

Follow the Fox—An Inquiry Into the Vicissitudes of Psychoanalytic Supervision

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ONE MIGHT WELL WONDER WHY a paper on the problems of psychoanalytic supervision would carry such an odd title.⁴ But there may be more similarity between supervision and riding to the hounds than at first appears evident. Oscar Wilde, my favorite aphorist, took a particularly dim view of fox hunting. It was, he said, a marvelous example of the *unspeakable* in pursuit of the *inedible!* With a very slight shift, much the same might be said about the process of supervision. It is a marvelous example of the *infallible* in pursuit of the *ineffable!*

This may appear to be a rather strained bit of punning, but I have something quite specific in mind. First, there is something oddly infallible about the experience of doing supervision; and secondly, as we would all agree, something ineffable (or beyond words) in the process of doing therapy. In the ordinary course of my work, I spend (as I'm sure we all do) a very considerable part of my time perplexed, bored, confused, and at sea. Sometimes I dream of a mid-life career change to something simple, clear-cut, say dermatology; but when I supervise, *all is clear to me!* With the rare exception of the supervisee who is so confused or inchoate that I can capture no sense at all of what he's doing, the problems that the supervisee is having with his patient, the difficulties, technical and theoretical, seem to me surprisingly clear, most of the time. As far as I can tell in reports on other people's supervision, this phenomenon is not so very unique. People whom I've supervised, who seem confused to me at the time, seem to be perfectly clear when they're supervising other people; and I've had the experience, at a White Institute seminar, of presenting my own adumbrated clinical material and having a class of seven or eight candidates seeming perfectly lucid about what's wrong with what I'm doing, and what I should be doing instead. I don't think this is a consequence of any obvious pecking order in psychoanalytic institutes, but rather, some odd, seductive aspect of the phenomenology of the supervision process itself. It is extraordinarily out of synchronization with our own clinical experience, and is misleading to our supervisees, inasmuch as they are led to believe that when they "grow up," all will be clear to them, too. It also creates considerable discord in the supervisee's own training analysis, where obviously no such coherence or clarity of concept and purpose can exist. Of course, this claim that doing supervision breeds infallibility may simply be my own grandiosity, or, in the preferred pejoration of the times, narcissism, but I consider it an issue worthy of further examination. I think it does exist and that it's the consequence of what Bateson called (following Bertrand Russell), a "failure in logical typing". That is, it is a failure to understand that supervision is of an entirely different level of abstraction than therapy (Bateson 1979). Briefly, the theory of logical typing posits that a class, and the members of the class, are of different levels of abstraction. In other words, a class cannot be a member of itself. Applied to the process of supervision, it follows that what we are doing is discussing a *class* of transactions of which the particular patient is a *member*. We are never really discussing, in supervision, a specific patient; but a class of transactions applicable to *all* patients and illustrated by a specific patient. The apparent clarity is a consequence of this step up in abstraction level, and as Count Korzybski noted, clarity

⁴This paper was first presented at an April, 1981 weekend meeting of the William Alanson White Psychoanalytic Society. As it happened, the meeting was held in the heart of fox-hunting country, thus rendering relevant the foxy simile.

increases with the level of abstraction (Korzybski 1954). If the supervisor were really to participate in, for example, "parallel process"; that is, to become part of the therapy, he would be largely rendered speechless, since it would become evident that the interactions were so complex that he could say nothing. The moment one moves from the general category of patients for whom this patient is an example to the actual patient, one has plunged into a complex interpersonal morass that is now no longer limited to the three participants, but encompasses all the usual ramifications that proliferate in any analysis. Now there are three participants in a poorly controlled and delimited field. The number of persons symbolically present in the room increases exponentially and the field becomes virtually chaotic. One is left with a psychoanalysis run wild.

Caligor quotes Doehrmann on parallel processes as stating that "one is struck by the multifaceted nature of what on the surface seems to be a simple, and even limited, relationship" (Doehrmann 1973). To repeat, the ramifications of supervision, transference, counter-transference, all the orchestrations of patient-therapist-supervisor would become so complex as to defy any real understanding. In a word, I am suggesting that supervision is possible only because it is *not* therapy. It is something altogether different, operating at a higher level of abstraction.

I don't think that the second referent of my aphorism, the *ineffability* of psychoanalysis, that is the difficulty of putting it into any kind of words, requires much elaboration. It seems perfectly clear that in any process which is both performed and talked about, what is said and what is done are not in a direct relationship to each other. One cannot learn to do anything exclusively by being told how to do it, and no one who knows how to do something well can transfer that knowledge by telling the other person how to do it. Anyone who has practiced a physical activity, a sport, a craft, or an art, is perfectly aware of this discrepancy. *The art of teaching operates in the interstices between the word and the act.* So, we are confronted with an apparent paradox: we feel very clear about what it is we wish to teach, and we are equally clear that we don't know exactly how to formulate it. From this perspective, there is nothing unique about the problems of teaching psychoanalysis; or, for that matter, psychoanalysis itself. The psychoanalytic act seems to be a very special case of human discourse; and its effectiveness lies, not in any esoteric distinctions, but in a rigorously maintained, focussed attention. I'll elaborate that, but for the moment, I want to simply suggest that, in golf, skiing, tennis, playing the piano, or painting a picture, the same paradox operates. We have, most of us, learned (at least, those of us who have any friends left) to avoid supervising in non-analytic situations. Somehow, our wives, our children, our tennis mates, our skiing partners seem to become oddly angry and resistive if we point out to them the obvious shortcomings in their techniques. Why do people have such trouble listening to good advice? Well, maybe because it's irrelevant.

Now, if it's true that we're not helping the supervisee with a specific patient, but rather, abstracting the analytic process, it would be most useful to have a classification of supervisory interventions: that is, different styles of intervening in supervision. As an attempt at classification, I have delineated a number of rough categories:

1. *Holding or confirming*
2. *Teutonic, or by-the-numbers*
3. *Algorithmic*
4. *Metatherapeutic*
5. *Zen, or opening-the-fist, supervision*
6. *Preceptorship*

I shall briefly review each of these rather arbitrary, and surely incomplete, categories of ways of teaching psychoanalysis, or rather, supervising psychoanalysts.

Holding: Erwin Singer and I were in joint supervision in our candidate days at the White Institute with Clara Thompson. Erwin and I were in supervision with her for, I think, well over two years. During this time she hardly said a word to either one of us. She would sit quietly, scratching her crossed forearms, her deceptively mild, porcelain, blue eyes looking vaguely off over our heads, nodding occasionally. Erwin and I would have coffee later, absolutely convinced that she had not listened to one word that we had said. However, when trouble came up, when we were blocked or confused, she could, with a couple of casual sentences, pick us up and set us back on our wheels. It was, in many ways, an extraordinary experience. She was not warm or maternal or benevolent or supportive; nor was she critical, derogating or obstructionistic. She didn't seem to want anything from us—to be reassured that she was a terrific supervisor and theorist, lovable, nurturing—anything. She was like the Matterhorn—simply there. I don't know exactly what happened, but it was one of my better supervisory experiences, and I learned a great deal, although I couldn't tell you what I learned. It was, I think, technically a holding atmosphere. She established (in the psychiatric sense, not in the derogatory sense) a "playground" in which she let us find ourselves. If we asked, we received advice, but otherwise we were left alone to explore our own idiosyncratic styles and talents. It may be a wonderful way to do supervision. It was certainly a catalytic process, in the literal sense of the word, but it takes someone of very considerable presence and reputation to do it and get away with it. It establishes no structure to the supervision at all, but allows the therapist to listen to and feel for the movement of therapy on which I'll elaborate later. It also allows the therapist to fall by the way, and being supervised by Clara was a little like having an eagle for a mother: she took you out of the nest and dropped you; if you flew, fine, and if you didn't, tantpis!

Teutonic, or by the numbers: This method of teaching operates on a manual of prescribed situations and responses. It is also inevitably lock-stepped into a metapsychology which is both authoritarian and omniscient. For everything the patient says and the supervisee does, the supervisor has a theoretical formulation and a corresponding piece of behavior. The patient is explained to the supervisee in terms of the metapsychology, and the therapeutic intervention follows automatically, to wit: "The patient is narcissistic and unable to ... and therefore one must ..." I confess, I find this process as abhorrent as painting by the numbers, and I think the outcome is about as predictable and esthetically miserable. This neat fit between theory and practice is, I believe, the last resort of the unimaginative; but it has considerable appeal and tends to make the supervisor rather popular among psychoanalytic candidates who wish to believe that *someone* is clear about what they are doing. Moreover, this genre of supervisor radiates great confidence and cheer—the unjust reward of the true believer. Sullivan once said, "God keep me from a therapy that goes well, and God keep me from a clever therapist!" I think this is what he may have had in mind.

The algorithmic approach: This method is superficially like the authoritarian, or by-the-book way of teaching psychoanalysis, but it has some extremely important and subtle differences. An algorithm is defined as a series of systematic steps that lead to the solution of a problem. The algorithm is so designed that one step leads to the other. Now, here's the important distinction: the algorithm simply claims that, if one follows the steps, the outcome results. It doesn't claim that it has an intrinsic relationship to the problem itself. Let me clarify that. The book method, the interpretation-by-the-numbers method, claims that therapy works because the theory is right, and if the theory is followed correctly, and applied correctly, and timed correctly, the outcome will be correct. Therefore, a successful outcome demonstrates the validity of the metapsychology. It is a tautological device. In contrast, an algorithm is simply an operational series of steps. It may or may not have a theoretical idea behind it, but it makes no claim that the theory is necessarily related to the outcome. As a very simple example, in the Middle Ages there was an algorithm for preventing the ague. They knew that you had to close the windows at night (i.e., avoid night air), build your house on high land and make sure there was no stagnant water in the house or surrounds. Now, this was based in some way on the assumption of the evil effect of humors and night air. They didn't know about the anopheles mosquito, and they didn't know about the malarial protozoan; but they had a step-wise procedure, an algorithm, for preventing malaria, and if one followed it, it worked. Now, this, essentially, is the position I'm going to develop later: namely, that the function of supervision is essentially to supply the supervisee with an algorithmic approach to the analytic process, with the caveat that this algorithm facilitates treatment only through an indirect relationship to how treatment works. I suspect that very probably the algorithm taps into some deep structure, as does the treatment for ague, but that our hermeneutics, our explanatory systems, really may be irrelevant to that. In other words, therapy depends, not on the rightness of the hermeneutics, but on the relevance of the algorithm. I think the metapsychology one chooses—whether it's interpersonal or Freudian or object relationship—is really more a matter of personal aesthetics, and I would prefer

the supervisee to find his own system of belief, as long as he recognizes that successful therapy doesn't depend on his indoctrinating the patient with his beliefs or translating his theoretical beliefs into systematic action, nor obversely does it prove his metapsychology to be correct.

The metatherapeutic approach: This approach consists largely of seeing the supervision as an extension of the supervisee's analysis; that is to say, the supervisor works with "countertransference." This usually means that he feels entitled to inquire into the therapist's personal problems and sees the supervision as an opportunity to help the therapist to expand his self-awareness and to see where his anxiety points are located. Thus, psychoanalysis becomes the analysis of countertransference, either (in the classical sense) to minimize it, or (in the interpersonal sense) to utilize it (Epstein and Feiner 1979). The supervisor sees himself in the role of a special catalyst for the supervisee's personal psychoanalysis and psychological growth. My objection is not that it doesn't help the supervisee's therapy with the patient (since I think it does), but that it doesn't advance the basic issue of supervision, as I see it, which is not how to get the supervisee to learn what we already know, but how best to facilitate, or at least, not interfere with, some ineffable process of learning by which he settles into professional competence.

The Zen method: This technique is one in which the supervisor confronts the ineffable by creating an atmosphere of creative disorganization. He harasses, raps, interferes, until the therapist, the supervisee, in the Zen term, "opens the first," that is, lets go all of his preconceptions and tightness out of a sense of despair. It may appear as if I'm ridiculing this method, but I've been on the receiving end of it, both in psychoanalytic supervision and in learning other activities, and it really works, particularly with tight, obsessional people. If one is screamed at long enough, one gets despairing and suddenly lets go, stops thinking, and to one's absolute amazement, discovers that the activity now seems natural and easy.¹ Anyone who has had a "by-the-numbers," Class II supervisor should certainly have a "Zen," Class V supervisor as an antidote. In fact, I think they sometimes make a useful team, like the hostile-and-kindly interrogator teams used by the police. One first learns the rules, and then gets them knocked out of one's head. It's a combination worth considering.

Now, *preceptorship:* Here, the therapist learns by watching what the supervisor does with the same situation. This is the technique that Searles, Caligor and Bromberg wrote about, as "parallel or reciprocal process." (Searles 1955), (Caligor 1981), (Bromberg 1981) The supervisee brings the therapy into the supervision process by playing out (albeit unconsciously or automatically) the interaction with the supervisor in such a manner that the therapist plays the role of the patient. The supervisor can then, at first hand, experience the intersubjective psychoanalytic situation and react to it. It has the value of showing the supervisee the homeostatic power of systems, but I don't much like this method, because: although it illuminates the therapy for the supervisor, so that he can formulate of the metapsychology. It is a tautological device. In contrast, an algorithm is simply an operational series of steps. It may or may not have a theoretical idea behind it, but it makes no claim that the theory is necessarily related to the outcome. As a very simple example, in the Middle Ages there was an algorithm for preventing the ague. They knew that you had to close the windows at night (i.e., avoid night air), build your house on high land and make sure there was no stagnant water in the house or surrounds. Now, this was based in some way on the assumption of the evil effect of humors and night air. They didn't know about the anopheles mosquito, and they didn't know about the malarial protozoan; but they had a step-wise procedure, an algorithm, for preventing malaria, and if one followed it, it worked. Now, this, essentially, is the position I'm going to develop later: namely, that the function of supervision is essentially to supply the supervisee with an algorithmic approach to the analytic process, with the caveat that this algorithm facilitates treatment only through an indirect relationship to how treatment works. I suspect that very probably the algorithm taps into some deep structure, as does the treatment for ague, but that our hermeneutics, our explanatory systems, really may be irrelevant to that. In other words, *therapy depends, not on the rightness of the hermeneutics, but on the relevance of the algorithm.* I think the metapsychology one chooses—whether it's interpersonal or Freudian or object relationship—is really more a matter of personal aesthetics, and I would prefer the supervisee to find his own system of belief, as long as he recognizes that successful therapy doesn't depend on his indoctrinating the patient with his beliefs or translating his theoretical beliefs into systematic action, nor obversely does it prove his metapsychology to be correct.

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I have presented a simple three-step algorithm for doing therapy. One notes that it promotes no metapsychology, no manual of tactics or timing. I want to emphasize that I think this algorithmic three-step process is at the core of any psychoanalytic position, from the most conservative to the most extreme interpersonal. The therapeutic leverage lies in the resonance of the second and third steps made psychologically tolerable for both participants by the containments and constraints of the first step.

How the transference is perceived varies a great deal between psychoanalytic groups. In the Freudian system, the patient's problems are projected onto the analyst. In the object-relationship position, the problems are projected into the analyst. In the Sullivanian position, a much more complex mélange of distortion and accurate perception occurs, and it is the function of the therapist to aid by consensually validating and sorting out the patient's perceptions. There is also considerable diversity (and no small acrimony) in the debates about how active the therapist may be, and where the therapeutic leverage lies. The therapist may see himself as a nonparticipant purifying the field, as providing a holding environment, providing a corrective emotional experience, involved in a heroic struggle for authenticity, for the patient's sanity, or explicating a homeostatic system that can be only shifted by increased awareness.² In other words, there are many different ways of perceiving one's participation.

²See Epstein L. and Feiner A. H. (1979) for an extended discussion of uses of the counter-transference.

For me, the transference is not particularly a place of projections, projective identifications, or parataxic distortions, but rather, a real transaction. In the course of a detailed inquiry into the patient's life, including his fantasies and dreams, within the constraints of the therapeutic agreement which limits and contains the anxiety of both participants, something relatively simple happens. As the therapist inquires into the patient's life and as the events that are reported become more complex, it becomes evident that it is possible to view them from a variety of perspectives. That is to say, anything the patient tells you is subject to an almost infinite number of observational perspectives, a veritable *Rashomon*. Indeed, it is virtually impossible to say anything to anyone, even a stranger accosted in the street, which is not, from some perspective, true. So, it seems to me very unlikely that the therapist can listen to anything that the patient is telling him and be perfectly clear that there is only one possible explanation. It therefore follows that, however the therapist sees or understands what he is listening to, whatever questions he asks to extend the data, whatever interpretations he makes represent a posture or position about what he is hearing. He is therefore, willy-nilly, participating in what he observes. This participation is both called out by, and calls out, some response from the patient who will color and select his data, either obligingly, defiantly or whatever. This dialectical exchange constitutes the act of participant observation and consensual validation. It is not simply listening to the patient and then helping him sort out what is real and what is not real, it is a much more complex dialectic between what he's telling you and what you're selecting to hear and to respond to. Both participants can and will respond to that exchange (the transference exchange) from an almost infinite variety of positions, and they will choose those most consistent with their life experience and security needs. To put it succinctly, *the transference is the way that the patient and therapist will behave around what they're talking about within the framework established by the constraints of the therapy*. Analyzing the relationship between what is talked about and the behavior that goes along with what's talked about constitutes the psychoanalytic process, as I see it; and is what distinguishes it, essentially, from all other forms of psychotherapy.³ The transference from this perspective is seen as a dialogue of two real people, interacting in a real way out of their own particular interests and experiences and investments. Therapy is rooted in a matrix of real relationship defined by the terms and agreements of the psychoanalytic setting. The traditional psychoanalytic view is to see the therapeutic leverage as lying somewhere in the correlation of the transference and the patient's infantile life; i.e., in a transformational correlation between what happens in the transference and what has happened early in the patient's life or what he has fantasied as having happened early in his life. I would prefer to see the therapeutic leverage as lying in the resolution of a redundant interaction with a great deal of homeostatic power. The therapist and the patient struggle through to a different kind of engagement against the pull of the homeostatic system. This, then, permits the patient to review and enrich his perception of his earlier life and permits him a wider range of participation with people with whom he is currently involved. I do not think a therapy works unless it is authentic and unless both participants are engaged and changed by the experience.

To get back to the issue of supervision, with beginning therapists I would work on structuring the therapy, delineating it, helping the therapist to pace and control the flow of material, helping him to learn how to do an inquiry, how to visualize what he is being told, so that if he cannot see it and he does not know it, he can ask more questions about it. I tell supervisees that, if they were directors with a script and they could not show their actors how to play out a particular part, they really do not understand the whole matrix of metacommunication which is taking place. psychoanalysis, in this sense, is the science of omissions. Lastly I would introduce the therapist to the notion that, while he is examining the patient's life, he is also interacting with him, and to notice the extent to which parallel or isomorphic interactions seem to take place in the patient and in himself, in the process of the therapy. The next level of supervision would have to do with elaborating the nature and intentionality of interpretation; that is, to indicate to the therapist that every time he interprets he is taking a position about the material, that this is only one of many positions that can be taken about it, and this position represents a participation with the patient which is both isomorphic or resonates to the patient's life experience but also comes out of who the therapist is and what his real life experience is. Simply examining the expanding ramifications of this network of interactions enriches the therapy and, as Sullivan pointed out, is like widening the beam of a flashlight on the patient's life. The third level of inquiry which I would reserve for more sophisticated and senior analysts, and particularly those working in the termination phases of therapy, is to begin to examine their realistic participation with the patient. In this sense, the therapy is seen as genuinely in the intersubjective realm; that is, occurring between the patient and the therapist, and a situation in which they are equal coeval participants. Herein, the distinction between doctor and patient becomes blurred. I would reserve this inquiry for the termination periods of therapy, not because I think it is limited exclusively to that time, but because it requires a certain amount of experience and familiarity with the psychoanalytic technique to be able to use this methodology. Like all learning procedures, one starts with a set of rules, then learns to violate the rules for virtuoso purposes.

³See Levenson (1979) for an extended discussion of this issue.

You will note that the supervisee is not instructed on how or why this works, how he should *use* the transference, *how* to make the patient change. He is not supposed to figure out what is wrong with the patient or how to change him. As Bion put it, each session is entered without memory or desire; that is, without conscious intention or direction (Bion 1970). Most supervisees have extensive experience doing psychotherapy. They are used to goal-oriented, defined, purposeful therapies and they are disconcerted by the loose, floating quality of what I am suggesting. It is only when they hear the material begin to enrich and shift, hear the recurrent themes emerging through the material and experience the extraordinary recapitulation of the material in the intersubjective realm that they come to see that some process is going on which they have not initiated or energized. There is the remarkable experience of being carried along by something larger than both therapist and patient: a true sense of an interpersonal field results. The therapist learns to ride the process rather than to carry the patient.

I do not think that steering the therapist by helping him clarify his countertransference or showing him how to do it or giving him an interpretative, metapsychological armature on which to rest his interpretations is ultimately very useful. It may well be political, since it reduces anxiety and is very endearing to supervisees. Let me use a brief example: Supposing a therapist comes to me for consultation, a single session, around a patient with whom he has been working for some time and with whom he is having difficulty. As usual, it all seems perfectly clear to me. Suppose I tell him the way it looks to me; he seems relieved, leaves happy and grateful. It is indeed the infallible in pursuit of the ineffable! The real question is, why, if it's so clear to me, isn't it so clear to him? Does he not see something because he has "countertransference"? Is he dumb? Is he bound by theory? I think, actually, I would be telling the therapist what he is telling me to tell him. And at this point one has entered a very complicated hall of mirrors, and, I think, violated the constraints of the psychoanalytic process.

What can one do? First, one can maintain the constraints of the supervision, which is not to violate the privacy or limits of the psychoanalytic inquiry. In a word, stay out of the supervisee's analysis. Two, one can listen to the data, show him how to expand blind spots, point out that in the process of doing so, the supervisor is taking a position about the therapist's position about the patient—not that this position is necessarily clearer, or closer to the real truth. It is only more explicated. Hopefully this would permit the supervisee to detach himself from the supervision and look at his own position *vis-à-vis* his own patient. It's the exploration of this engagement which is the leverage of psychoanalysis; and for that, the therapist must go back and work with his own patient, not with the supervisor.

To be sure, I've set up a whole series of artificial boundaries and distinctions. Clearly, in the actual process of supervision, as in therapy, these categories overlap and often become indistinct. Nevertheless, what appeals about the algorithmic approach is that it's useful to have a method that works, even when you can't be sure why. I'd like to think that this algorithmic approach would work with any metapsychology. If the patient spends an hour talking about bad mothering, has a dream in which she is lying in a bathtub and finds that the water is floating with cockroaches, looks under her legs and sees that her little dog is drowning under her feet, and then tells you that she spent the entire night lifting the real, aging dog on and off the bed every two hours because it would jump up and then be unable to get down, and that she's planning to have a baby in a year; one would certainly hope that the therapist would see this as a continuous, recurrent theme having to do with mothering and nurturance. If the therapist points this out, it is psychotherapeutically useful and, above all, reassuring. It says to the patient, "By naming this, I indicate that your fears about mothering are only fantasy expectations." If the patient then proceeds to explore her own experience with mothering as a child, her own fantasy systems, and so forth, one is enriching the contextual field. However, I still don't think it's psychoanalysis. If the patient calls out in the therapist an unnurturing, hostile response, or if the patient acts with the therapist in a cold and unnurturing way, the transference dimension has been introduced, and one would hope that the therapist could correlate what he has heard with what is being played out between them. If mutual warmth emerges, or either participant is called upon to be excessively nurturing, another transference perspective is being played out. There is an infinite variety of ways they can engage the issue, but until they are aware that what they are talking about and expanding is simultaneously being enacted between them, I don't really see it as psychoanalysis. There are, beyond that, all sorts of extrapolations of how one does that and how one participates, but I think they constitute, largely, variations in technical approach and are not so central to the psychoanalytic principle.

As I said earlier, Harry Stack Sullivan once said, "God keep me from a therapy that goes well!" No one seems to say that about supervision. Supervision is not therapy. It operates, I repeat, on an entirely different level of abstraction. To confuse supervision with therapy is, in Korzybski's famous aphorism, to confuse the map and the territory.

We should find another name. I think it is not supervision. It is really *continuous consultation*, which is something else altogether. The moment the supervisor violates the consultant role and becomes "the supervisor," he drops into and becomes, along with the patient & therapist, a member of the class he was previously observing. He then stops treating the class of events and begins to work on the specific therapist-patient event, at which point, the constraints have been completely violated and one has an uncontrollable situation. If the therapist becomes passive, he can become the conduit for the supervisor and the therapy can go relatively well. He'll likely receive a good supervisory report; but, as I've said, I think these are the people who tend every year to start over again right from the beginning, as if nothing has been learned.

I think we best grapple with the process of supervision by focussing, not only on the value of what we're teaching, but the phenomenology of learning. To do that, we have to involve the supervisee in the process. What is his experience? Not only, how do we teach, but how does he learn? If we are the infallible in pursuit of the ineffable, we're "following the fox." Our problem from this perspective is how to teach the supervisee what we know but simply cannot clearly say. We are in hot pursuit of the elusive truth. Rather, I think the problem is closer to how to teach the therapist a *procedure* which calls forth a *process* which carries us all—supervisor, therapist and patient.

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