

On the Use of Reflection in Supervision

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Abstract

Analytic supervision may be described as a space in which two types of reflection upon clinical-analytic material are made possible for the supervisee: reflection-after-action and reflection-in-action. The latter is increasingly employed in supervision by psychodynamic therapists, since there is now a greater understanding of the importance of non-verbal and action oriented authentic communications in the analytical interaction. These communications require immediate, in the moment consideration, reflection and authentic response by analytic therapists. This reflection is claimed to conceptually combine the authentic-human and the planned and weighed analytic-clinical.

Keywords: Psychoanalytic; Supervision; Reflection; Non-verbal communication; Authentic; Therapists

Introduction

Literature on psychodynamic supervision explains how, in the relational space between supervisor and supervisee, new insights and meanings may be found to help supervisees work analytically in complex therapeutic situations with patients suffering from various kinds of distress. It instructs therapists how to understand more levels of the therapeutic interaction so as to construct a complex, rich and a multifaceted narrative of the development of therapeutic relationships and patients' relational coping patterns [1]. Supervision is generally perceived as a tool for helping young professionals to establish their self-definition so as to develop patients' self-definitions and help them realize their potential [2,3]. Further aims of supervision identified in the literature are to create a platform of internalized self-supervision for the rest of the supervisees' professional lives [4], integrate conceptual thinking, developmental-personal therapy and apprenticeship [5], help supervisees examine their subjective reactions as a means for reading patients' experiences and distress [6], explore the manners in which supervisees re-enact, in the relationship with supervisors, occurrences in therapy by means of a 'parallel process' [7], contribute to clinical experts' professional identity shaping and development of self-managing skill in complex environments [8]. More and more it is becoming acknowledged that supervision is crucial to the professional practitioner throughout their practice lives [9].

In the present paper I wish to introduce the concept of 'reflection-in-action' [10-12] which may enrich the understanding of analytic supervision as an encounter-facilitating the entwinement of the personal-authentic and professional-analytic among both supervisees and their patients. This concept of reflection-in-action essentially integrates the need to authentically and humanely react to patients and the demand to react professionally-analytically. These two demands seem very different and even contradictory, yet many clinicians today consider their blend essential to the management of an analytic treatment, which is both engaging, encouraging therapists to personally participate and grow, and true to analytic principles and values. It remains unclear as to the importance of the authentic response.

Many contemporary writers [13-15], emphasize the importance of responding to patients' verbal and non-verbal, implicit and explicit communications as authentically and honestly as possible, implicating *the therapists' humanity*. Mitchell [16] explains that the basic concepts of the psychoanalytic technique of neutrality, anonymity and abstinence have much faded, allowing for an "emphasis on interaction, enactment, spontaneity, mutuality, and authenticity" (p. IX). The designation

of authenticity as the focus of the therapeutic effort stems from the existential assumption that in order to free themselves of anxiety, people always tend to do as they are expected and please others, abandoning their principles. Psychoanalysis adopted this existential outlook, although the word 'authenticity' does not often appear in the literature [17]. Many contemporary analytic thinkers accept the postmodern stance, which designates patients' subjectivity as a central curative therapeutic aim, considering the analytic therapist as a facilitator of that which is authentic and vitalizing for the patient.

In the struggle for authenticity, analytic therapists aspire to connect patients to their internal passions so that they feel vital and empowered. They wish for patients to openly and honestly bring themselves to the analytic therapeutic relationship. Such a demand of patients makes it difficult for therapists to hide their humanity behind analytic professionalism. Moreover, we understand well today that there are also curative factors other than the traditional ones. Such writers as Stern et al. [18] and Mitchell [16] endorse the claim that many human factors operate in the analytic process other than formal analytical ones.

At the same time, it is clear that what makes the encounter with patients an analytic therapeutic process is the theoretical-clinical concepts analytic therapists hold concerning their actions and responses in the matrix of transference- countertransference relations. It is the ability to theoretically conceptualize the interaction with patients that may afford the attainment of essential clinical aims. It may also turn analytic therapists' interventions to professional ones, expressing expertise as well as analytic values and ethics and clinical knowledge accumulated over the years. In addition, it allows the communication of the occurrences of therapy to other experts.

How then, is the personal-human-authentic to be combined with the professional-conceptual, expressing therapists' expertise? The present paper suggests that the mental activity of reflection-in-action constitutes one answer to this question. It will elucidate this concept vis-à-vis that of 'reflection-after-action'. There are numerous references

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Received December 15, 2012; Accepted January 17, 2013; Published January 21, 2013

Citation: Yerushalmi H (2013) On the Use of Reflection in Supervision. J Psychol Psychother 3: 109. doi:10.4172/2161-0487.1000109

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to this concept termed 'reflection in action' or 'knowing in action' already in the literature [19].

Two Forms of Reflection

Reflection after or on action describes the mental activity, in which supervisors and supervisees consider the development of the analytic treatment and transference-countertransference events and meditate upon their meaning. Gabbard and Ogden [20] write about these points in time in which this reflective process takes place. They explain that analytic therapists often broadly reflect upon that which took place in the course of the analytic hour, forming integrative understandings about their treatments and about themselves as therapists. They claim that such moments may occur while therapists await their patients who are late to arrive, for example, or while driving.

Supervision provide the secure and consistent environment that allows supervisees to reflect upon what went on in their treatments. In addition, the supervisor participates in this process both as an observer reflecting upon it and as one reflecting upon the process which goes on between himself/herself and supervisee [6,9]. Analytic therapists thus evaluate and reconsider emotional, theoretical and ideological positions, and reshape patients' perceptions concerning the intersubjective reality in therapy and their narrative of their past and present lives.

Reflection in the context of any relationship is a form of deep observation, allowing the understanding of additional meanings of an interaction between the person reflecting and another person or people. Reflection constitutes a meditation about the events of that interaction, shaping relational perceptions and positions. The Boston Change Process Study Group [21] explains that reflection means the re-experiencing of a relational event in a different context and time, allowing a reorganization of that experience. They add that the quality of the reflection and the degree of abstraction to which people are capable depends on the extent to which their personality has developed.

Such reflection in the course of supervision will allow supervisees to contain emotional storms and unconscious anxiety that ensue therapeutic and supervision sessions, at times interrelated [22]. It may be likened to Ogden's [23] concept of "dream", as a mental function of 'digesting' and 'processing' the most complex experiences in life and in analytic therapy. The function of supervision, according to this view, is to allow supervisees to dream the analytic treatment so as to allow further processing and digestion of analytic material. Supervision offers an opportunity, according to Ogden, to continue with the dreams patients could not fully dream due to disturbing and frightening unconscious thoughts, or due to foreclosure, preventing psychological processing.

This mental activity, practiced by supervisees with the active and participating presence of the supervisor, allows not only for finding new, deeper, more integrative meanings of the analytic material, but also advances the development of supervisees as analytic clinicians. This function of reflection and processing, gradually incorporated into the supervisory discourse by the supervisor, is internalized by supervisees as clinicians. This would make them better capable of being immediately and directly present and involved in the analytic situation, as well as systematically and optimally process the transference-countertransference evolutions and construct their meaning in hindsight.

This hindsight process may be termed 'reflection-after-action' or 'reflection on action' as it is termed in the relevant literature. Such

distance in time and space allows a quieting perspective and the ability to organize the analytic material and find new and deeper meanings in it. The role of analytic supervision is, therefore, to temporarily become distanced from pressures and threats within the treatment to allow emotional peace in which such mutual reflection may occur and prosper. This reflection is also characterized by a consideration of the materials in therapy as a whole, as a broad and complete essence. Such an inclusive perspective is enabled also by the freedom from the need to act immediately. The supervisees are invited to examine impressions and perceptions from the broadest perspective possible. This is in order to find the most authentic meanings for them of each of the transference-countertransference events in therapy, without necessarily translating them into action.

Another form of reflection that will further develop the analytic treatment and clinicians' analytic identities is reflection-in-action. This form of reflection does not occur at the comfortable timing of suspension of action and it does not treat the therapeutic material inclusively. Rather, it treats it in segments, fractions, in given moments and as part of action itself. It answers to clinician's need for responding, spontaneously and authentically, and at the same time level-headedly, to the interlocutor's messages and communications in real time.

It seems that the importance of teaching and developing such a form of reflection increases the more we understand that an important part of the clinical-analytic work takes place in the arena of physical action, behavioral reactions and nonverbal communication. One of the manifestations of this recognition is the fact that many psychoanalytic writers deconstruct the distinction between speech and action. Speaking is considered a type of an action and actions as a form of communication [24-26]. In addition, action in analytic therapy was brought into the focus of attention by such concepts as enactment [27,28]. Bass [29] explains that from the relational perspective, enactment is omnipresent in the analytic process and relevant to each manifestation of transference and countertransference. Enactment is the manifest content of the relational unconscious, which is constantly propelled to express what may not be consciously known and properly verbalized [30]. Shapiro [31] maintains that the hesitation in psychoanalysis concerned with dealing with real actions may have to do with Freud's warning against the possibility of 'uncalled-for-action' in analysis [32]. He convinced psychoanalysts that development in therapy, as in life, means that impulses and fantasized wishes must be controlled and shaped by means of contemplation, reflection and understanding.

The deconstruction of the distinction between speech and action and the development of the concept of enactment, the unconscious yet authentic expression of one's self, made it clear to therapists that enactments need to be identified as a way of intersubjective communication of the internal drama to the interlocutor. This physical system of communication obligates the therapist to act immediately and spontaneously.

It appears that these two forms of reflection are essential for the establishment of skilled analytic capability. These two forms of mental capability complement one another rather than compete. Naturally, not everyone possesses an ideal balance between them. Analytic therapists differ in their ability to implement this mental function of reflection, which includes the capability for thought organization, meditation upon phenomena and exercising optimal judgment. Some may better implement one of these two forms of reflection. The following part of the paper will offer an investigation of the function of reflection-in-action vis-à-vis developments in analytic theory.

Reflection-in-Action

We need to develop within ourselves, and teach others, this complex and subtle skill which entails a good connection to interlocutors; a keen perception of their verbal and nonverbal communications; an empathic affirmation of receiving and understanding these communications; and a proper response to them in real time. We need to responsibly and immediately include in our reactions level-headed and processed messages that will encourage the development of the analytic relation, strengthening the patient's sense of being understood and even serve as role models for them. Moreover, this must be executed in a highly complicated situation, entailing many parallel levels of communication and influenced by the sensitivities and vulnerabilities of both patients and therapists.

In the past, artisans acquired their skills through an organized system of apprenticeship. Beginner artists used to follow experienced ones, serving as their apprentices. Complex artistic skills and different types of professional practices were thus learned and instilled from generation to generation. Nowadays, we seek ways to instill such skills and practices in beginner practitioners who study in the course of an organized and comprehensive framework of training, designed for them by the professional community to which they aspire to belong.

One of the people who have elaborated on the elements of this type of learning and clinical development was Schon [19,33]. He has examined the manners in which managers, architects, analytic therapists and other practitioners solve their problems, dilemmas and difficulties at any given moment and when working under pressure. He has learned that these practitioners do not follow an organized doctrine and do not rely on scientific laws of conduct in dealing with particular instances they encounter in the course of their ongoing work and which require them to find immediate solutions. Schon [19] found these practitioners to operate in a complex, unstable and often changing unique situations, many times relying on trial and error and on what he calls 'reflection-in-action'. This is a type of reflection triggered by unexpected events, helping the agent remain alive in light of the many possible modes of action and pressure of circumstances. He claims that these situations are comprised of a number of stages: at first, experts operate according to their experience, following familiar patterns. These patterns grow from the understanding of different phenomena and constitute a framing of familiar tasks and strategies of action, which together express 'knowing-in-action' - an implicit, spontaneous professional know-how (p. 72). Upon encountering surprising or unusual events, different from their internalized schemes of knowledge-in-action, experts must exercise reflection, which is at least in part conscious, although many times it is not conceptualized. Experts consider the quality of the phenomenon they face and the manners in which they have thought of it thus far. They critically examine the assumptions at the base of their 'knowledge-in-action', which has not sufficiently prepared them for this surprise. This process leads to a new understanding and reframing of the essence of the phenomena and to the formulation of new strategies of action. This mental activity of reflection-in-action may lead to a spontaneous examination of new modes of action.

Psychoanalytic therapists, claims Schon, being reflective professionals, should occupy the position of artists. Unlike technical rationalists, implementing general laws of conduct, they must actively employ in their work processes knowledge-in-action and reflection-in-action. The model of reflective practitioner considers human problems and meanings, as well as human knowledge, not only highly complex, but also ever-dynamic. The clinical practice could not, therefore, have developed through isolation, quantification and artificial manipulation

but rather through trial and error and accumulation of a repertoire of images, experiences and modes of action.

It is proposed therefore that there is a need to learn how to combine reflection-in-action, the personal-authentic, with the professional-analytic. This refined activity examines the analytic interaction from within and without, without actually interfering, so that it does not block human and personal expression.

This reflection will guide the choice of phenomena to focus upon, and their manners of exploration and conveyance of interpretative messages to patients. In order to engage in the process of reflection-in-action, experts must acknowledge the insufficiency or irrelevance of their knowledge to the specific difficulty they face. Only such recognition may afford an exploration of the thoughts and mental processes that led them to a therapeutic deadlock. This renunciation of grandiose fantasy is not easy for experts, for it subverts their professional image and the authority they attribute to themselves and demand of their patients.

As an organizing activity of thought, which concerns immediate response, reflection-in-action deals with the tactics of the therapeutic action and not its strategy. As such, it is essentially adequate to serve as a potential space between the authentic-personal and the professional-analytic. It is powerful enough to influence impulsive and inappropriate responses yet it is not too influential as to oppress a freer response that wishes to leave a personal mark on the analytic interaction. Reflection-in-action is a paradoxical concept for it designates a space involving both action and thought, which mutually depend on one another. Like other forms of human activity, the ability to make use of a paradox is a mark of rich and high personal and interpersonal mental activity. Examining the concept of reflection-in-action may therefore promote the understanding and articulation of the essence of the analytic clinic so as to better substantiate it.

Reflection-in-Action in Supervision

Frawley-O'dea [34] claims that the consideration of the transference-countertransference system of enactments, un-symbolized somatic and affective experiences significantly can enrich supervision. Upon reflecting on the actions and failures of supervisees, supervisors are also to be playfully attentive to their own physical sensations and range of thoughts and images that cross their minds. According to Sarnat [35], the value of regressive moments, which supervisees and supervisors experience in supervision, should be recognized. These emotionally intense experiences of regression from complex higher modes of thinking and feeling and mature object relations to more primitives ones, may include dreams or conflicting emotions directed at the supervision partner or a patient, enactments and dissociative or somatic experiences of an altered state of consciousness.

While reflection-in-action often entails stress and conveys a sense of segmentation, it forces analytic therapists to some extent to deconstruct their therapeutic self and reconstruct it a bit differently. Analytic therapist's surprising and unpleasant discovery that implicit and explicit knowledge does not suffice to guide them through specific clinical situations entails embarrassment, which motivates them to reformulate and reorganize their experience of self. Even when these changes are not dramatic, they gradually change their identity as analytic therapists.

These points of reflection-in-action encourage analytic therapists to recreate and reformulate their personal truths concerning the clinical capabilities they attribute to themselves and the boundaries of their definition of themselves in their professional lives. While

normally contributing to the development of the analytic clinical self-perception, these interludes often go by unnoticed, undervalued and even considered as little to be proud of. An analytic supervision, which gathers these moments and sheds light on this important process of establishment of analytic identity may be highly significant for supervisees. Such supervisory effort may be likened to the work of art researchers, who examine manuscripts of classic artists, abundant with deletions and corrections. These deletions and corrections serve as road signs indicating the artist's ways of self-organizing and identity construction as part of the creative process itself. By the same token, analytic supervision follows the development of the supervisee's mental and creative processes, which establish their analytic relations and at the same time their identity as analytic therapists.

Illustration of Types of Reflection

D tells his supervisor A about P, a patient he has been seeing for about two and a half years. P has known many upheavals in her life, when she was abandoned by her father at a tender age and when she had to tolerate her mother's changing of partners and long periods of depression. Much of the mother's distress was projected onto P in the form of anxiety about potential problems and she used to warn P over and again against terrible disasters. P internalized an image of an engulfing, alienated and hostile world and had trouble sustaining a stable life and facing challenges. One of the manifestations of this instability and internal disquiet is frequent job changing. She has held some impressive positions in which she was successful, yet many times she chose jobs that were much beneath her capabilities and qualifications. When a workplace had grown into a relatively familiar and safe place for her, sudden feelings of anxiety were evoked in her about something that might happen and force her to leave. These situations were so difficult for her that she tended to abandon the workplace herself.

D describes in supervision the dialogue he had with P concerning his coming vacation. P has asked him over and again where he intended to spend his vacation. When he inquired into her occupation with the idea of him traveling, he found she feared a disaster having to do with his flying to vacation. He insisted that they understand how this anxiety evolved and its relation to her life history and experiences of abandonment. At one point in the conversation, P reprimanded herself, saying this anxiety is unnecessary and unrealistic. And yet she added: "I know that you may die crossing the road next to your house, but somehow a trip abroad seems scarier to me." When D recounts this anecdote, he repeats this sentence, and says that he suggested that they meet once more before his vacation.

A wonders why D repeated this sentence twice, given it didn't seem that P's reaction surprised him, abandonment being one of the most recurrent issues in her treatment. A feels D isn't afraid to hear a saying concerning his death coming from a patient, for he has therapeutic experience with a wide range of patients, some of whom are prone to extreme and threatening emotional states. He wonders whether he should wait until he better understands this therapeutic reaction or stop D's flow of speech and elucidate this point, fearing it might fade. He decides his relationship with D is established enough to handle "experiments" stops D's flow of speech in order to examine his experiences and associations at that given point.

A says: "I have noticed that you repeated this unpleasant sentence twice. I wonder what you felt at that moment of hearing of your potential death."

D answers: "I don't think that this sentence scared me, it mostly

seemed strange to me." A says: "Does it seem strange to you now when we mention it or when you have heard it in therapy?" D says: "It does not scare me now, but when it was said it seemed strange to me." A asks: "Can you tell me in which way it seemed strange to you at the time of hearing it?"

D said he now thinks that what was strange about it was that it was said indifferently, as if it had no importance whether he was killed or not, when he knows well that P isn't indifferent to him. As A continues with questions of clarification, D says he was surprised by the indifference directed at him in general. Upon recalling his thoughts at that time in therapy, he says that at that moment he solved the dilemma by understanding P as indicating: "I am so angry with you that I don't care if you die or not." A asks: "If this indeed was the thought that crossed your mind, what encouraged you to offer another meeting before the vacation?"

A explains that P's experiences of abandonment are being reenacted in therapy. She tries to regain control by means of trying to find out more information about the therapist's vacation. D is deterred by this, perhaps feeling that her questions invade his personal life and also believing he must remain as anonymous as possible. This interaction to some extent echoes, explains A, the instability the patient experiences in light of the vacation and communicates it to the therapist by means of an enactment. Normally, D manages to understand the essence of P's messages and reflect it to her.

D says that at that moment he stopped and thought to himself: How did we reach this point? I cannot believe that people may feel so much rage that they want someone's death just because that someone threatens with abandonment. Yet I cannot deny P's such reaction. It may well be that I do not fully understand how regressed people can get in therapy, as I was told once by a supervisor, so I need to think differently about this phenomenon. At that moment in therapy D thought about the literature he had read on the primitive pole of experience and manifestations in one's actions. He also asked himself at that point whether he acted out of panic or whether he was in control of the situation. D realizes now that he concluded he had to take a different course of action vis-à-vis his patient's response, taking into account the psychological state she was apparently in. He wishes he would be able in the future to handle such cases more easily.

A suggests that something may be learned from this incident about the way in which D deals with therapeutic challenges. He explains that the very moment in which D stopped to think is important as a moment of reorganization of his analytic knowledge of relationships. At this significant moment, D apparently understood that something in his clinical perception was lacking or inappropriate (in the case at hand, the understanding of patients' regression in analytic therapy) and that he needed to reorganize it. D seems to have reconstructed some of his beliefs about patients' reactions to analytic reality. This deliberation has led D, says the supervisor, to a decision about the next step to be taken (suggesting an additional session).

Discussion

What significantly distinguishes analytic work from friendly relationships is analytic theories that delineate directions for understanding an interaction and taking proper action to achieve therapeutic goals. In addition, analytic therapists are capable of examining their complex interaction with patients from an involved and at the same time external position, at times critical. This external position which must never replace involvement and direct relation

with the patient but complement it brings in an element of systematic thought, reasoning and reexamination of different meanings of actions and communications. Part of this process of evaluation-consideration is accomplished after analytic interventions have been carried out and so may be thought of from a broad perspective.

Another form of such reflective activity does not conveniently occur after the fact but at the time of acting. When analytic therapists realize that they do not possess sufficient knowledge in order to freely and naturally act and must immediately decide how to respond to patient's input with optimal consideration, they feel a need to hectically seek other answers from different sources of knowledge within themselves. This activity, called reflection-in-action, is a critical mental activity that expands practitioner's professional coping capabilities. For a long time, analytic supervision has been portrayed as an important way to increase analytic clinician's capacity of reflection and contemplation upon the sum of transference-countertransference events as a whole, explaining particular phenomena from a safe and calm distant perspective, focusing on associations and verbal symbols. And yet a lot of the clinical activity takes place in physical levels, such as implicit nonverbal communications, posture, facial expressions, patterns of movement and vocalization, as demonstrated by the concept of enactment [28]. This physical system of communication of immediate unconscious interpersonal messages without the mediation of secondary processes, obligates the therapist to act immediately and spontaneously. This response is not always the result of clinical-analytical planning and deliberation yet it does necessitate immediate considerations so as to incorporate analytic aims. It is therefore clear that it is essential to engage in the critical mental activity of reflection-in-action in order to process these messages and respond to them in real time.

Any analytic therapeutic session, entails many dilemmas for clinicians: for example, react immediately or await the right moment; follow long-term therapeutic goals or short-term ones; react to patient's gestures and communications from the position of individuals or from an interpretative analytic one? Many times, therapists face a dilemma that has to do with a collision between contradicting values or ethical principles, or between clinical ethical rules and simple human rules of conduct. In such moments analytic therapists must decide on an act or on a cessation thereof. What guides therapists in such moments is the ability to reflect upon occurrences in therapy at the moment of occurring and react as level-headedly and professionally as possible.

It is important to stress that a dialectical process occurs between the capability to fully observe the process as a whole from a distance in time and space, on one hand, and partial and immediate moment to moment observations on the other. Surely, the observation of fractions of moments does not allow simultaneous observation broad and inclusive, just as observing the large picture does not allow simultaneous examination of the short and unique. And yet these two positions define one another to a large extent and also encourage and enable one another. Skilled analytic therapists are capable of switching between these two positions.

In supervision, these two types of processes dialectically create a supervisory process with more potential for growth than a process in which only one type of reflection is present. Besides complementing one another, the two types also constitute opposites: instability and relaxation, deconstructing analytic constructs and at the same time constructing larger, more comprehensive ones, micro and macro processes. These contrasts create a tension that may propel development and growth within the supervision relationship: it may motivate the examination of these contrasts and help supervisees reach deeper and

richer insights. This dialectic movement allows analytic therapists to create a reliable interpretative sequence that is well linked to clinical observations and moment to moment conduct, remaining within the broad context of transference-countertransference occurrences. So a 'hermeneutic circle' is created of understanding the meanings of the patients' experience [26,36].

All too often, supervision which explains and clarifies inclusive and broad processes is considered prestigious and powerful. However, supervision which examines particular processes that change from context to context, from moment to moment, seems more relevant and consistent with our growing knowledge concerning the presence of enactments and unconscious bodily communication. This type of supervision helps to develop a clinical-analytic capability of utmost importance to reflect in real time upon imminent dilemmas and difficulties, choose the appropriate reaction.

Clinging onto small details, such an activity may sometimes seem technical or essentially limited. And yet one must remember that analytic therapeutic work is to a large extent based on the willingness of therapists to get involved with patients and relate to them and on their ability to be attentive and serve as a container echoing the patients' analytic material. In order to accomplish this, they must engage in reflection-in-action, which entails self-examination, examining patients' reactions and the choice of appropriate and level-headed reactions. It is the dialectic between these two forms of mental activity that constitutes real clinicians, implementing the many accomplishments of psychoanalytic theory and at the same time imprinting the clinicians' personal seals. This tension may lead to seeking higher, more significant ways of clinical action.

An analytic supervision which maintains this tension between the finding of the self and its creation encourages a creativity that consist of both poles and higher understandings of the events of analytic therapy and of the supervises organization of the analytic self.

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