The story of the lazy, incompetent therapist who always blamed her client.

Reflective supervision the treatment of borderline personality disorder
The program

- Dpsych program at Wollongong has a specific focus on the treatment of personality disorders and in particular Borderline Personality Disorder.
- Interns complete a year long placement at both the clinic and Specialist Psychologist Services which is part of Area Health.
The program

- As part of the SPS placement they are expected to co-lead a DBT group and undertake client assessments for suitability to the program.
- At the clinic they are expected to take up to five personality disordered clients and provide longer term treatment (32 to 50 sessions).
The program

- Delivered utilising a psychodynamic approach either objects relations or schema therapy focus.

- Supervision is provided individually by myself one hour a week plus extras during emergencies
The therapists and their issues

• Students have not had their own therapy, have not worked in this model and are sitting down to work with the more complex end of the personality disorder spectrum.

• They have a feeling of moderate competence in CBT but often feel quite deskillled as they are moving to a totally different model.
The therapists and their issues

- They carry fantasies (negative) of the type of client they are going to work with that are often quite unrealistic. This combines with an over idealised idea of what a good therapist should be to create considerable anxiety.

- On the positive side they come to this with enormous talent and intelligence and a positive if somewhat idealised picture of the experience.
The clients and their impact

• The capacity for BPD to evoke powerful negative and positive emotions in therapists along with at time uncontrollable emotions is well known.

• The term projective identification seems tailored made to describe this reaction. Although it is often more experienced like a projectile.
The clients and their impact

• It is not like this is just a temporary state of affairs. For the most part it is a roller coaster for most of the time.
The clients and their impact

There is a range of intense feelings evoked:

- Frustration and rage
- Guilt and resentment
- Anger and sadism
- Fear and avoidance
- Pity
- Disgust
- Helplessness and hopelessness
- Despair
- Feelings omnipotence and power
- Protectiveness
The clients and their impact

- ...and that can be in just one session
The treatment and its techniques

• Because BPD is a disorder of relationship then this becomes the central focus in therapy.
• There is a semi-constant need to rework the working alliance back to a positive position over and over again and to rebuild a sense of safety in the room (for both client and therapist).
The treatment and its techniques

• To do this the therapist needs to come back to a position of empathy for the client no matter what is projected onto the therapist in terms of idealised or negative emotions. Without this the working alliance cannot be maintained.
The treatment and its techniques

• Looking at the recent overviews of all the effective therapies for BPD Fonagy comes to the conclusion that they all have a central theme of building a reflective space within the client.
The treatment and its techniques

• Call it what you will, wise mind, integration of internal objects, re-parenting at the end of the day we are looking to develop an internal space where the client can consider their feelings and their needs and make more useful choices about meeting those needs.

• A place where the client can be more in touch with their humanness.
The treatment and its techniques

- The focus of supervision is on development of technique.
- This is at the expense of theory and deliberately so. Theory is intellectual and the basic techniques are to some degree theory neutral. (Wallerstein 1990 Abrams et al 1989).
- Even more, new interns to this model can only absorb so much.
The treatment and its techniques

- Far more important they are able to focus on the relationship and development of an empathic and neutral stance towards the client.
- They can fit all this into their theoretical model later on.
- There are strong counter arguments to this approach as well. Rangell 1988
The treatment and its techniques

• A simplistic model is presented aka Scheslinger of “doing family therapy inside the clients head”. To do good family therapy then all family members need to be in the room.

• The need to give different aspect of the self a voice
The treatment and its techniques

- Concept of always refocusing inside an individual. Take the outside in. In other words external interactions, relationships and conflicts are likely to mirror internal dynamics.
- The concept of holding and making it safe a la Winnicott
The treatment and its techniques

- Focus on therapist’s counter transference i.e. their emotional reaction to the client.
- Therapeutic errors are inevitable. Lurching from one therapeutic error to another.
The treatment and its techniques

• Active neutrality and the concept of multiple empathy. In other words finding statements that allow empathy to both sides of a conflict or to multiple voices within the client.
Supervision and the supervisor

• It is amazing how little literature there is too guide a supervisor in this type of supervision. The move from practitioner to supervisor is no less greater than what the supervisees go through starting to work in a dynamic model.
What is reflective supervision?

- Reflective supervision tends to focus away from the client and onto the therapist and their reactions and thoughts, feeling and fantasies about their client.
- It is non-directive and uses Socratic questioning in a more open ended way rather than as guided discovery.
What is reflective supervision?

• There is a trust that the therapist has the answers and it is supervisor’s role to assist them to find them.

• The supervisors power comes from providing a safe reflective space rather than as an expert or someone with more insight. The supervisor can be visualised as a container for the therapists’ anxieties.
What is reflective supervision?

- Processing and voicing of emotional reactions and when safe enough exploration of the therapist fantasies in regard this.
- Doing this, until a new place of empathy is reached.
- Relating all of this back to the client.
What is reflective supervision?

- Reflective practice however at the end of the day has to have a purpose.
What is reflective supervision?

- As good as a good bitch about a client feels if this information is not utilised to change what is happening in therapy then it does not have real value.
- All this humanness, political incorrectness, humour at the expense of the client still has to be translated into a psychological formulation about the client.
What is reflective supervision?

- Reflective supervision starts with where the therapist “really is” not where they “should be”.
What is reflective supervision?

- My own influences on this have been primarily:
- Susan Gill’s book: *The Supervisory Alliance*
What does this type of supervision require

• Supervision needs to becomes a mirror for therapy and vice versa.

• The need for safety and boundaries. This needs to be made overt but must be demonstrated by the actions of the supervisor.
What does this type of supervision require

- The need for neutrality and empathy to the therapist’s internal states and needs.
- It is the supervisees job to do the work the supervisor’s job to make the space for that to happen hence the concept of laziness.
- If the supervisor is working then the supervisee is not working.
The need for the supervisors to reflect on own needs

- How does our own narcissism, need for attention and praise interfere with encouraging reflection.
- How to balance our needs for this with best interests of the student.
- Understanding our own needs as supervisors
- Understanding our driving schemas/conflicts
- Managing our own sense of incompetence
- Envy
- Anxiety about intern incompetence reflecting on our competence/value/esteem
De-idealisation of the supervisor

- It suits the supervisee as much as the supervisor for the supervisor to be the expert. This minimises anxiety and defends against a sense of incompetence on both sides.
De-idealisation of the supervisor

Interns come with highly idealised view of myself due to:

- Previous interns
- Reputation
- Own insecurities (deskilling) about both the complexity of the client group and shift to a new type of therapy.
- I am an older male
De-idealisation of the supervisor

• Delicate balance of supporting and informing at the same time gradually de-idealising myself. Recognition of one’s own narcissistic pleasure in this position and trading this for vicarious pride in interns achievements.
Use of self disclosure

Self disclosure is usually more common in supervision and it can serve a vital function in helping humanise and de-idealise the supervisor.

- Own emotional reactions
- Human and often politically incorrect reactions
- Use of humour
- Sharing of own weaknesses and examples of therapeutic errors from my own therapy
- Own up to my own confusion and unsureness
- Enabling the sitting with ambivalence and unsureness
Counter transference and its reflection

- I want to spend the rest of the time looking at one particular aspect of reflective process and providing a vignette on its use.
Counter transference and its reflection

- Counter transference is defined in its widest sense as whatever the therapist feels or fantasises about the client without implying anything about the origins of those feelings. (Racker 1957, Hunt 2001)
Counter transference and its reflection

• Many supervisors are reluctant to explore therapist’s reactions to clients. This is often on the basis that it may intrude into the personality and inner life of the intern-therapist or may turn into psychotherapy.

• It is easy to justify that supervision should focus on the client and technique and that CT is more related to the therapist own “stuff”.

Counter transference and its reflection

- Nothing in my view particularly in the treatment of BPD could be further from the case and this focus on CT using reflective techniques has become the central part of my supervisory work with Dpsych interns on our program.
Counter transference and its reflection

One can see that yes you can explore this on a personal level:

• What memories does this stir up
• What underlying needs does this interaction activate in the therapist
• What does this reflect about the therapist life now and in his past.
Counter transference and its reflection

However this can also be explored with a view to reflecting on what is happening with the client.

- What emotions did the client evoke in the therapist?
- What are the client's motive for evoking these emotions?
- What does this say about the therapeutic relationship?
- What might this tell us about the patient's history?
- What might this tell us about the patient's interaction with significant others?
- What might this tell us about the client's internal dynamics?
Counter transference and its reflection

- This is the primary focus of using reflective techniques in supervision. If the therapist also learns something about himself then this is a bonus but not the primary focus.

- If nothing else this processing of emotional reactions clears the therapist head to think more clearly about his work with the client.
Counter transference and its reflection

- This process can only occur in a relationship that feels safe enough to the therapist.

- Intern therapists often carry a particularly rigid and Jehovian idealised internal therapist and emotional reactions, impure thoughts, and politically incorrect characterisations are judged harshly frequently evoking enormous amounts of guilt.
Counter transference and its reflection

- As a result, the therapist frequently attempts to find an explanation within themselves or within their own life. Far easier to manage the guilt if it is my own fault.
Counter transference and its reflection

- I call this the hypothesis of last resort. The rule in our supervision is that one can only blame oneself for what has happened in therapy after we have explored the view that it is the patient’s fault. After we have blamed the client and developed hypotheses around this.
Counter transference and its reflection

• This also demands that the supervisor put away their anxiety and their fears that the therapist may act on some of their emotions.

• Accepting more importantly a curious attitude to all any reactions that come up is part of the process of making it safe enough for the therapist to explore these reactions.
Counter transference and its reflection

- If the supervisor doesn’t pay attention with this attitude, he communicates a message that this is not to be talked about.

- If the therapist is feeling guilty about it may lead to some type of mistrust or resentment directed toward the supervisor and lessen the sense of safety.
Counter transference and its reflection

• The supervisor also has CT reactions to the therapist and these also should be food for discussion.

• The sharing of the supervisors CTs can significantly deepen the supervisory relationship. The therapist can see the supervisor as human, fallible, unsure.
Counter transference and its reflection

- The interactions between therapist and client and therapist and supervisor all become useful grist for the mill to hypothesise about what is going for the client.
Counter transference and its reflection

• At a basic level simple assumptions are made
• The interactions between client/therapist and therapist/supervisor directly reflect the clients' relationships with significant others both in their present and past and should be explored as such (aka Malan’s triangle).
Counter transference and its reflection

• More importantly we hypothesise that these interactions reflect internal interactions between different aspects/modes/objects/selfs within the self.
• For the therapist the processing of this counter transference moves them from an emotional position often accompanied by helplessness and guilt to a position of understanding and deepened empathy for the client.
Counter transference and its reflection

- This can then be taken back to the therapy room and tested out and explored with the client.
### Symmetrical and asymmetrical parallel processes

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<thead>
<tr>
<th>Patient</th>
<th>Therapist</th>
<th>Supervisor</th>
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<tbody>
<tr>
<td>Helpless, whining, victim</td>
<td>Frustration, anger,</td>
<td>Frustration, anger,</td>
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<td></td>
<td>directive</td>
<td>directive, controlling</td>
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<tr>
<td>Helpless</td>
<td>Helpless</td>
<td>Helpless (Neil Young triad) Incompetent</td>
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<tr>
<td>Aggressive attacking sadistic</td>
<td>Defended angry</td>
<td>Directive and controlling</td>
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<td></td>
<td>attacking back, guilt</td>
<td>and critical</td>
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<td>Frightened, closing down</td>
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<tr>
<td>Disconnected, dissociated</td>
<td>Overactive intrusive</td>
<td>Angry or critical</td>
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<tr>
<td>Dissociated or defended</td>
<td>Bored, unable to recall session</td>
<td>Bored sleepy</td>
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