AAPC Diplomate Theory of Supervision Paper

Theory as Guide to Supervisory Practice: A Hermeneutics of Imitation and Reflection in Dialogue

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Theory emerges out of reflection on practice. Indeed, we can say, with Ricoeur, that theory is *imitative* of practice.[1] So it is that this paper begins with a supervisory case and that I return repeatedly to reflect on this case and a second case from the perspectives of my Kleinian object relations theoretical orientation, my pastoral theological method, and my supervisory theory. These theories are rounded out through a discussion of the interplay of anxiety and other dynamics in several modalities: in the individual and group supervisory process, in supervision of couples therapy, and in the impact of contemporary understandings of transference and countertransference upon the "teach/treat" dilemma in supervision. Reflection on practice is also the mainspring of ethics, which subjects both my practice and my theory to critical self-review. My thesis is that reflection on practice occurs in dialogue. It is object-relational, whether it occurs in the medium of practice in the supervisory relationship or among colleagues who practice this art.

THE CASE OF J WORKING WITH T

J was a 66-year-old supervisee with more than twenty-five years' experience as a high school English teacher. She was a gifted soprano soloist and church choir member who had excellent writing skills and often brought incisive illustrations from her knowledge of literary classics into

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peer group case and interpersonal group seminars. However, a pattern of conflicts appeared in J's occupational history. First she had conflicts with two high school principals to whom she reported. These conflicts, in which she felt "angry at the principal," led J to resign from these teaching positions in which she "no longer felt safe, supported or understood." At age fifty, J decided to leave teaching and go into ministry. After seminary, she began to have conflicts with judicatory officials to whom she reported. This prompted her to leave the roll of the United Methodist Church to become ordained in the United Church of Christ.

In her family of origin, J described her recently deceased mother as envious, hateful, and sabotaging of J from the time of her earliest memory. Mother had several psychiatric hospitalizations, and J survived childhood emotionally by attachment to her strong, loving father. In her nuclear family, J has been married for forty-one years to a high school band teacher, and this relationship is warm and stable like her relationship to her father. They have three adult children, all married, and several grandchildren. She has a strong relationship with her oldest daughter. Her second daughter married a fundamentalist minister, and she excluded J and her husband, preferring instead to be "adopted" by her spouse's fundamentalist parents and to restrict J's access to the grandchildren. J is close to her married son, who lives two blocks from her and whose children she babysits.

In spite of all her experience teaching adolescents, J was intimidated by her patient T, a seven-year-old boy diagnosed with conduct disorder who swore at her, called her a "bitch," and contemptuously tried to order her around in the play therapy setting. This behavior alternated with episodes of affectionate relating to J. It was difficult for J to recover enough from T's verbal assaults to assimilate my supervisory interpretations and the interpretations of her peers. T's behavior acted out his father's behavior toward both his mother who brought him to therapy and toward the pregnant girlfriend with whom the father lived. During T's episodes of affection toward J, he acted out the other side of his split relationship to his mother, whom he also loved. J was a receptacle for T's evacuations of the daily violence and contempt he witnessed in his home settings, as he lived sometimes with mother and sometimes with father and father's girlfriend. *Negative projective identification* into J was T's means to rid himself of the domestic violence that he could not metabolize.

T was already court-ordered to therapy with J, but we regularly reviewed the case in supervision from legal and code of ethics perspectives

to assess whether any additional "duty to report" issues had arisen, such as his possible exposure to abuse. Although father's verbal behavior toward mother and girlfriend remained an ongoing concern, T's behavior slowly improved and no legally reportable ethical incidents could be documented.

In individual and group supervision, J had difficulty thinking or reflecting on her therapeutic work with T. In J's countertransference, she felt flooded by T's violent regard for her as a bad mother ("bitch")—a flooding similar to that inflicted by her own disturbed mother. T's contempt toward his mother, his father's girlfriend, and J herself was similar to J's contempt for her own mother, for her high school principals, for her judicatory officials, and for the strong people in her peer group, all of whom were women. In response to T's *negative projective identification*, J *introjectively identified* with T, feeling as though she portrayed the bad mother he projected into her. Less apparent, and more confusing, was J's guilty feeling that she, like T, was a "bad, mother-hating child."

J agreed with my recommendation to resume personal therapy to do more intrapsychic work on these issues during the course of her training experience. Her mother-father split was also apparent in her fragile and persecutory supervisory transference to my female colleague in contrast to the more trusting and warm relationship she had with me. I liked J, but she often arrived for individual supervision feeling emotionally overwhelmed. She could describe what T did in the last therapy session and, with prompting, what she did in response. But, she was unable to articulate the psychodynamic meaning of what was going on in her work with T or describe how she might deal more effectively with T in therapy. Our exploration of these issues and my interpretations seemed to restore J to a more solid mode of functioning by the end of the hour, but she arrived for the next session feeling overwhelmed again, like she was starting all over. I would compare her learning progress in her work with T to the image of a stock market chart with many up-and-down spikes but displaying a very, very gradual upward slope.

THE KLEINIAN THEORETICAL ORIENTATION

This supervisory case illustrates many phenomena described by Melanie Klein and her followers. Kleinian object relations psychoanalytic theory comprises the core of my theoretical orientation, and since Klein's pioneer-

ing work began with the psychoanalysis of children, I will place J's case in the context of Klein's theory. Some history will be helpful.

Klein's perspective as a woman added immeasurably to psychoanalysis in that her innate relationality and perspective as a mother and child therapist became a source of metaphors she developed to deeply understand and describe psychodynamics. Although Freud spoke occasionally about "the object" and about patients' "object relations," it was Klein who elaborated and extended Freud's theory to develop *object relations psychoanalytic theory*. Throughout her life, she remained fiercely loyal to the basic tenets of Sigmund Freud, yet she was in theoretical disagreement with many ideas of Anna Freud and her colleagues of the Viennese diaspora who developed the ego psychology school of psychoanalysis.[2]

Klein discovered that although little children are not able to lie on the couch and free associate like adult patients, they do, indeed, free associate through their play. This led her to develop her "play technique" in which she interpreted the child's conflicts that are invariably acted out, or dramatized, through their play. She noted that more disturbed children suffered from inhibitions of play and that the most disturbed children were unable to play at all. For children, play is as much a window on the internal world as free association is for adults.[3]

The play technique not only revolutionized the methods of child psychoanalysis but also helped Klein extend Freud's theory and practice and led her to new discoveries. She realized that children need a proper psychoanalytic setting just as do adults and thus moved her work with children away from their homes and families and into her own consulting room.[4] In contrast to Hermine Hug-Helmuth and Anna Freud, Klein found that children do, indeed, develop strong transferences to their therapist and that it is both unnecessary and not psychoanalytic to take an approach to child analysis that is "educative" or that avoids the child's negative transference.[5] Moreover, Klein interpreted children's erotic phantasies in straightforward language, using correct anatomical terms such as penis, vagina and breast.[6]

The therapeutic results were dramatic as Klein worked with children, some of whom were very young.[7] Moreover, this work led her to make additional discoveries. First, whereas Freud dated the Oedipus complex as occurring from ages four to six, Klein observed a little girl, "Rita," age two years and nine months, who was having phantasies of her parents' intercourse that indicated Oedipal dynamics were already well under way. Second, Rita's night terrors of a "punishing mother" indicated that her super-

ego was already taking her to task for her jealousy of her parents' conjugal relationship that excluded her.[8] Whereas Freud saw the superego as "a precipitate" at the conclusion of the Oedipus conflict (at age six),[9] Klein found early superego and Oedipal dynamics in children before age three. Klein's play therapy with children, in real time, contrasted with Freud's retrospective investigation of child development through the lens of adult patients free-associating on the couch.[10] Klein agreed that people pass through the developmental stages that Freud described, but she found they enter these stages earlier than he had thought.

Working with very young children, Klein also discovered their early relationships to "part-objects" such as the "good breast" and the "bad breast."[11] As cognition develops, children realize that the good breast and the bad breast belong to the same mother, whom they need and love. Normal splitting between the good and bad breast in the first months of life gives way to ambivalence toward mother, which is characteristic of "the depressive position."[12] Children with developmental problems, due to either nature or nurture, have difficulty achieving the depressive position and experience frustration as acutely persecutory. When they suffer from persecutory anxiety they are said to be functioning in the "paranoid-schizoid position."[13] These developments led to Klein's theory being known as a *positions theory*. She held that people oscillate between the paranoid-schizoid and the depressive positions throughout the life cycle. In clinical practice, Klein and her followers found that attending to moment-to-moment shifts in the patient's position enabled them to make interpretations in the immediacy of the shifts the patient makes within his internal world. These discoveries also enabled them to work with patients who had personality disorders as well as other more deeply disturbed patients, both children and adults.

For Kleinians, the depressive position, characterized by ambivalence toward the object, is equivalent to what Freud called the "normal neurotic" level of functioning, whereas the paranoid-schizoid position corresponds to functioning in the borderline-manic-psychotic range in which splitting is prominent. These positions are thought of as occurring on a continuum from adjustment disorders and mood disorders on the higher end to personality disorders and psychoses on the lower end of the range. Episodes of panic or outbursts of anger are examples of a relatively normal person's momentary movement into and out of the paranoid-schizoid position. Kleinian therapists and supervisors are always attentive to the presence, and degree,

of fluctuations of persecutory anxiety in the patient's functioning from moment-to-moment in the treatment setting.

It is also critical for supervisors to monitor these fluctuations during dialogue with a supervisee. A spike in the patient/trainee's persecutory anxiety is a signal, in the moment, that a pause is needed to explore and interpret the anxiety. Empathic therapists and supervisors who are adept at this this can avoid many impasses before they blossom. As we know from William J. Mueller and Bill L. Kell,[14] and from Bion,[15] too much anxiety blocks the patient/trainee's capacity to learn from experience. On the other hand, too little anxiety deflates motivation to participate in therapeutic and supervisory experiences in which learning occurs. As with Goldilocks and her soup, the anxiety level should be "just right."

The leading post-Kleinian theorist is W. R. Bion. He extended and elaborated Klein's theories in penetrating ways, centering on the deepest processes of mental functioning. *Reverie, containing,* and *alpha function* are three such processes. Reverie is a mother's

> state of calm receptiveness to take in the infant's own feelings. . . . Having taken in the infant's feelings, she then gives them meaning (*containing*). The idea is that the infant will, through projective identification, insert into the mother's mind a state of anxiety and terror which he is unable to make sense of and which is felt to be intolerable (especially the fear of death). Mother's reverie is a process of making some sense of it for the infant, a function known as 'alpha function.' Through introjection of a receptive, understanding mother, the infant can begin to develop his own capacity for reflection on his own states of mind.[16]

Applied to the roles of therapist and supervisor, the functions of reverie, alpha function, and containing are Bion's ways of understanding elements of the therapeutic and supervisory process. The therapist or supervisor provides a calm *reception* of the patient's/trainee's projections or transferences (reverie), she *digests* these inchoate projections into material ready for thinking (alpha function), and through *interpretations* (hypotheses), she returns the material to the patient/trainee for use in therapeutic or supervisory reflection and exploration (containing).[17]

Through reverie, the therapist/supervisor seeks contact with the font of psychic activity, the point where human instinct crosses over from soma to psyche. For Klein and Susan Isaacs,[18] instinct emerges into psychic life as *unconscious phantasy*. As R. D. Hinshelwood puts it,

> When Isaacs called unconscious phantasy the 'mental representative of instinct' she conveyed a conversion process of some kind across the

> body/mind discontinuum. Bion gave the conversion process the name 'alpha function' and began to fill in the clinical detail. . . . The term 'alpha function' stands for the unknown process involved in taking raw sense data and generating out of it mental contents which have meaning, and can be used for thinking. These resulting products of alpha-function are *alpha elements*.[19]

Symbol formation is based on alpha function. Words, numbers, mathematical signs, religious images and gestures, artistic productions, etc., all emerge from the realm of unconscious phantasy via alpha function to inhabit the kingdom of symbols. Speech, text, and thinking are all symbolic; feelings also cross over the body/mind discontinuum to be expressed in words, gestures, actions, or acting out. So, Klein and her followers would concur with Paul Ricoeur's dictum that "the symbol gives rise to the thought."[20] The "talking cure," and the supervision of persons learning this art, live in the kingdom of symbols. Moreover, we need these healing arts because we live in an imperfect world where people not only misuse symbols and language, but at times alpha function itself malfunctions, thoughts become bowdlerized into delusions and hallucinations, and mental illness develops. As Hinshelwood puts it,

> When alpha-function goes wrong or fails, another (abnormal) kind of mental content is generated, which Bion called *beta-elements*. [These] . . . particles of 'undigested' sense data accumulate . . . [or] agglomerate into collections . . . (a schizophrenic's 'word salad' type of speech). These accumulations are processed by evacuation, not by thinking thoughts into dreams and theories. The process of evacuation is that described by Klein as projective identification in its pathological form.[21]

Two notable Kleinians who pioneered psychoanalytic work with the defective mental processes of psychotic patients were Bion[22] and Herbert Rosenfeld.[23] They and their colleagues also identified elements of psychotic process in neurotic patients which, when understood as such, can be treated more effectively.[24]

A SUPERVISORY REVISITATION OF J'S TREATMENT OF T

As J's supervisor, my Kleinian perspective enabled me to recognize three factors in this case. First, J failed to maintain a state of reverie because she was overwhelmed by T's hostile, intrusive, negative projective identification. T needed to evacuate the intrusive rage he saw his father act out on his mother and on father's girlfriend—a rage that flooded and overwhelmed T's own childhood capacities to metabolize this experience. T's

only recourse was to "identify with the aggressor" (father) and seek to overwhelm his female therapist as father did to the women in his own life. The second factor was J's reception of T's violent projections. J's history of being violently overwhelmed by her mother's negative projective identifications left her vulnerable to similar events later in her life, including negative and/or suspicious feedback from school principals, from church judicatory officials, from her female peers, from her own fundamentalist-convert daughter, and now even from T—a seven-year-old boy patient. Her personality structure as her mother's daughter set J up to introjectively identify with others' negative projections that she could not metabolize. Third, I helped J understand and interpret T's use of what Klein termed *manic defenses*, which he internalized from his father. T denied his own weakness, vulnerability, fear, and depression by imitating his father's omnipotent behavior of aggression and disparaging triumph over others. He sought to control his mother and his therapist while idealizing his father's antisocial behavior that was destructive of others and ultimately of self as well. The manic defense was all too toxically familiar to J, whose mother had used it on her. My supervisory stance gave a calm receptivity (reverie) to J's confusion and despair. In reverie, my alpha function converted experiences J could not digest into thoughts or interpretations ready for J to use in thinking, functioning, interpreting, and reflecting from a professional ethics perspective as a therapist to T rather than as his victim.

My supervisory interpretations of these phenomena during individual supervisory sessions restored J's capacity to relate as a competent therapist/mother to T in the next session. But her incapacity to hold onto these interpretations in her sessions with T reflected her need to return to individual psychotherapy to shore up her identity vis-à-vis the destructive negative projections of her envious, mentally unbalanced mother. Her persistence in individual psychotherapy and our joint persistence in supervisory sessions led to J's gradual differentiation from her mother's negative projective identifications and from the negative projective identifications of T in their therapeutic situation. As a new therapist, she was learning to retain "a mind of her own."[25]

METHODOLOGY FOR SUPERVISION, TEACHING, AND ADMINISTRATION

I maintain a balance between teaching, supervising, and administrating. Teaching in the American Association of Pastoral Counselors (AAPC)–approved curriculum of the Alamance Institute for Pastoral Counseling doctoral program carries a responsibility to impart a broad array of didactic content necessary for the formation of pastoral counselors in training. On the other hand, in leading group process, group case conferences, and individual supervision I deploy an analytic, interpersonal supervisory approach.

Excluding the concrete details of center administration, teaching, and supervision, I specify three aspects of my supervisory methodology: my *supervisory style*, the *supervisory approaches* I take with specific students, and the occasional *supervisory stances* I take with students to cope with the educational and interpersonal crises that arise from time to time. I think of my supervisory style as congruent with my Myers-Briggs type, which is I/E,NTJ. In this mode, I take on an analytic attitude of active, receptive listening (reverie) that leads to interpretations—all within the parameters of a carefully monitored setting. Adjunct to my supervisory style are modifications of that style. I call the first modification my supervisory approach, which takes into consideration the unique interpersonal style and gifts of the trainee. In this mode, I pay attention to how much or little structure, support, or confrontation the trainee needs in order to learn from the supervisory experience. My supervisory approach is the application of my style of supervision to the specific needs and character structure of a particular student.

Finally, when a trainee has a personal or professional crisis, I assume a supervisory stance that is my adjusted and temporary approach to any sudden change in the trainee's capacity to function. For example, with my trainee J (above), I became a bit more active and structured when she arrived in a state of panic or despair for supervision of her work with T. As the crisis resolved, usually within the same session, I was able to return to my supervisory approach. In Kleinian terms, I view J's crises as movements into and out of the paranoid-schizoid position, and the supervisory approaches, or stances, I took represent my shifts to remain congruent/symmetric with her state of mind. However, with some trainees, their crisis does not improve rapidly, if at all. In these cases my supervisory stance becomes my new supervisory approach.

HERMENEUTICS AND SUPERVISION OF PASTORAL COUNSELING

In 1881, Anna O described her psychotherapeutic work with Dr. Josef Breuer as the "talking cure." Her metaphor has since become a touchstone for the work of psychotherapy and psychoanalysis.[26] From cradle to grave, it is through speech, text, and dialogue that humans come to self-understanding in relation to each other. Christians, Jews, and Muslims are known as the "people of the book." All ancient texts began as oral traditions, stories people told each other and handed down for generations until they were written and redacted to reach their current canonical form.[27] From children's bedtime stories and prayers to rites for commendation of the dying, we are formed, nurtured, and carried through life by words.

Anton Boisen saw persons as "living human documents."[28] Supervision of psychotherapy is also done through speech, writing, and dialogue. Theology, theories of psychotherapy, codes of ethics, learning, and supervision are conveyed through the media of speech, text, and conversation. For Ricoeur, myth and symbols emerge from the primal origins of pre-verbal human experience, both historically and developmentally. Myth and symbol are the taproots of human self-understanding, and they converge to form speech and writing.[29] As such, "the text" becomes his metaphor for self-reflection. Ricoeur applies his model of the text to three types of enquiry: narrative in literature, exegesis in biblical studies, and the mind as a text explored by psychoanalysis.[30] In each, he finds a threefold hermeneutical process ("hermeneutical circle") through which persons move into deeper self-understanding.[31] Parenthetically, the level of myth and symbol for Ricoeur corresponds with the Kleinian understanding of unconscious phantasy as described by Isaacs, as the first appearance of mentation to occur as impulse crosses over from soma to psyche.[32] Hanna Segal also explores symbol formation.[33] Bion gives a similar account of these phenomena in his description of alpha function, which converts unconscious mental contents into consciously representable symbols and thoughts that are ready for use in dreaming and thinking.[34]

For Ricoeur, literature, theology, and psychoanalytic theory describe human action in that they are *imitative* of human action. Language is *mimetic*, and *mimesis* is a key concept for him. Children learn by imitation, and, although it is less obvious, so do adults. Drawing on Aristotle's *Poetics*, Ricoeur grounds his textual description of human activity as imitative, or mimetic.[35] Emerging from primal origins in gesture and symbol, mimesis

occurs in three "moments": *mimesis*$_1$, *mimesis*$_2$, and *mimesis*$_3$. In its first moment (mimesis$_1$), people imitate or represent human action through the use of symbol, metaphor, and language.[36] Language in mimesis$_1$ is spontaneous but not thought out and corresponds to free association in psychotherapy. Language in mimesis$_2$ takes the form of the plot in literature. Its parallel in psychotherapy is thinking theoretically and analytically so as to make interpretations. In literature, mimesis$_3$ is the moment in which the reader receives, appropriates, and is transformed by the narrative she has read. Reading and application of the story is governed by the capacity of the reader to receive and grasp the message. In drama, the audience is moved and enriched by the tragedy or comedy they view. Like mimesis$_3$, the imaginative hypotheses known in psychotherapy as interpretations are integrated into the patient's lived experience, and the patient is transformed by new self-understanding.

In biblical studies, as the reader encounters a text, his first interpretive step consists of an initial pre-grasp of the text's content as a whole (understanding). The second level is written discourse in which ostensive reference, such as gesture, diminishes. The mental intention of the speaker is no longer accessible in the text because the hearer (now the reader) cannot ask the speaker (the author of the ancient text) what he meant by a particular statement. We cannot get "behind the text," so to speak. So, the meaning of the text on the page has become autonomous from the mind of its author. At the third level, the moment of personal appropriation arrives when the claims of the text are applied to the here-and-now life experience of the interpreter. Here the text's meaning emerges "in front of the text."[37]

In the contemporary life of the worshiping community, the congregation receives the message as proclaimed—as a kerygma that emerges from the pastor's critical-constructive exegetical interaction with the ancient text as well as from his pastoral care in current relationships with the congregation regarding their present needs and their orientation toward the future (shared sense of mission). For Ricoeur, the hermeneut must relate in the present moment, informed by the past while anticipating the future. The movement from exegesis to proclamation to reception of the message constitutes the hermeneutical circle. The outcome of the text's message emerges "in front of the text" as the hearers are transformed by its meaning for them today.[38]

In the supervisor's understanding and acceptance of the supervisee, who is awash in an upwelling of his countertransference that is evoked by the patient's transference, grace and liberation may happen. The superviso-

ry couple, working in the immediacy of the present moment, beholds the intersection of three histories: the patient's, the trainee's, and the supervisor's. The power of interpretation opens a way into a future for the therapist-patient couple and for the supervisor-supervisee couple. Often this "way" is not merely psychological understanding but the experience of something sacred. Pastoral counselors are familiar, from our training in biblical studies, with the hermeneutical task of "demythologizing" the text. Ricoeur notes that we can no longer go back to the primitive naiveté of children, or of ancient people, with their immediacy of belief:

> If we can no longer live with the great symbolisms of the sacred in accordance with the original belief in them, we modern men [*sic*] aim at a second naiveté in and through criticism. . . . It is by interpreting that we can hear again. . . . This second naiveté aims to be the post-critical equivalent of the pre-critical hierophany.[39]

Similarly, patient, therapist, and/or supervisor can be liberated by the post-critical realism of interpretations, given and received in dialogue, "to hear again" and to experience joy in living life.

My pastoral theological methodology follows the thought of Theodore W. Jennings, Jr., who introduced the concepts of first-, second-, and third-order theological thinking.[40] First-order theology, also known as "embedded theology,"

> is the collection of phrases, narratives and liturgies which are employed to give expression to the way in which a person or community's life is related to God.
>
> Second order religious language (theology) is the explication and critical evaluation or appropriation of their basic meaning, with the more or less provisional result yielding a theological judgment or proposal. When an entire community of faith attains or accepts the same judgment, the result is a doctrine.
>
> Theological method, including pastoral theology, is a third order reflection upon the way in which such judgments are made and a critical evaluation of the appropriateness of such procedures."[41]

Deliberative theology, or second-order theology, denotes the critical biblical studies and the historical and systematic theology introduced in seminary.[42] In pastoral counseling and supervision, third-order theological reflection involves working with patients and supervisees in ways that respect their embeddedness in a particular cultural, spiritual, or theological location (their first-order language of faith).[43] A third-order theological perspective also enables us to join supervisees and/or patients in the second-order reflective

work of deliberating about their ethical/theological struggles to live authentically and responsibly in relationships, including psychotherapy.[44] Personality growth can foster shifts or crises in people's faith and values that require our *collaboration in dialogue*. In sum, the work of Ricoeur and Jennings provides a hermeneutical and theological frame for the application of Kleinian theory to supervision.

Collaboration in dialogue is especially important in the intercultural relationships that are increasingly a part of life in our post-colonial global village. Following the work of Melinda McGarrah Sharp, we can explore how misunderstandings that are so much a part of couples, family, and group life become deeper and more frequent within intercultural relationships, where people tend to overlook differences in social, cultural, and theological/spiritual locations.[45] The same respectful and open attitude is crucial to supervision with persons of different gender identity and sexual orientation.

The embeddedness of others in theologies, cultures, gender-specific perspectives, sexual orientation, and languages different from our own poses a powerful ethical challenge to supervision. The thought of Emmanuel Levinas guides me here.[46] The fallacy of clinging to the totalism of only one perspective is exposed by face-to-face encounters with other persons. The "face of the other" not only exposes my own egocentricity and love of "sameness," it introduces an obligation for responsibility to this "other" who not only embodies difference but stands for the absolute Otherness of God who loves both of us.[47]

For me, the wonderful and challenging otherness of my wife and all women introduces feminist perspectives that enrich and challenge me every day. Drawing on the work of Catherine LaCugna and Elizabeth Johnson, Pamela Cooper-White sketches "a relational understanding of God."[48] God, in the three persons of the Trinity, is imaged by the fourth-century understanding of *perichoresis* "in the complete, equal, and mutual interpermeation of the three persons."[49] She cites LaCugna to say,

> Perichoresis expressed the idea that the three divine persons mutually inhere in one another, draw life from one another, "are" what they are by relation to one another. Perichoresis means being-in-one-another, permeation without confusion. No person exists by him/herself. . . . To be a divine person is to be by nature in relation to other persons.[50]

As the Trinity, God models for humans that human relationships should extend cross the lines of gender, race, cultures and faith communities.

GROUP THEORY

The predominantly two-person focus of psychotherapeutic theories is balanced in pastoral counseling supervision by the use of group process theories. In our doctoral program, group conferences occur in multiple modalities, from didactic or teaching seminars to case conferences to interpersonal relations seminars. Peers and supervisors have much to teach and learn in dialogue with each other in group seminars. My style of work, even in didactic seminars, is dialogical. The psychoanalytic literature is not "light reading," and a straight lecture format both enhances resistance to learning and puts people to sleep. I want people to wrestle with the concepts, with the authors, with each other, and with me. Dialogue moves learning from the head to the gut, making new understandings more readily available to incorporate into practice. Consistent with my Kleinian orientation, my main group theorists are Bion and Foulkes.[51] Group case conferences are the format in which supervisees most easily experience and internalize Bion's model of the *work group*.[52] On the other hand, the relatively unstructured nature of interpersonal relations seminars provoke the most anxiety and most effectively expose the group's operant *basic assumptions*.[53]

For the past twenty years, Bion's group theoretical perspective has helped me stay grounded in the sense of what is happening in the moment in group process. My supervisee J found group to be a horrible experience. The issue she had most in common with her all-female peer group was the fact that all had had painful relationships with their mothers, and each peer projected her bad mother issues onto others who attempted to engage them. As a result, the group functioned mostly as a *fight-flight* basic assumption group, although two peers *paired* and/or sub-grouped to avoid conflict due to a longstanding friendship that preceded their participation in the training program.[54] Based on her longstanding therapy experience and previous CPE residency, J repeatedly tried to engage her paranoid and prickly peers around the unspoken dynamics in the room, and around her own negative transference-laden concerns that she was not being heard or understood. In response, the group scapegoated her and ignored or rationalized her attempts to engage. J responded with periods of silent, impotent rage until her next attempt to engage.

Faculty group leaders had little more success with engagement of the group at deeper levels of trust as the group proceeded to "learn by vigorous denying."[55] Interpretations of the group's behavior as an acting out or as a

transference of their respective family of origin dynamics[56] were resisted in the group format, but they all did better work in the safer environment of individual supervision.

COUPLES THERAPY

Even though it is obvious that my primary theoretical orientation is an individual, Kleinian object relations psychoanalytic perspective, nearly one third of my clinical practice is done with couples. I am intrigued by David and Jill Scharffs' concept of "centered holding,"[57] which in a traditional family depicts the mother holding the baby, the father holding the mother and the baby, the extended family holding them, etc., as a succession of concentric circles of care that surround the child, mother, and father. The application of centered holding to family and couples therapy excites me, and their book led me in many productive directions—especially to Klein and her followers.

To me, the most important North American Kleinian author is Robert Caper, but the Tavistock Institute of Marital Studies has also had an impact on my work.[58] My practice and understanding of couples and family therapy is informed by Caper's comparison and contrast of Bion's *container/contained* function with Donald Winnicott's concept of *holding*. Caper says,

> Holding does not, by definition, present the patient with a proper object. Its purpose is to accommodate to the patient in order to reassure him that the analyst is not hostile, and for this reason the analyst identifies with the patient's state of mind, and conveys to the patient that he has done so. . . . The analyst has not moved the patient into territory that is unfamiliar to him, but has, on the contrary moved himself into what is already familiar to the patient. . . . In other words, it tends to move the analyst toward the good side of the patient's splitting.
>
> Containment, on the other hand, does move the patient into unfamiliar territory. It presents the patient with an object that has gone beyond identifying with him to gain some insight into what the patient himself is unable to know, namely his own unconscious. This puts the analyst in the position of being a proper object, an object that the patient experiences as different from himself— . . . not a narcissistic or paranoid-schizoid object. At the same time, containment provides the patient with an experience of a proper self.[59]

Healthy marriages have certain characteristics. First, the container/contained apparatus described by Bion as pertaining between a healthy mother and her child, or between a therapist and patient, exists in some

way between the couple—within their relationship. Second, this container/contained capacity operates as an intrapsychic function within each partner. This internal containment capacity of each partner is the equivalent of integration. The external relationship between these two partners—the marriage—provides reciprocal containment by each partner for the other. People need to feel safely contained in order to function creatively.[60]

Coleman says the aim of couples therapy is to "promote the capacity of the marriage to function as a container for the individuals within it." Thus, in couples therapy "the patient is the marriage."[61] People seek couples therapy when the above conditions of containment do not exist. Looking into deeper levels of these phenomena, we are reminded that Bion's container/contained model is rooted in his exploration of the origins of thinking. Mother's reverie enables her to gather the infant's inchoate projections and make sense of them. Over developmental time, the child internalizes mother's capacity to exercise containment and does so for himself. In this model, Bion gives an account of what the therapist's containment promotes in the patient. She gives back to the patient, through interpretation, the psychic phenomena that the patient was unable to process, thus enhancing the patient's capacity to think about her own experiences.[62]

In contrast to Bion's "container" model, Winnicott speaks about the mother's "holding" function in which she allows the child to discover his own being in his own way and in his own time. However, Winnicott does not describe the process going on inside the mother's/therapist's mind, the functions of projective identification and alpha function. Instead, her "holding" provides a protective management role that prevents excessive impingements on the developing ego.[63] A clinical vignette will illustrate this.

TN is a supervisee doing therapy with AE and BE, a clergy couple in their early thirties with three young children and the experience of one miscarriage. In her family of origin, BE was physically and verbally abused by her mother and at age six was sexually abused by an uncle. Recently, BE has further distanced herself from her mother after mother physically assaulted one of the couple's children. In his family of origin, AE was the youngest of three siblings and went through the traumas of his brother (the oldest sibling) sexually abusing his sister (the middle child), for which the brother did hard time in prison. More recently, the older brother died as a drug addict.

AE and BE came to couples therapy with a presenting problem of sexual conflict in their marriage. Periods of relatively warm intimacy reportedly alternate with times when BE gets overwhelmed and retreats, feeling

that AE is too sexually needy. In response to BE's distancing behavior, AE becomes tearful but has no words for his tears. They act out these distancing behaviors in the couple's therapy format, demonstrating their incapacity to contain the projections of the other. No violence occurs, but neither spouse is able to think or relate helpfully when anxiety spikes upward, and silent, mutually stuck impasses occur. The couple's behavior in therapy in effect says, "This is what we deal with so often in our relationship." So, TN works with each partner in individual sessions that alternate with sessions using a couple's therapy format to provide the containment for each partner that they are unable to provide for each other.

My supervision of TN explores and interprets the periods of vague confusion he has when one or both spouses "get stuck." AE and BE project their confusion into TN, whose mind, at times, becomes numb and unable to think—unable to apply alpha function to the feelings of drowning in despair that they project into him. We explore the parental couple that each partner has internalized, and enacts, in their marriage, and we explore the depleting internalized parent-child relationship they transfer onto each other.

SUPERVISORY THEORY

Decades ago, I worked my way through college by managing a municipal swimming pool and teaching swimming lessons to hundreds of kids. One of the first lessons I learned was that I could not stand on the deck beside the pool and teach water-phobic children to swim. It was imperative that I get into the water and invite the students to join me. They needed to know that I was there, immediately available, to assuage their fears of drowning while learning to swim. At a primal level, supervision of pastoral counseling is the same. I invite my trainees to join me in immersing ourselves "in the water" of pastoral counseling. Doing so evokes anxiety—often a lot of it—in people for whom psychotherapy is a new medium in which to practice. They have a high need to know that I am within reach if a "drowning" patient begins to "pull them under." Needless to say, these dynamics also evoke anxiety in me as their supervisor. I will never forget my shock, nor the pain of my college lifeguard friend, after a thirteen-year-old child drowned while he was on duty. In our business of pastoral counseling, some patients do commit suicide or do awful things to themselves and others. Fear and anxiety are real for pastoral counselors, and oftentimes realistic. So

a major supervisory question is, How do I manage the anxiety that comes with the territory?

In their classic book *Coping with Conflict,* Mueller and Kell approach the issues of clinical supervision from the perspective of the anxieties inherent in these phenomena.[64] They make a number of salient points: Therapists and supervisors do not develop through a dispassionate study of the conflicts with patients or trainees (the swim instructor and the student must get into the pool together for learning to occur.). Patients and trainees are uncannily accurate in discovering those things we find distasteful about ourselves and that can make us anxious and angry (cf. Kleinian projective identification and introjective identification). So, supervision should focus on the sources of anxiety in the supervisee and the supervisor, not just the anxiety in the patient. For effective use of self, supervisor and supervisee must understand the motives, conflicts, and anxieties that are activated by the patient, supervisee, and supervisor. Trainees begin supervision as neophytes who feel vulnerable, inadequate, and uncertain about the supervisor's criticism. They cautiously reveal their uncertainties. Effective supervision allows the trainee to lean on the supervisor for support and to struggle with inner conflicts in the supervisor's presence.[65]

A Kleinian commentary on the issues raised by Mueller and Kell emphasizes that anxiety to some degree is inherent in all human interaction. "No anxiety" is one of the characteristics of death. Rather, we ask, What kind of anxiety is operative? Is it *persecutory* (paranoid-schizoid, as in fear of being attacked or fear of annihilation) or *depressive* (in the awareness of one's own aggressive impulses, the person becomes anxious that he has damaged the love object)? And, to what extent, if any, does the supervisor's or supervisee's anxiety interfere with their ability to think and function within a normal range?

I concur with Mueller and Kell that *the goal of supervision is learning to be therapeutic*. This fact is the heart of the learning contract for every pastoral counselor in training. Learning to be therapeutic involves learning to use one's knowledge of personality development in its normal and pathological iterations to enhance a patient's development. Therapists (and supervisors) must be able to postpone their reflexive reactions to the patient's (or supervisee's) anxiety-producing behavior in order to metabolize the behavior's dynamic meaning before responding with interpretations. This was a major issue with J in her work with T. She had to learn that T's hostile, confused behavior that immobilized and confused her was his means of emotional

protection in the violent family context that overwhelmed him. Only as J came to understand the dynamic meaning of her own immobilizing anxiety and its roots in her traumatic development could she trust herself to engage T's dynamics, using her self-knowledge to interpret his anxiety and foster his self-understanding.[66]

ANXIETY AS A THEME IN THE HISTORY OF SUPERVISION

A theoretical red thread running through this discussion has been the patient's, supervisee's, or supervisor's *anxiety* as it emerges from the individual's developmental history into therapeutic and supervisory settings. Parallel to anxiety's emergence in the life history of individuals and their relationships, it is also helpful to trace the emergence of anxiety as a theme of importance in the history of *psychoanalytic supervision*. *Anxiety hysteria* and *anxiety neuroses* were present from the beginning in Freud's thought and practice as diagnoses and clinical phenomena,[67] but Freud's own anxiety in his mode of doing supervision was neither visible nor discussed. Mary Gail Frawley-O'Dea and Joan E. Sarnat describe Freud's classical analysis and supervision as a

> one-person model of clinical work, with power, knowledge and authority resting primarily with the analyst. . . . A relatively healthier, more fully analyzed, more completely conscious analyst takes on a patient who is a relatively sicker, more conflicted, less conscious individual.[68]

This classical model rested on positivist scientific assumptions of the analyst as an external observer and was patient-centered. The supervisor was viewed as an uninvolved, objective expert who was focused on the patient's mind and the use of correct technique. Supervision was an authoritatively didactic imparting of information to the receptive and dependent supervisee-learner. It was expected that the supervisee would work through her emotional conflicts in a separate training analysis. Any anxiety of the supervisor or the supervisee rarely got mentioned in the literature.

By 1958 in the United States, ego psychology was the regnant mode of psychoanalysis. Ekstein and Wallerstein described the "resistances" of supervisees, but they seemed incurious about the anxiety driving these resistances. They enumerated, quite helpfully, a long list of "problems *about* learning" that they defined as particular ways in which the supervisee seeks to learn from the supervisor. These include: 'learning by vigorous denial'; 'learning by submission'; the 'mea culpa' attitude of learning; the 'problem of finding a problem' style of learning; learning 'on the run' because

of over-involvement elsewhere; the problem of 'skepticism vs. faith' in the treatment process; and the problem of trying to 'convert supervision into personal psychotherapy.'[69] However, the psychodynamic meaning of these problems about learning was largely to be addressed in the trainee's own personal training analysis, which occurred outside the supervisory context. Stated in Kleinian terms, there was a tendency in earlier models of supervision for the anxiety of supervisor and supervisee to be split off and projected into the training analysis or the supervisor's own personal analysis.

By 1972 the attitude toward anxiety was changing in supervisory theory. Although Frawley-O'Dea and Sarnat did not know about the work of Mueller and Kell, the latter directly approached anxiety in the supervisory context in their new book. For Mueller and Kell, anxiety was front and center. They spoke of three key behavioral options in response to anxiety: *anxiety binding*, *anxiety avoiding*, and *anxiety approaching* behavior. They saw the first two options as unhelpful and efforts to approach anxiety as the most efficacious.[70]

In 2001 Frawley-O'Dea and Sarnat completed the full turn to an "anxiety-focused" supervisory model, founded in object relations theory. Their focus is primarily on the self psychology of Kohut as well as the object relations theories of psychoanalysts such as Klein and Winnicott.[71] It is here that the Kleinian impact on supervisory theory begins to emerge. Klein and the Kleinians were the first to finally offer a full developmental description of the role of anxiety in human life, from birth and through the life cycle. For Kleinians, the supervisor is still an authoritative expert but is also a receptacle for feeling states induced by the patient and the supervisee.

This history leads Frawley-O'Dea and Sarnat to the postmodern "relational model" of psychoanalysis in which the supervisor is seen as "an embedded participant" rather than "an objective expert," engaging in a "supervisory-matrix-centered relational model of supervision."[72] My own position, as stated throughout this paper, is Kleinian, albeit with acceptance of many of the interpersonal aspects of the relational model—aspects that are really Kleinian in origin. For example, Bion's learning theory is thoroughly grounded in projective and introjective functions that are the basis of all human conversation. The simple greeting "Hello" is a projection by person A, who acknowledges the presence of person B. When B responds in kind, she acknowledges the presence of A. The result is a mutual introjection of friendly recognition. Hundreds or even thousands of reciprocations may follow, as a supervision develops or a psychoanalytic treatment develops, as

the case may be. The Kleinian therapist or supervisor is always attentive to the quality and quantity of anxiety in these projections and to the possible meaning of any fluctuations in this anxiety.

TRANSFERENCE, COUNTERTRANSFERENCE, AND THE TEACH/TREAT DILEMMA IN SUPERVISION

I close this paper with a discussion of relationships between transference and countertransference, on the one hand, and the so-called "teach/treat" dilemma in supervision on the other. The phenomena of transference and countertransference have been present in psychoanalytic work from the beginning (1880–82), ever since Josef Breuer's work with Anna O.[73] Breuer did not recognize either concept until Freud identified them during their consultations, a realization that disturbed and frightened Breuer, causing him to flee both his treatment of Anna O and the fledgling discipline of psychoanalysis.[74] However, the case of Anna O illustrates two key psychoanalytic issues regarding transference and countertransference. First, they are powerful forces of unconscious origin in both the patient and the therapist. Second, these forces have the potential to rupture the therapeutic relationship through acting out, and/or fear of acting out, by the patient and/or the therapist. As Joan Berzoff summarizes,

> Freud initially thought that transference could and should be avoided, but he would shortly discover, in the case of Dora, that transference was an unavoidable part of the talking cure. Even later he came to see transference not as an impediment, but as *the* major vehicle for psychoanalysis.[75]

Similarly, countertransference was originally understood as derived from neurotic aspects of the therapist that get stimulated by the patient's transference.[76] It was seen by Freud and his early followers as an indication that the analyst needed more analysis. In many cases, including the case of my supervisee J and her countertransference toward the little boy T (above), therapists do indeed need more psychotherapy. This has been, and always will be, a crucial issue in psychoanalysis and its supervision. However, for decades it was an issue that received little serious study. Reflecting on the large body of psychoanalytic literature that had accumulated by 1953, Heinrich Racker observed wryly,

> In case histories countertransference is seldom mentioned, still less treated with any profundity. To my mind these facts are due . . . to a resistance. Among analytic subjects countertransference is treated somewhat like a child of whom the parents are ashamed.[77]

Avoidance of the study of countertransference began to abate in the 1940s thanks to Klein's work in developing the concepts of projection, introjection, projective identification, and introjective identification. These tools enabled analysts to develop a more mature understanding of countertransference. Object relations theory moved away from Newtonian and positivist paradigms of the analyst as "objective external observer." Changes in the view of countertransference were symmetric with the shift in the scientific community from Newtonian assumptions to Einsteinian understandings about scientific observation. The observer's act of observing has effects on the observed, and vice versa. Then in 1950 a major theoretical shift occurred with the publication of Paula Heimann's article "On Countertransference." She said,

> The analyst's response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious. . . . The aim of the analyst's own analysis is . . . to enable him to sustain the feelings which are stirred in him, as opposed to discharging them (as the patient does), in order to subordinate them to the analytic task in which he functions as the patient's mirror reflection.[78]

The next conceptual step in was made by Roger Money-Kyrle, whose thesis is stated in the title of his article "Normal Countertransference and Some of Its Deviations." He wrote,

> We used to think of [countertransference] mainly as a personal disturbance to be analyzed away in ourselves. We now also think of it as having its causes, and effects, in the patient, and, therefore as an indication of something to be analyzed in him. . . . Of course [this] . . . does not imply that it has ceased ever to be a serious impediment.[79]

Accordingly, Bion (1959) distinguished the "normal" form of projective identification from the "pathological" one and saw normal projective identification as what happens in empathy and in the acquisition of knowledge about other objects and the world.[80] In summary, it is never a question of *whether* transference and countertransference are present in therapy or supervision. They are ubiquitous. The pertinent questions are rather, What is happening in the transference and countertransference?, and What are its meanings?

This Kleinian account of the developmental history of the concepts of transference and countertransference provides background to the teach/treat dilemma that has raged in the supervisory world for sixty-five years. Frawley-O'Dea and Sarnat[81] give an elegant account of the teach/treat de-

bate from an American psychoanalytic perspective. From both an object relations perspective and a post-modern relational model, I can now assert, with Frawley-O'Dea and Sarnat, that "a rigid boundary between teach and treat is neither desirable nor truly achievable."[82]

In accordance with this position, I will highlight three claims that Frawley-O'Dea and Sarnat make about the maintenance of a teach/treat balance in supervision. First,

> It is no longer possible to differentiate the supervisee's professional from her personal growth, or her professional persona from her personality. Rather, the professional is personal.[83]

This view maintains that relational supervision cannot be conducted effectively without addressing the trainee's countertransference to her patient. Their second claim holds that

> supervision is most effective when supervisor and supervisee thoughtfully cooperate in ensuring that the "treat" aspect of supervision remains indentured to the overarching goal of facilitating the supervisee's growth as a clinician.[84]

In my view, therapeutic issues of the trainee are relevant to the supervisory work only to the extent that their illumination enables the trainee to use her countertransference effectively as she works in and with the patient's transference. Finally, Frawley-O'Dea and Sarnat claim that

> the supervisee is empowered to limit the extent to which supervision focuses on her own psychology . . . how deeply and broadly her psychic processes are available for mutual exploration in supervision."[85]

This last claim is congruent with the AAPC Code of Ethics regarding the maintenance of safe boundaries in our work with both supervisees and patients. These boundaries apply both to these relationships and to careful maintenance of the educational setting in which the people who work in these relationships develop and pursue their objectives in the teaching, learning, and practice of pastoral counseling.

CONCLUSION

In this paper I have employed several theoretical and theological perspectives to reflect upon my supervision of pastoral counseling. These perspectives included Kleinian psychoanalytic theory; Paul Ricoeur's hermeneutical approach to "texts" in literature, biblical interpretation, and psychoanalysis; the theological methodology of T. W. Jennings and the provocative contributions of three feminist theologians (Pamela Cooper-White,

Catherine LaCugna, and Elizabeth Johnson); the intercultural theory of Melinda McGarrah Sharp; the modalities of key theorists of group, couples, family, and play therapy; and the supervisory theories of Rudolp Ekstein and Robert Wallerstein, William Mueller and Bill Kell, and Mary Gail Frawley-O'Dea and Joan Sarnat. These perspectives have been applied to two pastoral supervision cases to explore a number of dynamic themes that recur in pastoral supervision. These theoretical and theological perspectives serve as "maps" that guide my practice of pastoral counseling supervision. As I use them, I seek to demonstrate my proficiency in this practice.

Descriptively speaking, we pastoral counselors claim that theory and theology provide accounts of what we do in practice. In this sense, theory and theology are *imitative* of what we do in practice. Prescriptively speaking, theory and theology state *what we are to do* in practice. Here, our theory and theology *norm* what we do in practice and have ethical implications for our professional guild. But *imitation, norms,* and *guilds* have no life outside of relationships—dialogue with peers in which we reflect on, learn from, and revise what we do and why we do it. Reflection on practice occurs in dialogue.

NOTES

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4. Ibid., 40–41.
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7. Segal, *Klein,* 42–43.
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9. Ibid., 55.
10. Ibid.
11. Ibid., 48–51.
12. Ibid., 78–90.
13. Ibid., 112–21.

14. Bill L. Kell and William J. Mueller, *Coping with Conflict: Supervising Counselors and Psychotherapists* (New York: Appleton-Century-Crofts, 1972), 202–45.

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29. Ricoeur, *The Symbolism of Evil,* 161–63.

30. Paul Ricoeur, *Freud and Philosophy: An Essay on Interpretation,* trans. Denis Savage (New Haven: Yale University Press, 1970), 344–552.

31. Paul Ricoeur, *The Conflict of Interpretations: Essays in Hermeneutics*, ed. Don Ihde (Evanston: Northwestern University Press, 1974), 19, 30, 33, 55, 298, 384, 389.

32. Isaacs, "The Nature and Function of Phantasy," 82–85.

33. Hanna Segal, "Notes on Symbol Formation," in *The Work of Hanna Segal: Approach to Clinical Practice* (London: Jason Aronson, 1981), 49–65.

34. W. R. Bion, "A Theory of Thinking," *International Journal of Psycho-Analysis,* 43 (1962): 306–10.

35. Ricoeur, *Time and Narrative,* 1:31–50, 52–54.

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