapeutic approaches. In a personal discussion with many sub-themes, the panellists expressed their views in favour of essentially clearly marked boundaries and their non-transgression, or non-transgression as one of the variants without any particular value. Interaction, supervision processuality, responsibility, the need for awareness and self-restraint of the supervisor were discussed as well.

Key words: supervision, supervisor-supervisee relationship, borders on the supervisor-supervisee relationship

Opening remarks

Supervision is one of the basic forms of teaching psychotherapy. It is a process in which "a psychotherapist works with a more experienced colleague to constantly develop their skills" [1, p. 13]. It ensures the well-being of the patient and provides the therapist with a sense of safety. This simple, unambiguous definition does not reflect the complexity of the supervision process which covers various aspects and assumes different forms depending on the therapeutic approach, the context, the nature of the problem and experience of the psychotherapist and the supervisor [2, 3]. In addition to the educational and sometimes instructional aspects, an important feature of supervision is the relationship between the two

parties which includes negotiation to build an alliance. Lesser [4] emphasises the importance of this dimension when he says that supervision stands for joint establishment of the relationship and negotiating meanings. In the supervision process the psychotherapist brings in issues related to ongoing therapy but also other issues key to their professional development. The supervision relationship is as intense as the emotions with which the psychotherapist is confronted. Disclosure of feelings such as helplessness, anger, shame, guilt, enchantment is possible in a situation of trust and safety. Feelings experienced in therapy provide an answer to what the patient brings in, but also reflect the psychotherapist's personal experience. Clarifying what is the psychotherapist's personal theme is an important aim of supervision and it may open up personal problems of the supervisee. This leads to the important question of how to maintain a suitable boundary between what should be the subject of supervision and what is appropriate in the psychotherapeutic relationship.

It is worth noting that psychotherapy is a different field than supervision. The aim of the former is to bring to an end the suffering of the patient and to develop their potential, whereas the aim of supervision is the well-being of the patient. It is implemented "through a thorough reflection and critical study of the therapeutic relationship, making space for reflection on the process of psychotherapy; looking for connections between practice and theory" [1, p. 14 and 15], as well as "encouraging the psychotherapist to realise the potential impact it has on the course of therapeutic talks" [5, p. XI]. The complex context of the supervision relationship, which consists of dependency, hierarchy, trust and safety, may promote the supervisee's regression and willingness to share their private matters.

The question formulated above prompted us to invite representatives of different psychotherapy approaches and practices to a panel discussion to share their reflections on this issue. The script of a discussion which took place in Bochnia on 4 October 2013 during the Supervisors' Conference organised by the Psychotherapy Section of the Polish Psychiatric Association is presented below.

<Barbara Józefik>

I would like to begin our discussion with the most basic issue, namely how is supervision understood in the approach you represent since we know that there are many definitions, that it is a complex process, many phenomena occur during the supervision process. So let us see if your ideas are similar. Are there any differences? I would also like to ask you to reflect on the supervision relationship.

<Krzysztof Rutkowski>

What is supervision? From the psychoanalytic point of view which I present, it is something of distinctly advisory nature, to put it succinctly. When I was listening to the discussions earlier today and there was talk of immense responsibility and even taking over responsibility for the supervisee, it occurred to me that what is important and historically stems from psychoanalysis, is a specific kind of outlook. A certain common process occurs firstly at the level of the patient and the analyst; later this process becomes visible and is verified one way or another, depending on the needs of the analyst, i.e. the supervisee

supported by the supervisor. It is harder for me to imagine a more paternalistic approach which may be helpful. This is because, now moving on to the second point, that of the boundaries, the patient has direct transference and in analytical work it is an almost everyday phenomenon. So it is impossible to imagine a supervision process which does not take this phenomenon into account on the level between the supervisee and the supervisor in such a way that it could either directly concern the relationship between these two people, but could also take place on an unconscious, unintellectual level, and this process occurs between the patient and the analyst.

<Jarosław Gliszczyński>

I have an identity conflict as a supervisor. I represent psychodrama, which I consider a distinct therapeutic approach, historically the second school, therapy group which follows psychoanalysis. I am also a psychotherapy supervisor. I was one even earlier, before I became a psychodrama supervisor which only happened two weeks ago, after 20 years of education.

Therefore, I will describe the supervision process from the perspective of my modality, but there is a vibrant question about my supervision identity in me. Supervision in psychodrama does not differ substantially from the very psychodrama – both are a kind of experimental theatre. Psychodrama is a kind of play in the course of therapy; it is used therapeutically and for therapeutic purposes. Its essence is to play roles. Role reversal is not only a technique but also a way of understanding relationships and understanding people to a large extent. Psychodrama is primarily a method which expresses itself in action, that is, a greater role from the verbal one is played by acting and experiencing all kinds of situations in the defined field of psychotherapy. Defined meaning one that is neither emotional reality, nor the inner world of our patients. Therefore, play-acting and experimentation also occur in supervision. Extending the reality is a term which is very important in psychodrama and which accompanies us psychodramatists. Its counterpart in psychoanalysis is corrective emotional experience to put it briefly. Therefore, extending the reality, going beyond reduced reality, also takes place in supervision, meaning that play-acting takes place in supervision. And it is an essential tool in supervision, in which the supervisee has the opportunity to experience different roles; for example, how it is to be in the role of their patient, how difficult it is to take on the role of the therapist, how one can experiment with different kinds of behaviours that help to work through transference in a specific way, unlike in psychoanalysis or in the psychodynamic approach.

<Zofia Milska-Wrzosińska>

In the psychodynamic approach, supervision may be understood as a form of professional development or professional learning. How this development or professional learning takes place largely depends on the stage of the supervisee's development. The needs of a person who is at the beginning of their professional development are completely different from those of an experienced person: for example, if Professor de Barbaro wanted supervision, both forms would be different. But how does this form of professional development different from the others? It applies largely to assistance in grasping phenomena

which for some reason the supervisee does not see or sees only partially. The scope of assistance depends on the stage of the supervisee's professional development. It may sometimes mean the supervisor showing something and at other times that the supervisee reflects on something in the course of supervision. However, in contrast to such forms as e.g. workshop training, or theory, or joint diagnostic groups, where the patient may be jointly diagnosed psychodynamically with mutual support from everyone, in supervision in the strict sense we are talking about transference of emotional or relational aspects and reaching what is hidden. The methods depend on the supervisor's assumptions, and on the stage of the supervisee's development.

<Bogdan de Barbaro>

I agree with what Zosia has said that supervision depends on the stage the supervisee is at. Therefore, I see it as a kind of continuum, from a situation in which a supervisor is a teacher in a relationship with a student to the other extreme, where I would see the supervisee as a creative participant in a dialogue. And where between the two extremes the dyad is located will depend on the stage of the supervisee's development. If we were to seek some elements related to social constructionism, I would say that the supervisor has to be useful. It is not their task to find out the truth in the strict sense of the word, but it is their task to find a usable version. What seems more important to me, especially considering the extreme close to symmetrical dialogue, is the supervisor as someone who presents their thoughts. This is in contrast to psychotherapy with its "push" and "pull" where we either push someone to do something or pull them to do something. In supervision we neither push nor pull, but we present, and the supervisee may choose from the supervisor's thoughts what they like. Of course, the responsibility will be different in case of a person starting out as a therapist and in such a case, the role of almost an educator seems necessary. My answers in the role of the supervisor should be responsible, and therefore adequate, complementary to the needs of those who come for assistance. I also agree with the belief that in supervision there should be respect for the supervisee, concern for safety and an atmosphere of mutual interest.

<Zofia Pierzchała>

I agree with what the professor has said at the end. The humanistic-existential approach is based on a relationship marked by mutual respect, interest and dialogue, which develops "here and now" through the growth of both people concerned. Such an approach is based on philosophy and equips us with a methodology and way of thinking. Philosophers have guided psychotherapists to look at values and the human being in general, at specifically human values, which have so far been the domain of philosophy and which now belonging to psychology. Values such as love, freedom, free choice, search for the meaning of life.

I would like to draw your attention to the definition of supervision as a relationship between the Two, where firstly the client comes to see the therapist and secondly the therapist comes to see the supervisor. So we have to consider the two relationships which must be based on what happens in them. I am particularly close in this regard to the views of Martin Buber. According to his approach we may consider supervision as a situation which from the

point of view of the client is described as a meeting about them without them. From the point of view of the supervisee it is a discussion over their competence and personality traits which allow them to be the therapist of that particular client. If this situation is beneficial for both, the supervisee and the supervisor, then the Rogerian demand of growth of the Two as a result of the Encounter is being met.

<Magdalena Sariusz-Skąpska>

In the cognitive approach the issue of what is supervision is very difficult. A description is necessary of how the cognitive paradigm has changed over the past three or four decades to be able to say how the term was originally understood and how it is understood today, in light of the so-called third wave of cognitive therapy, in which therapy models we rely on they are very sophisticated. Therapy takes a long time and it is therapy of patients with complex problems. It may also be said that originally supervision, as its name suggests, was a kind of superintendence of the therapist, superintendence of a more technical nature. Following the changes in this paradigm today we may talk about some kind of continuum between the technical and relational aspects. Working with the supervisee only on how they work as a therapist from the "technical" aspect (where various assessment tools are used) is insufficient due to all relational aspects. Thus we use the continuum between the technical aspect and own work of the therapist with their own cognitive patterns. Increasingly, we use the pattern therapy or dialectic therapy where the aspect of supervision which involves own therapy cannot be avoided. Supervision is therefore on the one hand monitoring of the therapeutic process: the supervisor sees things which the therapist cannot and does not see. I am not even talking about mistakes, but about some aspects which are worth noting in the therapeutic process. On the other hand, apart from the monitoring, elements of the therapist's own themes always appear in the context of patterns which are opened up, for example, the frequent pattern of devoting oneself which affects the quality of their work.

<Krzysztof Szwajca>

I have the impression that you have been talking a lot about equality, partnership, common development, complementary needs and flexible adaptation of the supervisor. And what about skewness or authority relationship with which we are also dealing in supervision? And one more aspect, you mentioned supervision "tailored to the needs". And what if a part of these needs is the need for regression or the need to work on the own themes of the therapist?

<Barbara Józefik>

I would also add that there is a theme here of own development, support and learning, as well as dealing with personal themes. This is a topic which is interesting for us, we all basically agree that the therapist's own work constitutes a separate training and is not way the same as supervision. But at the same time in the supervision process we have access to such experiences which will be connected to what I shall generally refer to as own work. In your thinking and approaches is there place to take up themes of own work or isn't there by

definition. And if so, where are the boundaries? How to do it? After all the supervision relationship, with all that respect and understanding, is also an assessment relationship. There is also an element of authority in the relationship.

<Jarosław Gliszczyński>

This is a very interesting issue. I wondered before the discussion how to mark out the boundary in psychodrama which I represent. I noticed in my own work as supervisor that depending on whether I am closer to the psychodynamic approach, or to psychodrama, I use a different "language". And that different language makes me a different supervisor in the two approaches. It makes me think of research on personality changes in bilingual people, depending on which language they speak. When I am using psychodrama, the boundary between own therapy and supervision shifts and is not rigid. It seems to me that it is related to the specificity of psychodrama as an approach in which the therapist is much more transparent than in other approaches. For example, in a therapy session a so-called "shake" is produced, which means sharing what is personal also for them and it is very different from psychoanalysis, or the psychodynamic approach. Besides, in supervision we often using play-acting: the therapist assumes the role of their patient, the patient's mother or their psychotherapist and, in a sense, in the process of supervision they play their own psychodrama, but in a substitute role, not in their own identity. In psychodrama this is called psychodrama with an auxiliary protagonist. Therefore, we don't just talk about the process of therapy, we act it out. If the therapist is in the role of their patient, they play a role, it is not possible without activating very personal themes in themselves. How they act their patient depends on both the patient's and therapist's own world. In view of the fact that such work is very involving, one cannot disregard in supervision what the therapist brings in. We frequently do not stop at a conclusion that there is an unresolved issue or the therapist's problem to delegate it to his/her own therapy. Of course, psychodrama does not completely blot out the boundary between supervision and own therapy and naturally own therapy is a big and distinct part of psychodramatist training. However, in supervision, we go a step further towards the exploration of the inner self of the therapist using specific psychodrama tools. Therefore, to answer the question about the boundaries, it seems to me that they are set a little differently than in many other approaches.

<Barbara Józefik>

Would it mean that the next supervision session could be dedicated in a planned way to the therapist's own work? Is that how it is in this approach? It is obvious that in supervision we touch personal themes of the therapist, but the question is, what does it mean exactly that we touch them. How deep do we go? Is some own work possible in the supervision process, in the sense that the problem is investigated, not just named?

<Jarosław Gliszczyński>

Unfortunately, I have no single answer to this question because psychodramatists differ from each other in this respect. And even when I read various supervision reports

written by different psychodramatists, I see that there are those who go in this direction, and even at some point do the work of a therapist. But many do not. So it is an issue not yet fully established. There is no standard in this respect. In contrast, supervision in the educational process of a psychodramatist is very interesting because this more advanced process of education is primarily based on live supervision. So there is a group process, people do fragments of therapy, i.e. there are roles of psychodrama therapists, there is the supervisor, who reflects on it and immediately provides some advice and information. So at the same time in the process of learning, self-therapy takes place because the participants of the training group are sometimes in the role of the therapist or in the role of the patient in the protagonist's psychodrama. Therefore, there is a lot of role reversal between the role of the patient and therapist, which is quite fruitful in the process of learning. Quite often I use this element of psychodrama during the supervision of non-psychodrama therapists because it teaches flexibility, moving from empathy to distance. From being in someone else's shoes to being in the role of the therapist. Therefore, in the process of therapist training both take place in the same location, but are not done by the same person.

<Zofia Milska-Wrzosińska>

I can answer this question more unambiguously. In the psychodynamic approach this difference exists and it is very clear, boundaries are clear and I would say that they should remain so. Of course, respect and openness to others are needed everywhere, in any profession which involves working with people. However, professional activity in the psychodynamic approach is understood differently. Many decisions have been made not to confuse and blot out the boundary between supervision and self-work, both in terms of the work methods and in organisational issues. And by the way, let me say that perhaps the reason I like this approach so much is that at the beginning of psychoanalysis it was different, I would say that it was quite the contrary. Successive psychoanalysts, beginning with Anna Freud, generally took their training with people who had analysed them. In the case of Anna Freud it was her father. Melanie Klein was analysed first by Ferenczi, who later began to prepare for her for her work and eventually she cooperated with him. She had the same relationship with Karl Abraham. Melanie Klein was eager to supervise Winnicot when he was analysing her son, whom she had analysed a little earlier. Roles were often mixed. I think that maybe the rigour which later began to emerge is a response to the trauma of the early double and sometimes triple bonds and various negative phenomena which occurred in this early period. I identify with the rigour: the supervisor's and the therapist's roles are different and they should be two totally separate elements of work. Similarly, psychotherapy or own experience, should be as distant from training and supervision as possible. Various schools of psychotherapy, especially the psychoanalytic one, take great care not to confuse these two orders, so that the patient who also learns psychotherapy retains a sense of safety. We the people who think psychoanalytically, sometimes have our doubts whether the so-called self-experience groups which appear at various courses are the optimal solution. Especially, if they are taught at the course by more important people or if the self-work takes place in the group in which the therapist later studies.

What is the difference between working with the patient and working with the supervisee? In the work with the patient, the psychodynamic psychotherapist is focused on the inner experience of the patients, on what is happening to them, their emotions, but also on their relational patterns when it comes to the more external phenomena. This is what focuses the therapist's attention, this is what they deal with, what they analyse as closely as possible and as thoroughly as the patient is ready for, the psychotherapist has such opportunities. In supervision, however, the situation is different. In fact, the patient, the patient's emotions, the patient's experiences, the patient's relational model are at the centre. The supervisee's emotions are important to us, the supervisee's emotions tell us something, but only in the context of their work with the patient or patients, this follows from the parallel occurrence of the two processes. And it is a completely different way of working, a completely different way of talking, a completely different way of contact. If for example, I notice that my supervisee has a tendency to attribute anger to patients and the patient rather displays despair and hopelessness, I ask whether there are other emotions which appear, and they may accept such a question or not. However, if it is a kind of reaction treated as transference which persists and will be present in our supervision process repeatedly, then I attract their attention to the fact that it is a problem which needs to be looked at in their own psychotherapy. But I do not deal at the supervision with how they understand that they are prone to this kind of reaction. I would regard it a transgression of the frames of the supervision process. I do not think I have the legitimacy to do it, I do not have the contract. My job is to tell them: "Look, this has appeared for the fourth time this year. It makes me wonder. What do you think?" Sometimes you have to draw the line. If countertransference appears in the supervisee in the form of crossing some boundaries, then I as the supervisor may say that I do not agree. In psychotherapy, I would not say that unless it was a physical attack on the psychotherapist or some other dramatic breach of the rules of social coexistence. I think that supervision and psychotherapy are simply different ways of functioning, even though at the overall level they require a similar attitude. But once again I would like to emphasise that the focus of our attention is always the patient, both in psychotherapy and in supervision. And this is an important distinction, because in psychotherapy we deal with the patient, and in supervision we have to deal with the patient indirectly.

<Barbara Józefik>

And if we consider that the therapeutic relationship lies at the centre?

<Zofia Milska-Wrzosińska>

The therapeutic relationship is to serve the patient and not the psychotherapist. It's good when it serves the psychotherapist, but it has to serve the patient.

<Zofia Pierzchała>

I would like to draw your attention to the relational aspect where the supervisor actually deals with the relationship atmosphere which the supervisee creates with their client. In this sense, the contents provide evidence of parallel processes. From the humanistic-

existential perspective the supervision relationship is guided by people puzzling over the well-being of the client. There are certain moments in which the therapists-supervisees do not understand something, they feel bad about something, they make mistakes, or are aware of an impasse. Something in therapy "is not working". They open up areas of their own difficulties before the supervisor. They say "help me". A long-term supervisee-supervisor relationship abounds in such moments. Then the supervisee asks the supervisor to address the issue which cropped up when discussing what happened at the sessions with the client. I occasionally take the role of the therapist for my supervisee because he/she has no other option for self therapeutic work, than during my supervision. Why? Because they come from a small town, because they finished their own psychotherapy a long time ago, because the resumption of their therapeutic process is impossible due to limited time until the next meeting with the client (e.g. in two days), because they are convinced that one-off work over his/her limitations or problems is enough, etc., etc. I trust that the therapist is a mature person, that assimilation of the effect of therapeutic intervention is enough to effectively help their client. Sometimes at supervision, a therapeutic process happens incidentally, just once, so that the therapist regains the strength and power of the therapeutic "self". I do not, however, transform supervision into therapy. It would be a mistake. Experience has taught me that in the process of training young psychotherapists the supervisor is the object of different expectations. At the beginning of training the future therapist usually expects and needs specific information, specific instructions, specific "regulations", a great deal of support. Intermediate students already have the knowledge and the necessary skills to conduct therapy. They are afraid of making a mistake. They are often focused on their own experiences, and then usually there is the question about the possibility of therapeutic work on a specific topic or issue during my supervision. When I see independent psychotherapists, usually with the certificates, supervision becomes a meeting of professional colleagues and then requests for a therapy session under supervision are not numerous. And if they do appear, I do not refuse. For a moment I become a therapist, and having worked out difficulties, supervision is naturally continued. Together we analyse the client's therapy.

<Bogdan de Barbaro>

I am sitting between the two Zofias, I understand that you differ and I will try to describe the situation in the middle. I will begin with a reflection on an important text by Penn, Sheinberg entitled "Is there therapy after consultation?" [6]. This article shows that in the context of family therapy if in-depth consultations are carried out and a problem is investigated thoroughly, it may turn out that the questions asked by the consultant necessitate finding important answers by family members and finding those answers results in a change in the family. New ideas appear which create a new reality. I see this as an analogy to the situation of supervision. It may be that supervision if this term is applied is a kind of creative dialogue and such a meeting could lead to new descriptions, new names, or finding new keys, and it may inspire change in the therapist who is being supervised. So if we refer to the category used by Zosia, that there are two trends, I would say that there are two trends, assumptions, and that these two trends meet at some points. In other words, investigating

something may generate change. If we assume that supervision is only a kind of investigation and therapy has to result in a change, it may be imagined that the investigation itself also may lead to a change.

<Barbara Józefik>

Zbyszek, I have one more question for you. I understand that you are talking about a theoretical model. I would like to ask about the practical side, how you would work with a person who is starting out or is in supervision training, which does not have the character of a consultation. In what this person presents, in the issues which are significant, associated with the feelings and experiences of the person – the therapist.

<Bogdan de Barbaro>

I would indicate. I would not go as far as saying something which would be therapeutic in nature, even more so I would not formally go into the role of a therapist, but I would additionally indicate that this is a matter which may be further explored with the help of someone else called a therapist.

<Barbara Józefik>

Do you as a supervisor of systemic therapy opt for analysing the family genogram of the patients, their family, and for comparing it with the genogram of the therapist and for tracking correlations between them?

<Bogdan de Barbaro>

Only as far as to the point of naming a problem or perceiving an analogy. Indeed, when I started to work as a family therapist, this is how I was supervised. We worked in groups: on one card we presented the genogram of the family in therapy, and on the second one, our own genogram. Analogies were perceived between an instance when I was at an impasse as a therapist and at an impasse in the therapy of this family and what was a hot spot in my genogram. But when my supervisor said, "let's now deal with your unfinished mourning for your great-grandfather", it did not succeed. It only got to the point of naming.

<Zofia Pierzchała>

I just wanted to add something. This point when the supervisor tells the therapist: "this is your problem", "this has to do with your limitations", that possibilities for therapeutic work open up. However, I not encourage it, I do not suggest "let's do it now", or "let's do it together". The humanistic approach is strictly based on freedom of choice and responsibility. Both the therapist and the supervisor are two people with equal rights to decide whether therapeutic work on the therapist's problem which limits their therapeutic potential to the client should take place in the course of supervision.

<Magdalena Sariusz-Skąpska>

In the cognitive paradigm, we would ideally like to have a therapist with completed training who is a certified cognitive therapist, who has done self work and completed work on themes which they had been working on during the four-year training.

But of course this is not always the case, and hence the usefulness of the concept of the continuum. A newly trained therapist expects concrete help and guidance. Especially clearly they formulate the question: "what am I to do next?" They have very specific and technical questions. The continuum between the technical and relational aspects develops during the training, during the supervision as well. With time and experience acquired by the therapist, they move from themes related to strategies to various own themes. A suggestion was made here that it would be good if the supervisor's noticing of the therapist's own theme resulted in concentrating on it, stopping and working on this problem and that it would be good if it was limited to this one consultation so that the therapist would be trained to know how to deal with this theme. Of course, sometimes we suggest considering self work, but not in the context of work with the supervisor. If work on their own themes exceeds one or two consultations, it is worth considering seeing a therapist. However, the intertwining of supervision and therapy seems to be inevitable, especially in the situation of complex problems of the patients with whom we work.

<Krzysztof Rutkowski>

Referring to psychoanalysis, but from today's perspective, I would like to emphasise the equality of the two people involved in the process of supervision, e.g. in decision-making. It is hard to imagine analytical work without what you have recalled, that is knowing, recognising own emotions. The only difference is that we do not share them, which is similar in the process of supervision. It is hard to imagine a precise contract regarding boundaries between self-therapy or therapy in general, analysis and supervision. And it is impossible to arrange with the supervisee that their unconsciousness will be revealed in the analysis but not in supervision. It is obvious that it will be revealed. It may be included in the contract that we will work on the origin of the contents disclosed in supervision. We assume that they are the aforementioned parallelism. It is difficult to tell someone, "here is your problem, go solve it yourself". We rather say "such a phenomenon occurred there" and it is the supervisee's or the analysed person's responsibility to search for the origins of this phenomenon. We do not ask at the time of supervision, "and what are your associations with this, where did you get it from?" On the other hand, please allow me to disagree with the statement that the supervisee's emotions are not in the spotlight, are not important, and the patient occupies the first place. I would say that this happens in descriptions, and even there not fully so because there is always need to add something about transference and countertransference. It is difficult to describe some phenomena which occur in the relationship and take place at the conscious and unconscious level without considering the supervisee's emotions. How else to work e.g. on identification projection than by recognising their emotions? Then the supervisor uses the tool which is their own psyche. I'm not talking about knowledge, I'm not talking about the intellect to help describe such a phenomenon, but simply of the psyche. These phenomena which occur at the deeply unconscious level involve emotionally, but of course

their primary source which only stimulates and resonates in other psyches exists in the unconsciousness of the patient. What is very similar in both the analytical and the supervision processes is revealing of unconscious processes. But a very important and essentially uncrossable boundary is looking for reasons and working on them. In the supervision process we let the supervisee wonder about them rather than look for causes and by saying "it will be somewhere in your unconsciousness", we avoid describing the phenomenon as such. It's about what happens in the process from the point of view of supervision, in the process between the patient and the analyst, i.e. the supervisee.

<Barbara Józefik>

Have you ever broken these rules that you are talking about? Zosia and Jarek both say it is possible to do some self work and others say it is not. But have you ever been in situations or faced with a problem where it was possible to transgress these boundaries?

<Krzysztof Rutkowski>

This is going into the details of what I said a moment ago. Looking for the cause of the difficulty only in the supervisee and their psyche or in some of their unresolved complexes, it is a warning sign. We should reflect on what is happening, why we are exceeding the process, going beyond the observations of phenomena and try to find the cause which is very specific, precise and closed.

<Jarosław Gliszczyński>

I think it is no coincidence that some common features appear in the humanistic and psychodrama approaches. What is common are the roots of these two approaches, e.g. Martin Buber and the concept of the encounter. Psychodrama perceives therapy as a place of an encounter or a very important relationship associated with another person, but also associated with oneself and therefore, if it is related to the issue of own therapy and the boundary, I would tentatively formulate the hypothesis regarding psychodrama. Why is this boundary seen here a little differently than in the psychodynamic approach and in psychoanalysis? In psychodrama firstly we focus on resources. Of course, contemporary psychodrama does not ignore disorders but we are talking about gradation of significance here. Accordingly, the disorders are often understood as a result of lack of spontaneity and creativity which are two important concepts in psychodrama. In a sense, the therapist can "recover" in supervision, not necessarily only in their own therapy, because their horizon, creativity, spontaneity, and creative skills are developing. Of course, a vast majority of supervisors in psychodrama also do not change supervision into therapy. Like in psychoanalysis, in supervision exploratory work is done, which expands creativity, but if someone has really serious problems that reveal themselves in the relationship, then they are also referred to one or another form of therapy.

To conclude, it is particularly important to adjust the nature of supervision, firstly to the theoretical assumptions underlying a given therapeutic approach and secondly to what therapy looks like in this approach. There should be a certain analogy; we should apply similar rules at different levels. And perhaps in this context it may be understood why we

approach differently the issue of self-therapy and supervision. I understand perfectly the position of Zofia, who represents the psychodynamic approach because it fits there, other approaches may go with different concepts. It is particularly important to notice the specifics of one's own approach, and in the case of an integration of approaches, to consider each time what fits and what does not. If we integrate, it must also be done at the theoretical level.

<Zofia Milska-Wrzosińska>

Since I am to represent rigour, I will make it even more strict. In the approach I identify with, I cannot imagine myself becoming a therapist of my supervisee at one or several sessions. We see it as an unnecessarily complication and forming dual relationships. I do not see any reason to do so. Similarly, if you have been in own long-term therapy with someone (I do not mean short-term crisis intervention), then apart from some exceptional situations, you will not see that person for supervision, even after several years have elapsed. There would have to be special reasons for doing so. In general, it does not happen. It is a little bit more liberal in the opposite direction, from supervision to therapy. Although even there, after a long-term supervision relationship, changing it into therapy would seem quite reckless. Perhaps it would be possible in the case of participation in a supervision group. But basically, this kind of rigour or ban on mixing of roles is inscribed in the psychodynamic approach. Therefore, Basia to answer your question, such a situation has not happened to me since the time I started considering myself an adult therapist, which means quite a long time. My therapeutic youth coincided with the times when everything mingled with everything else, and it was difficult to determine whether something was training, therapy, practice or something else. So with the exception of the period of my youth, I have not done such things later. On the other hand, I think that I have transgressed a different kind of boundary, i.e. sometimes I mix up supervision with a personal relationship. So, when I see in the course of supervision that the supervisee needs something, I give them some support. Or I behave in a quite unfriendly manner if I believe that the patient has been particularly badly treated. I sometimes react personally, I do not always maintain a neutral stance of the supervisor, but I never go into the role of a therapist, and I see no reason why I should do it so I do not even have that temptation.

<Zofia Pierzchała>

I would also like to draw your attention to the identity of the supervisor, because it is very important who they are. Is it a psychotherapist with a specific set of skills and features? Is it enough to know psychotherapy? Or a teacher of this profession? Who am I in the role of the supervisor? In my capacity of a psychotherapist I engage my professional experience and knowledge to help the client to overcome their symptoms, to stop suffering beyond measure, to cope with problems, to live in a more happy and healthy way. When I act as a supervisor I also involve my professional experience and knowledge, but on another level. I help the therapist grow their awareness of being a therapist for a particular client at a particular time of the therapeutic process. I identify what they need: what knowledge, what skills to effectively help the client if they have a sense that something "is not progressing" or "is going wrong".

The focus of the supervisor's attention is the therapist and the patient and their mutual relationship, but awareness is focused on the client. Being a supervisor means joint responsibility with the psychotherapist for the condition and health of the client.

OPINIONS FROM THE AUDIENCE

<Jerzy Aleksandrowicz>

What you have said amounts to shifting the responsibility for what is happening with the patient to the supervisee. How does this relate to our declaration in the contracts with the National Health Fund that the supervisor ensures a correct course of therapy? Secondly, I feel that all of you are talking about supervision as if it meant helping a healthy person. Such an assumption results in a directive that if we notice disorders, we refer them to their own therapy which is no longer supervision, it is something else. That for a healthy person it is enough sometimes that the supervisor helps draw conclusions such as that the therapist needs some more profound work on themselves. But does the same apply to the area in which even an emotional echo of what is happening in the therapeutic process appears in the supervision, i.e. a relationship with someone who is ill and for whom such supervision is not enough?

Hanna Zielińska-Pinkowska: I would like to voice my opposition to such a way of perceiving people as either ill or healthy. I have the following experience with supervision: my supervisee has a difficulty which does not allow her to perceive correctly, for example, our relationship, but it pains her, also the relationship with the patient pains her and only in certain areas does it manifest itself and only at some points in supervision. I suggest own therapy, which she agrees to and we suspend supervision for some time. After this time, she comes back and works quite differently. And she is happy with that, and me too. And she is not an ill person; she is a person who has a mental difficulty in a particular area. And I am not to solve it. I can indicate that it is difficult and that it would be better to deal with it.

<Jerzy Aleksandrowicz>

Own therapy of a supervised therapist is something different from treating a disorder.

<Bogdan de Barbaro>

I think that your question, Jurek, is very important. Just like Hania, I think that distinction into the healthy and the ill is very risky and on the one hand I prefer to refer to the perspective of resources than to a category such as pathology. This is because I am close to a constructionist belief that there are no healthy people, there are only those who have not been diagnosed enough. So if I followed this path, then a concept of insight could intensify in me but it has a drawback: if I have the tool, I will discover a way of using it. And then this very important relationship between the supervisor and the supervisee which is to be based on a sense of safety turns into a relationship which is based on who will outsmart who. And this is a very serious trap in this relationship. The idea to outwit is an idea that we often unconsciously or preconsciously have because we want to feel wiser than the supervisee. But then the supervisee will present their problems so as not to be hurt by the supervisor and not

to get scolded for being ignorant or for failing to do something. From this point of view, the answer to the question of who is responsible for therapy will ultimately be the therapist. My job is just to talk to the supervised therapist, to make them feel safe enough to reveal their serious problems, not only to play a game called "I am a good therapist". This is a serious danger.

<Magdalena Sariusz-Skąpska>

I can agree with it although in the approach which I represent we operate with diagnoses, but generally we try not to use the notion of healthy/ill and it is a very important aspect. We do not put up such a visible boundary. We recognise the nature of the problem, but this is something a little bit different. In the cognitive approach, responsibility for one's difficulties in the therapeutic process lies on the side of the therapist, hence the function of supervision is particularly important, these difficulties need to be discussed owing to the very construction of this paradigm.

<Zofia Milska-Wrzosińska>

Using the metaphor of health and illness, if the supervisee turns out to be "ill", or brings such emotions or information to the process of supervision that show me that they harm their patients in many ways, that they don't work optimally, it raises a question about my responsibility. I feel responsible for the patient and my supervisee but I know my limitations, I cannot undergo therapy instead of the supervisee. I am responsible for helping them to obtain the best tool to cope well in therapy. But let's just suppose that in spite of my responsibility and work the supervisee will do destructive, bad things and make errors which result from their internal mental element which makes them do it. If there is no possibility of change, and I have tried everything I could do, I would clearly tell them that I do not agree with what they do. Continuation of supervision would mean endorsing it, and therefore I would not able to cooperate. I, as the supervisor, do not feel omnipotent, even if I want to.

Concluding remarks

The discussion contained numerous themes and was inspiring. We cite it almost entirely, convinced that the complexity of the topics presented and the lively, personal nature of what experienced supervisors have said lend special value to this text. In this discussion the question of the boundary between the supervision process and the psychotherapeutic relationship acquired numerous aspects, descriptions, various views. And of course, there is no unambiguous answer. Experienced and renowned representatives of therapeutic schools either agree with the view of essentially clearly marked boundaries and their non-transgression, or with non-transgression as one of the variants and without any special meaning. This seems natural. Therapeutic orientations really differ and provide their students with somewhat different sets of desirable behaviours and techniques. This also applies to supervision. But it is not clear whether this modality has the biggest impact on our functioning in our roles, including the role of the supervisor. Nancy McWilliams [7] writes: "Supervisors are as diverse and as specific as therapists. Most experienced teachers of therapy

have developed their own style, combining their personality with the task facing them" (p. 82). What significance for supervision do our personal features, our attitudes, our individual work style have? Ours, meaning both the supervisor's and the supervisee's. Interaction in this process is unquestionable and such concepts as complementarity, mutual impact and fitting, flexible, mutual adaptation are an integral part of the description of the supervision context. The importance of personal factors, personality traits and interactions or the context is perhaps all the bigger as these variables remain in the shadow of the paradigm in which we work. From this perspective, an important, though perhaps rhetorical question appears whether these therapeutic schools which put more emphasis on the clearly marked boundaries or those which accept their fluidity and interaction, better support what happens in daily practice, in a very personal, intimate meeting of two people which is to benefit the third individual (i.e. the patient).

In the discussion the importance of supervision processuality, dependence of its nature on the stage of work and maturity of the supervisee were also considered. It seems that it is easier to accept a vague boundary between supervision and therapy in work with more experienced supervisees when the roles are naturally less rigid, the relationship is more personal and the risk of their regression or infantilisation is small. Indeed, despite the inevitable asymmetries and inequalities in the relationship between the supervisor and the supervisee, no one (neither the dyad nor the client) benefits from excessive identification of the therapist with the supervisor, their over-idealisation, seeking "a perfect parent" in the supervisor [8].

From this perspective, it seems that the panellists talked about the same thing: about the need for awareness and self-restraint of the supervisor, who may notice something, name it, and suggest something... but not much more. Because supervision is not a therapy.

References

1. Gilbert MC, Evans K. Superwizja w psychoterapii. Gdansk: Gdansk Psychology Publisher; 2004.
2. Józefik B. Superwizja – perspektywa systemowa. Psychoter. 2010; 3:11–22.
3. Popiel A, Pragłowska E. Superwizja w psychoterapii poznawczo-behawioralnej. Koncepcje, procedury, narzędzia. Krakow: Jagiellonian University Press, 2013.
4. Lesser RM. Supervision: Illusions, anxieties and questions. In: Caligor L, Bromberg PM, Melzer JD, ed. Clinical perspectives on the supervision of psychoanalysis and psychotherapy. New York: International Universities Press; 1983.
5. Bird J. Constructing the narrative in super-vision. Auckland: Publishing Press Limited; 2006.

6. Penn P, Sheinberg M. Is there therapy after consultation? A systemic map for family therapy consultation. In: Wynne L, Mc Danile S, Weber T, ed. Systems consultation. A new perspective for family therapy. New York - London: The Guilford Press; 1986.
7. McWilliams N. Psychoterapia psychoanalityczna. Gdansk: Harmonia Universalis; 2011.
8. Berman E. Psychoanalytic supervision: The intersubjective development. Rel. Psychoanal. Vol. 2: Innovation and expansion, 2013; 28: 145–170.

address: martaszwajca@gmail.com