Supervising in the Climate of a Pandemic

With a good deal of reluctance, I now work with Zoom in order to supervise groups and individuals. On occasion, I also use the telephone. I possess a profound dislike for the computer, for I harbor no intention of becoming a prisoner of modern day machinery. The computer demands too much attention to detail as well as the challenge of building up one's skill. Fortunately, in the past, I was able to employ others to perform this most horrendous task. Now, however, I can no longer avoid the reality of our time. I now accept that there is no other way to conduct my practice except through technology.

With the help of a technician, I have been employing Zoom for the last four months. The sessions have taken on a disturbing pattern. At first, there is a profound, flat silence. Slowly, the members address their confusion, loss and fear of the change that has occured in their lives. There is fury and rage for some, for many live in a traumatized climate. The need for processing is ever present. Some individuals report a change for the better. They have moved into their vacation homes and indeed can no longer avoid their partners. As a consequence, they have developed new ways of communicating with one another. For most people, however, they are potentially afflicted with some of the hallmarks of dissociation.

After a short period of a despairing discussion, I aggressively push for a case presentation. With reluctance, someone volunteers. The following is a case presentation that takes place in our most recent session that occurs just before a two month break.

The presenter states that his patient has been in treatment for over 10 years. The therapeutic dialogue feels like living on an endless emotional plateau. Obsessively, the patient elaborates through a litany of complaints and feels sad and hopeless. The patient blames the world for his misery, and the therapeutic dialogue presents an aimlessness that merges from one session to another.

A thumbnail sketch of the patient's history includes the loss of a sibling from an incurable disease when the patient was eight years old. This lost sibling played the role of a special child, and as a consequence the death led to a severe depression on the part of both parents. In fact, they gave up the role of parenting and withdrew from life. The patient in turn felt abandoned and lost. He became aware of the impact of his history but this knowledge did little to change his attitude towards life. Yet, the therapist, even though he has been irritated from time to time, feels empathy for he realizes that this individual has been traumatized and abandoned. Over the past ten years of treatment, the therapist has attempted a variety of different interventions. None have worked. He has confronted the

patient to end this deluge of sadness and loss. The therapist offers examples of positive thinking, but predictably this also does not work. Indeed, all interventions are ineffective.

The presenting therapist, with a shy smile, comments that he has presented this case some time ago but was unable to follow any recommendations or suggestions that arose from the group processing. In the past roleplaying, he simply was unable to adopt a stance of being firm though empathetic, and demand a change in the flow of material.

The group discussion shifts to the presenter's past history. His father was described as an overwhelming, frightening and authoritarian man. The therapist has spent many years in treatment in an attempt to extricate himself from his own traumatic relationship. Little has been said regarding his mother, for she seems rather unimportant from the patient's perspective. The presenter explains his identification with the patient as understanding how trauma can impact your entire life.

The discussion shifts again, this time to the here and now of our group interaction. I describe the presenter's relationship to me as both friendly and competitive. He takes issue with how I work and simply responds to all of my interventions. "This is simply not right for me." At the same time, he is very impressed with what I have to say, and admires the way I work, both as a therapist and supervisor.

We shift to playing out how one can work with this patient through roleplaying. The patient as the presenter complains about his own work supervisor who ducks responsibility. The supervisor is either too frightened or passive in dealing with lawyers on the job. I play the therapist and inquire whether the patient also was ducking his responsibility in confronting his own supervisor. I remark, he too has a responsibility to take care of himself. The presenter smiles and states "that seems helpful," but I suspect that this very short example will go nowhere.

I decided to shift to a clinical framework as the presenter seems to need something concrete and clear to hold onto. I elaborate on this clinical framework in the following terms: aggression can be used to inflict hurt and injury to another. However, assertion in the form of aggression can define boundaries and reinforce separateness. I further comment that rage may arise from a feeling of helplessness.

I offer the example of a paranoid/ masochistic adaptation. A paranoid individual attacks so that he or she can avoid exposing feelings of humiliation and or judgement. On the other side of the coin, be aware of the warm idealizing roleplay. This patient can equally adore and be very appreciative of your interventions. They will find you helpful, but of course nothing changes. This, too, becomes a form of manipulation and protection against the underlying frightening affect.

The current mental health scene emphasizes work on attachment, abandonment, and self-development. Shame becomes an important organizer of defenses. Shame, in this instance, is the shame of being humiliated that these two are shriveling up for a sense of self. By contrast, guilt arises from a very different set of circumstances. The effect can best be described as a feeling of dread that something awful can happen. There are fears of retaliation, punishment and judgement for one's impulses. Even a thought can present

fears of retaliation and punishment. Of importance, there are many protections against actually feeling guilt. There are reaction formations, evasions, and denial, as well as a paranoid/masochistic adaptation that may even lead to flatness. For many, they withdraw from anything that is competitive and that will lead to an exposure from others of confrontation or envy.

Depression can be seen as a defense against social interaction and a turning inward of self-affirmation or aggression. Profound depression can also arise from an early sense of helplessness and despair that is associated with an absence of any alternative.

I attempt to make a difference to the group, between external and internal power. The management of shame, guilt and anxiety makes a difference between how we handle external and internal power. The authoritarian experience expresses power through submission and domination from others. By contrast, internal power reflects an ability to define boundaries, to stand alone, and to respect the life force of another. It also implies not only a responsibility for one's actions, but an awareness of the impact of your influence on the other. In both instances, we are describing how we handle responsibility. An authoritarian approach only cares about oneself. Internal power can be utilized to fight for one's values without attempting to get into a power fight. Internal power frees, external power binds, and controls one's sense of freedom.

This discussion continues with many questions and responses. I refer to the current social scene, where there is a rebellion against a master-slave mentality. Occasionally, a hero arises to express and lead with this perspective. There is one exception: when our very survival is challenged, we are sometimes forced into a kill or be killed mentality. I refer to a dictatorship that forced us into a second world war. This entire description describes the building up or the lessening of an omnipotent fantasy. We start out in life with magical thinking, but reality either affirms or denies our inner belief in our omnipotence. There are enormous defenses against feeling and owning our inner arrogance and grandiosity. I comment, "Show me someone who is guilty, and I will demonstrate how quietly and secretly they feel powerful." You cannot confront a paranoid or masochistic individual for their defenses will simply firm up, and you will end up in a power fight. With warmth and empathy, as well as a clinical acuity, we can play with an individual's fear of their own power. In order to create a safe environment to explore power, boundaries are a landmark of good therapy. Obviously, when a boundary is overly restrictive, or protection is absent, there is little room to test out one's own power against reality.

I encourage people to develop their own style of interaction with this most difficult client. Too much empathy can be suffocating; too little can lead to further alienation and loss. These issues cannot be readily explained, for ideally they are discovered through therapeutic interaction. In most instances, there is a lack of a development of reflective or abstract ability to find interpretation useful. Guilt and trauma can occur at any level of life experience. The end result is fears of being helpless or panicked. When there is trauma or a very entrenched fear of guilt or humiliation, learning through transitional objects or metaphors can help. The underlying fear is to avoid being exposed and vulnerable. Consequently, we attempt to be nonjudgmental and accepting, and communicate through a safe distance. Thus, we can make our point and even though we may encounter resistance, we simply retreat and allow the patient time to absorb our intervention.

As we shift back and forth between the patient's history, the supervisory group interaction and our own personal encounters in life, there is much relief if not exhilaration. One member of the group observes similarities between the presenting patient and his own history. He realizes that some of his own empathetic interventions with patients are a defense against going deeper into the unconscious.

We shift again to a cultural perspective. We live in an age of busyness and achievement. To survive, we must ultimately know what we want and how to get it. We also must acquire the ability to be non judgemental toward our so-called mistakes and be able to shift direction. At the same time, aggression can be manifested in a form of ruthlessness that denies shame and humiliation.

Splitting may also occur when there is a good deal of guilt or anxiety. Dealing with the displacement of rage toward a minority group or scapegoating can be a way of avoiding anger toward the real authority.

Psychopathy is well and alive in our society. There are individuals who carry no sense of guilt or shame, or even anxiety. These patients show little respect for law and order. Only when we deal with our own power so that we are able to confront a bully are we potentially able to be effective. We must demonstrate that we are smarter and wiser than any psychopathic adaptation. This type of individual does not respect weakness, for their motivation is to live through power and self interest.

The presenting patient presents traumatic features in his background. Thus the character structure mixes fragility along with formidable sadomasochistic defenses. Above all else, I believe therapists require a sense of authenticity, clinical adeptness, and the ability to use one's unconscious to interact with patients. We cannot use our unconsciousness if we are not grounded with knowledge and clinical astuteness. We lose the capacity of working with underlying dynamics if we stay on the level of a surface consciousness. There are many instances where a therapist believes that they are working on a depth level, when in fact they stay on an intellectual surface. What we expose does not always ducktail how we actually work. I have witnessed so-called classical therapists who make quite an impact on their patients through their very presence.

I believe in a multi-level approach to supervision. We are not doing therapy but certainly are utilizing our emotionality in a creative response to our work. Supervisees have a right to develop their own style and approach, and take from whatever they find helpful to integrate into their own uniqueness and authenticity. I respect everyone's right to learn in their own manner and to find solutions that are right for them. The supervisor's responsibility becomes one of both imparting information and at the same time, opening up possibilities by demonstrating unconscious communication. Needless to say, this approach to supervision is not right for everyone. For many, however, the enactment of learning through experience and shifting to multiple levels of consciousness can create an effectiveness that makes a therapist an artist as well as a scientist. Integration is the key word to learning and growing.