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What Is the Right Time for Supportive Versus Expressive Interventions in Supervision? An Illustration Based on a Clinical Mistake

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Although supportive-expressive (SE) psychotherapy is one of the most studied psychodynamic therapies today, little is known empirically about effective strategies in SE supervision, or in psychodynamic supervision in general (Diener & Mesrie, 2015; Watkins, 2011). One of the important questions in SE psychotherapy is how to decide when to use supportive and when to use expressive interventions. As a parallel process, this type of decision is relevant also to SE supervision. The present case study focuses on the decision-making process in an SE supervision session: when should supervisors use supportive as opposed to expressive strategies with their supervisees? Our aim is to develop decision rules that reliably support supervisors' decisions. We analyze a clinical error made by supervisors in this type of decision making, and show how mistakes of this type can either be avoided or, when they occur, how to turn them into opportunities for learning and for the formation of new understanding and growth. Similarly to the finding that therapists with better skills in managing their countertransference feelings were shown to have better outcomes with their patients (Gelso, Latts, Gomez, & Fassinger, 2002; Hayes, Gelso, & Hummel, 2011), we suggest that the management of the supervisors' feelings, and working through their mistakes with the therapists, can contribute to the supervisory relationship and to the development of the psychodynamic therapists' skills.

Keywords: supportive-expressive treatment, supervision, supportive techniques, expressive techniques, supervisory relationship

Supportive-expressive (SE) treatment is one of the most studied psychodynamic therapies today. SE is a time-limited, manualized dynamic therapy that includes the use of both supportive and expressive (interpretive) techniques. Supportive techniques are aimed at establishing a positive helping alliance between the patient and the therapist (Luborsky, 1984). The expressive techniques focus on understanding the patient's problematic relationship patterns and helping them work through core relational difficulties. The Core Conflictual Relationship Theme (CCRT) is a scheme involving central wishes, the actual or anticipated response from others, and the patient's response from the self. The CCRT is reproduced repeatedly as a theme and variations of a theme despite its self-hurtful nature (Leichsenring & Leibing, 2007). SE treatment has received considerable empirical support (Leichsenring, Leweke, Klein, & Steinert, 2015). Yet, little is known empirically about effective strategies in SE supervision and in psychodynamic supervision in general (Diener & Mesrie, 2015; Watkins, 2011).

Supervision of psychodynamic treatment in general, and of SE in particular, was found to be effective in increasing therapists' adherence to the manual and increasing treatment success. Empirical studies showed that training with ongoing supervision is more effective than training alone (Rakovshik, McManus, Vazquez-Montes, Muse, & Ougrin, 2016), and that training in psychodynamic psychotherapy without supervision is not effective (Bein et al., 2000). Crits-Christoph et al. (1998) found that therapists show better adherence to the SE manual as they progress in a specific therapy while receiving individual supervision. Crits-Christoph et al. (2006) showed that therapists can be trained with the aid of supervision to have better alliances. Structured training with supervision in psychodynamic technique that included case formulations according to the SE manual (the CCRT formulation) was found to be related to greater use of psychodynamic interventions and to higher patient rating of the therapeutic alliance (Hilsenroth, Kivlighan, & Slavin-Mulford, 2015).

To expand the use of manualized short-term psychodynamic therapy, effective tools for training and supervision are needed. Such tools can help disseminate existing knowledge and enable therapists to provide manualized short-term psychodynamic therapy that received support in several randomized controlled trials (RCTs). It is important, therefore, to identify the core active ingredients in effective supervision (Sarnat, 2010).

Diener and Mesrie (2015) have recently argued that two of the most important tasks in SE supervision are guiding the therapists' work with countertransference, and formulating and using CCRT interpretations. We suggest that another important issue in SE supervision is training therapists in deciding when to use supportive and when to use expressive techniques during psychotherapy. This type of decision making is also relevant for the SE supervisor during supervision sessions. It has been argued that it is the supervisor's role to balance the need to support the supervisee with the need to supply new information

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and with confrontation at a given moment (Safran, Muran, Stevens, & Rothman, 2008).

The present case study involves clinical supervision and focuses on the decision-making process in an SE supervision session, specifically, on when supervisors should use supportive as opposed to expressive techniques with their supervisees. The case study is part of the pilot phase of therapists' training for a RCT on SE for major depressive disorder. The therapists answered ads seeking psychologists with at least 4 years of expertise, wanting to participate in the RCT. Respondents were interviewed, and the four therapists who successfully passed the interviews attended a 20-hr training workshop in supportive and expressive techniques. The training included formal teaching and role playing using the different techniques. During the pilot phase and after the start of the research, the therapists received group supervision on a weekly basis from two supervisors, and biweekly individual supervision from one of the supervisors. Individual and group supervisions made extensive use of videotaped sessions for feedback. The supervisors were licensed clinical psychologists, with expertise in psychodynamic therapy. One was a licensed supervisor, the other was knowledgeable in SE psychotherapy. The supervisors received supervision concerning the supervision process from an expert in SE. To protect the confidentiality of the patient and of the therapists involved in the following clinical vignettes, we disguised their background details and asked for their written permission. The two supervisors are the authors of this paper.

Background Information

The clinical case reported here occurred in the second meeting of the group supervision. The therapists were just beginning their work according to the SE protocol, and had their sessions videotaped for the first time. They were nervous about watching their treatment sessions with the other group members on videos. The patient was a 30-year-old single man suffering from dysthymia for many years, who started therapy this time because of a major depressive episode. The therapist was a female psychologist, in her mid-30s. The supervision reported here focused on the first therapy session of the patient.

Verbatim Account of a Clinical Exchange

Therapist:	*The session was not easy but I think it went OK. I felt the patient was cooperative.*

The group starts to watch the video. Group members make a few comments about the patient being nervous and talking shortly. The therapist also makes some comments about herself looking and sounding strange and weird. Twenty minutes into the session the patient stops talking, and so does the therapist. A long silence begins.

Supervisor (after a few minutes, stressed and irritated, feeling sympathy for the patient who seems to been forsaken):	*What is this silence about? Why do you choose to keep quiet here?*
Therapist (stressed):	*I thought he was thinking about what we were talking about, I felt it was good for him to be left alone to think and not to have to respond.*
Supervisor:	*He does look as if he was left alone.*
A different therapist from the group (angrily):	*Why do you say this?! I'm sure she* (the therapist) *did it because she felt it was helpful!*
Supervisor:	*OK . . . I was asking in order to understand better. I felt it was not clear . . .*

The group keeps looking at the video quietly.

Therapist:	*Now it looks really terrible to me. How could I leave him alone like that? I'm sure he will not come back for a second session.*

The supervising session is about to end. The group and the supervisors try to make comforting remarks about the patient, saying that the patient and therapist will meet the following week, and that the patient looked reassured at the end of the treatment session.

The two supervisors talked about the supervisory session when it ended. The supervisor who made the remark had uncomfortable countertransference feelings: she felt bad and guilty about making the therapist feel bad, about weakening her rather than strengthening her and increasing her confidence ahead of the next session. The supervisor thought she had performed poorly for the therapist; that she was being empathic toward the patient being left alone at his first therapy session, but that she herself left the therapist alone during the supervision, showing no empathy and providing no support for the therapist at this critical time in the therapy, when she was videotaped and observed. The supervisor thought that her countertransference feelings toward the patient made her angry at the therapist and critical toward her.

Recommendations for Better Approaches to the Situation

This was the first time that the therapist brought material to the group supervision, the group was in its early stages of development, and the supervisory alliance was not well established yet. We suggest, therefore, that the supervisor should have been more careful in the use of expressive and exploratory techniques, and should have used more supportive techniques.

We propose two approaches that could be followed in such a case.

A: Using Supportive Techniques in Supervision When the Supervision Alliance Is Not Sufficiently Strong

The supervisor manages her countertransference feelings and focuses on the therapist's countertransference. In an effort to prevent ruptures, the supervisor should manage her own countertransference, which includes negative feelings toward the therapist and dissatisfaction with the therapist's performance. We suggest that the supervisors should first validate the therapist's reaction and the decision taken in the given situation. This enables the supervisors

to focus on the therapist's countertransference without the therapist needing to defend herself. Next, the supervisor who felt stressed and irritated can model how to manage countertransference by self-disclosure of her own feelings of countertransference. As part of this process, the supervisor can model how she contains her feelings and benefits from them by using the important information these feelings convey about the situation. To further strengthen the therapist's self-esteem, the supervisors should express admiration for her strengths and help normalize her actions. All these can help avoid causing the therapist to feel blamed, and allow her to use her own countertransference as a source of information about the patient.

The following hypothetical vignette illustrates the above recommendations.

Supervisor (validating the therapist's choice):	*I assume you were there wondering what was right for the patient and decided to enable him to seat quietly, and it is very different to watch it after it is all over. Can you say more about how it felt to you to be there with him in this situation?*
Therapist:	*I'm relieved you see it this way. I was scared that you would all think it was terrible. . . . Actually, I felt I should be very careful with him, that anything I say might be very hurtful and invasive. I wanted to give him the feeling I understand this and we can keep quiet about it . . .*
Supervisor (using her own countertransference feelings of stress):	*I can feel how stressful it must have been for the two of you. When I watched it, I could feel the stress myself. It feels quite tense. Was it actually like this?*
Therapist:	*I felt tense and I felt he was tense too.*
Supervisor (strengthening the therapist's ego and self-esteem):	*It is not easy to contain these feelings, and stay with them, and not dismiss them. What can you learn from these countertransference feelings about the patient?*
Therapist:	*Well, I guess it was really hard for him to be asked all these questions. He is not used to talking about himself, and maybe felt ashamed . . .*
Second supervisor (normalizing):	*It is not uncommon in a first meeting to feel that the patient perceives us as invasive and insensitive, total strangers asking all these questions (opening for the group discussion). What do the rest of you feel about this situation with the patient?*

Research That Supports the Recommendations

According to this approach, the supervisor manages her countertransference and tries to be supportive of the therapist, helping her manage her own countertransference. Research shows that therapists with better skills in managing their countertransference feelings were shown to have better outcomes with their patients (Gelso et al., 2002; Hayes et al., 2011). We suggest that supervisors who manage their countertransference feelings are more helpful to therapists, resulting in more effective treatment.

Managing the supervisor's countertransference is complicated because the supervisor holds two, often conflicting, countertransference feelings: toward the therapist and toward the patient. In this case, management of the countertransference toward the therapist (criticism) and toward the patient (identification with him for being left alone) can help the therapist in two ways. First, by modeling of how to manage countertransference; modeling based on the supervisor–supervisee relationship was found to contribute to patient outcome (Tracey, Bludworth, & Glidden-Tracey, 2012). Second, by supporting her in a difficult moment, and thereby boosting her self-esteem and strengthening her ego for dealing with difficult moments in therapy (Pinsker, Rosenthal, & McCullough, 1991). Worthen and McNeill (1996) found that during training, therapists rated their supervisors as good and helpful if they experienced the supervisors as empathic, nonjudgmental, validating, nondefensive, and willing to examine their own assumptions.

B: Using SE Techniques in Supervision: Working Through the Rupture in Supervision

When ruptures occur, a potential strategy in supervision may include the sequential integration of both supportive and expressive techniques: first, using supportive techniques to strengthen the alliance, then expressive techniques to facilitate an opportunity for growth. As part of the first phase, where supportive techniques should be used, the supervisor should recognize the rupture and take responsibility for her part in it and for the distress it caused. If the alliance seems to be repaired, a second phase can follow, where expressive techniques should be used. In this phase, the supervisor and therapist can work together toward better understanding of what happened and what can be learned about the dynamics of the therapy, and possibly about the difficulties and challenges the therapist is facing. In the following vignette, we demonstrate how to work through the rupture between the supervisor and the therapist.

The next meeting between the supervisor and the therapist is a one-on-one session, the week following the group session.

Supervisor:	*I feel we should talk about what happened in the group session last week.*
Therapist:	*OK.*
Supervisor:	*Do you want to start by saying how you feel?*
Therapist:	*No, you start.*
Supervisor:	*You started the supervising session saying the therapeutic session was complicated but OK, and ended it feeling that it was really terrible. I thought the supervising session, and especially my comment about the silence, were difficult and invasive for you. It is not easy to be watched on the video, having little control of what is*

being exposed. You must have felt criticized, not understood. I was consciously curious about what was going on in the meeting, but less consciously, I was probably identifying with the patient. (The supervisor is using supportive techniques, showing as much empathy as possible toward the injury sustained by the therapist. She takes responsibility for her failure and chooses not to elaborate on her countertransference feelings. If the supervisory relationship were stronger, it would be possible to recommend elaborating more on the self-disclosure of the countertransference.)

Therapist: *I thought you were going to dismiss me from the pilot study. That this is the end for me here.*

Supervisor: *I'm really sorry, this is not at all the case. I can understand how you ended up feeling this way* (supportive technique).

Therapist: *I felt the patient was afraid of breaking down; that being invasive with him could cause a breakdown.*

Supervisor: *The issue of being left alone or invaded is repeating here. Maybe we can learn something from these enactments. At the therapeutic meeting you felt quite proud of being able to contain the patient's silence, not being too invasive, and giving him space. But at the supervising session you felt ashamed, helpless, not understood, maybe close to a breakdown yourself. These feelings are probably part of what the patient's depression is about, and perhaps related to the patient's CCRT.* (The supervisor suggests possible parallels between the supervisor–therapist and the therapist–patient interaction, and carefully invites the therapist to explore them.)

Following the individual supervision session, the supervisor brings up the issue at the next group meeting, taking responsibility for her empathic failure. The therapist did not want to discuss it further with the group, but shared that she hoped to learn from it and that the next therapeutic meeting was better. The supervisors felt that is was appropriate for the therapist to react in this way because the group supervision was just starting and the therapist was exposed more than she may have wanted to be. They felt that it was appropriate for her to choose at this time the exposure level that she can accept, which could be experienced as corrective, so that she does not develop the feeling that she has been invaded and is helpless against it.

Research That Supports the Recommendations

The first set of recommendations, above, was aimed at preventing ruptures using supportive techniques; these recommendations focused on strategies to repair the rupture and, when one occurs, to turn it into opportunities for growth, using both supportive and expressive techniques. There is evidence to support the proposed supportive phase in working on ruptures in the supervisory alliance (Burke, Goodyear, & Guzzard, 1998; Watkins, 2011). One potential strategy that has been suggested in the literature for repairing ruptures is the supervisor assuming responsibility (Safran & Muran, 2000). Research suggests that one of the main difficulties supervisees have with their supervisors, which harms their ability to use supervision successfully, is that the supervisors do not take responsibility for their part in a conflict (Nelson & Friedlander, 2001). It has been argued that the supervisor's supportive act of initiating measures to repair, through empathic recognition of the injury of the therapist, contributes actively to the development of the therapist (Watkins, 2016).

Before using expressive techniques, it is crucial to use supportive ones, given the power relations between supervisor and supervisee, and the supervisee's potential vulnerability as a therapist in training. The supervisory relationship has an evaluative component as well as a semitherapeutic one, therefore the supervisees may be afraid to adversely influence the supervisor's judgment of them (Muran, Safran, & Eubanks-Carter, 2010; Nelson & Friedlander, 2001). The supervisee can, therefore, be sensitive. Supervisors must bear in mind their evaluative role and be as supportive as possible before using expressive interventions. In Wachtel's (2011) words: Strike the iron while it is cold.

After a strong alliance has been achieved using supportive techniques in working through the rupture, a second phase can follow, in which expressive techniques are used. An expressive technique in working on the parallel processes of the therapeutic and the supervisory relationships was found to be useful in promoting the therapist's learning about the dynamic processes taking place during supervision and treatment (Tracey et al., 2012). The notion of parallel processes includes viewing the dynamics of the therapy as being reproduced in the dynamics of the supervision, with the therapist unconsciously acting in the supervision relationship in a manner similar to the patient (Ekstein & Wallerstein, 1958; Searles, 1955). The relationship themes enacted in the supervision relationship may provide new information about the patient's CCRT.

Adopting a stance in which first the supervisor works supportively on the rupture, then expressively on the parallel processes is a useful strategy for avoiding the common misuse of the expressive technique of parallel processes. Specifically, it has been argued that parallel process interpretations can be overused and misused, either as a way out for the supervisor not to assume responsibility for a rupture in the supervisory relationship and not to work it through but to refer it back to the therapist's relationship with the patient (Safran et al., 2008), or as a means not to address the developmentally appropriate narcissistic vulnerability of the supervisee, and again "blame the patient" for it (Watkins, 2016).

Implications for Research

Although research on SE psychotherapy is now common, research on supervision of SE is still rare. Existing research shows that therapists can be taught through supervision to better approach and handle alliance ruptures (Muran et al., 2010), and to show better adherence to psychodynamic techniques (Hilsenroth et al., 2015). But research is needed that focuses on techniques to be used by supervisors to facilitate therapists training. Randomized studies can compare types of supervision in which only supportive techniques are used with those using both supportive and expressive

techniques to determine which supervisor and supervisee characteristics may indicate who can benefit most from each technique, improving therapist development process and treatment success.

Summary

In this paper we presented a clinical example from a supervision to demonstrate the adverse effect of using expressive techniques in supervision before an adequate supervision alliance was formed. We propose that supervisors choose more supportive techniques when the supervisory alliance is not well established, or when a rupture in the supervisory alliance occurs. Expressive techniques should be used only after a good alliance has been established, when they can contribute to a deep process of understanding potential parallel processes. We recommend that greater effort be invested in investigating supervisory relationships and the utility of specific supervisory techniques.

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