A Clinical Supervision Dialogue
June 28, 1994 Tucson, AZ

Clinician (C): This client's first name is "Janis" (name changed in this example), a thirty five year old Caucasian woman with two small children under age six. She exhibits multiple phobias, obsessive-compulsive disorder characteristics. Both her parents are dead but when they were alive they dramatically protected her from bad news, from the down-side of life. When her mother was dying, Janis got the impression that things had been kept from her, that the world was quite a dangerous place, and this thrust her into a chronic worrying posture which is some of her motivation for coming into treatment.

Clinician, to the supervision group: Let me remind you that I have presented here before my frustration at clients who come to sessions telling some story over and over and in that way never seem to change, or get better. You brought to my attention that this was similar to my own frustration with my own personal family members who do this same thing, and that my counter-transference based frustration was blocking my contact with my client's underlying despair and helplessness that is expressed in this type of repetitive story-telling. And you pointed out how I was unintentionally protecting these clients by not expressing my frustration to them.

As a result of that conversation I stopped being so protective toward them, and also toward this client Janis. About this same time Janis found a malignant lump in her breast and began chemotherapy. We discussed her scaling back the frequency of her weekly individual visits because she feared she'd 'feel too badly from the chemotherapy' to come for psychotherapy. I accommodated her: she now comes in twice a month. Now all she wants to talk about is her fear of death. She maintains her sense of humor but has become hyper-sensitive to how people respond to her and to her illness.

As an example of this: a friend begins to give her an unsolicited sermonette on "living life to the fullest," even though she has cancer. Janis is quite offended by that remark and admits to me that she only wants to hear positive things all the time. I note also that Janis has begun getting quite concrete in the way she views her world. My question to you is 'should I confront this functioning or should I offer her some interpretation about what motivates the functioning?'

Group discussion: In the world of ego psychology, an interpretation is a remote statement that makes various explanations for what is occurring: it should come <u>after</u> a confrontation about 'what are you doing in the here and now.' This would be the correct sequence.

Supervisor (S): I am curious why Janis was offended by the remark of her friend (since it sounds like one of those 'only positive things' type of comments).

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Clinician (C): It came from an acquaintance who was more of a stranger -- it came unsolicited -- it came as just more 'shoulds' about what to do in the situation

S: The story is about 'someone offering an impersonal axiom,' where a person is offering some general platitudes. The derivatives of that story suggests that this client wants you yourself to be more real with her. I remember research on a group therapy project for women with breast cancer in which a significantly increased survival rate resulted for the women in conventional psychotherapy, where they had a chance to really talk about the nature of having cancer, etc. These women immersed themselves in the toughness of having breast cancer, where interventions were not censored, triturated for these clients.

Discussion among several present: The implication here is that anything the client presents to you regarding an outside relationship can be a meaningful comment about the therapeutic relationship. The way you work with this is, first, to hear the remarks in that context; second, to perhaps change your tactic with that client accordingly (in this case, by leading the client into more painful areas). After this tactical change you see how the client responds to your efforts. You might also just say to the client something like, 'I wonder if any of this might be applicable here with us,' or 'It may not be true right now here with us but do keep it in mind about what might happen with us,' etc.

C: I do notice that I have been more flexible, more available with her (since she got the cancer) [clinician implying that she is letting the client off the hook]

S: So now where is this stance of yours coming from? Is it again counter-transferential? Do you have some issues in your own past around feeling delicate, wanting delicate treatment, etc.? Does your client perhaps coerce the same sort of situation what she resented with her parents in her history? Does the breast cancer provide and opportunity for real psychological transformation here?

C: Even before she got the cancer, she made it clear to me that 'don't tell me this an "opportunity!" She rather dictated to me how to proceed.

Another Clinician (AC): That is one way to perceive what she was saying (but I'm not certain it is necessarily what the client meant, nor what you should do with her).

S: I am not certain she is telling you to 'back off.' Instead, I think she wants you to become more personal.

C: So how am I supposed to work with this?

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AC: You work with it by focusing on your own overt and covert deviations from the therapeutic frame of regular attendance, authenticity, psychodynamic interpretations.

C: So it is my projection that the client is overwhelmed -- I see now that I myself am overwhelmed with various intense situations in my own life. When I project that she is overwhelmed, and my backing off her as balancing things out in her life, (it is actually my own needs I am addressing, not hers).

AC: Right. You try to do the balancing for her. She needs to be working on balancing her life, not having you doing the balancing for her.

S: Also -- what are here the actual fantasies about her own death (you need to help her examine these and perhaps interpret these). It sounds like you often infer from her data that her life is intense (but this may be coming from your own intense life issues).

C: But she comes into my office saying 'this is the only place I can cry,' and she cries and cries.

S: But "overwhelmed" implies a loss of ego control -- she can control herself out there in her own life -- if she were truly overwhelmed she would be crying everywhere, not just in your office -- so she is definitely beleaguered, but still in control of her life.

Still Another Clinician: So owning your own projection [that the client is overwhelmed and cannot tolerate your confrontations or authenticity] is quite important.

C: She seems to use her emotional state to justify holding on to various phobias in her life.

S: These appear currently to be phobias about death -- you can help her experience these horrors [rather than to cognitively keep them at bay by obsessing about them]. Remember, her whole style is suppressive.

Another Clinician: My compliments to you both about this dialogue here, I think it is a great example of clinical supervision.

All: There is a remarkable level of love and real security in this group. Note above various components of the supervisory interaction. It's a tragedy that real clinical supervision is not funded in this State, that systems don't allow the time for it, that the State even insists social workers be supervised in public programs where they are likely to get little genuine supervision.

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