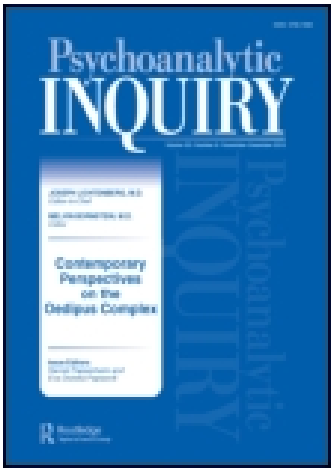

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Evaluation of Learning in Psychoanalytic Clinical Practice and Supervision

Jutta Kahl-Popp, DPV, VAKJP

In psychoanalytic training institutions, there is a pedagogical conflict inherent: The respective training/teaching generation of psychoanalysts regard their theoretical and clinical knowledge as learning goals for the next generation of psychoanalysts. If teaching goals and learning goals are merged together, teaching takes place mostly in a projective and possessive manner. From this perspective, supervision is probably the main place of transmitting the structural psychoanalytic superego-complex (Kahl-Popp 2005, 2007; Reeder, 2004), which can paralyze learning capacities and further development of the next generation of analysts.

To solve this pedagogical conflict it is necessary to abandon the paradigm *fulfilling the targets of teaching/training analysts and supervisors*. For this purpose, basic lines of a psychoanalytic concept of learning are described. The affinities between learning in psychoanalysis, psychoanalytic treatment, and learning in supervision are characterized. Symptoms, experiences of emotional discrepancies, and interactional dysfunctions are considered as demands of learning in both fields. Furthermore the answering interventions—interpretations, relational and supportive interventions or instructions—of psychoanalysts and supervisors will be investigated from the perspective of being helpful or not helpful for the learning capacities of patients and supervisees. A patient- and supervisee-centered psychoanalytic concept of evaluation is proposed. In this evaluation concept, the manifest and latent feedback of patients and supervisees, following directly to an intervention, is regarded as an important source for orientation, which will be needed to learn in psychoanalytic clinical practice and supervision.

It is illustrated how this evaluation concept can be used for research purposes to investigate the impact of supervision on learning psychoanalytic–psychotherapeutic competence.

INTRODUCTION: LEARNING IN PSYCHOANALYSIS

Although learning as psychic capacity is not yet conceptualized from a psychoanalytic point of view, there is an important approach in psychoanalytic history to understand clinical change in psychoanalytic treatment as result of the patient's learning process (French, 1937). In his investigation, French stated that psychoanalysts take for granted that the patient's improvement in adapting reality is a direct result of getting more conscious about their unconscious tendencies and memories. But psychoanalysts would not understand how patients develop an attitude

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of better adapting reality than before (French, 1937, p. 97). French investigated the relation between his patient's changes in adapting the psychoanalytic situation and their dreams in various treatment-sections. Correlations between dreams and (better) adaption to the psychoanalytic situation should illustrate the patient's learning process. From his findings, French inferred basic assumptions for a psychoanalytic theory of learning:

Every learning process is based emotionally. Learning is regarded as process of search, movement, and change, starting from a former method of satisfaction, which is no longer experienced as sufficient, to find and establish a new method of satisfaction. Within this search there is an experiential phase accompanied by disillusion, despair, anxiety and rage. French proposed to regard the patient's pathological psychic functioning as overcharge of his learning capacities. So the patient is fixed to negative emotions as result of traumatic situations in his emotional development, in which he was not capable of succeeding in required learning-steps (French, 1937). French inferred to understand the psychoanalytic situation as a learning task. This task should be styled for the learning capacities of the patient, if improvement should be brought about (French, 1937).

French (1937) has conceptualized learning in psychoanalytic treatment as an intersubjective process: When the analyst is styling his psychoanalytic task for the individual learning capacities of his patient, the patient will communicate latently or manifestly which learning step he or she is willing to do. The analyst could regard the patient's communications as indicator for his interpretations.

In the early years of psychoanalytic conceptual development, French has not only contributed to a psychoanalytic learning theory in combining empirically patients' unconscious processing of the treatment experience with their adapting to the analytic frame. From his findings, he has also derived basic lines of an evaluation concept for clinical interaction. That means that the analyst can learn from the latent and manifest communications and enactments of his patients, which intervention or interpretation would increase or decrease the learning capacities of his/her patients.

French's assumptions about the learning process in psychoanalytic treatment—especially his findings about perceiving, processing, and communicating experiences in a learning situation unconsciously[1] can be combined to the general learning theory of subject-science (Holzkamp, 1993) and with the findings of competence research and the philosophy of knowledge, in which complex competencies develop from intuitive and holistic learning processes beyond consciousness (Neuweg, 2004).

From my point of view, further studying the learning processes of patients and of psychoanalysts could bridging the gap between research and healing (Kahl-Popp, 2011a).

CLINICAL PRACTICE AND SUPERVISION AS LEARNING SITUATIONS

From a general point of view, there are no essential differences in the dynamics of learning competence dispositions for mastering intrapsychic and interpersonal difficulties of life and

[1] *Unconscious* here means beyond awareness in a sense of "tacit knowing," "procedural knowledge," or unconscious thinking (Bollas, 2011, p. 21).

for developing psychoanalytic competence. In treatment, the realization of clinical competence dispositions is a result of the patient–psychoanalyst cooperation (Kahl-Popp, 2007). In both situations, and for both participants, self-observation and the observation of interactions play a central role to investigate processes of learning also the own ones.

In psychoanalysis, it is not usual to regard the psychoanalytic attitude not only as an investigative attitude, but also as a learning attitude. This is well known in the area of training, especially in psychoanalytic supervision (Canestri, 2007). But to take over a learning attitude can stimulate the psychoanalyst (and the supervisor) to take advice by the unconscious meaning analysis of the patients (and supervisees) in treatment and in supervision and to learn about the effects of their interventions and interpretations on patients and supervisees (Langs 1978, 1992, 1994, 2004).

To accompany the moment-to-moment interaction in psychoanalytic treatment situations with a learning attitude focusing the patients' feedback seem to be a central aspect of effective psychoanalysts and psychotherapists in general. On the basis of psychotherapy outcome research results, which show that the factor that is most explanatory of the variability of outcomes is the psychotherapist regardless of the patient's diagnosis or the type of treatment (Lecomte, 2010; Wampold and Brown, 2005), basic factors of effective psychotherapists with high level therapeutic outcome are:

- Complex interaction of skilled application of a treatment and control of the therapeutic relationship;
- Control of relational fluctuations, ruptures and restoration of the therapeutic alliance;
- Support, management, or treatment of the tensions arising from the patient's resistance and openness to change; and
- Development of the awareness of the self and the other in interaction (Lecomte, 2010).

Further empirical findings by Lambert (2007), Miller et al. (2006), and Scovholt and Jennings (2004) seem to suggest, that the psychotherapist's sensitivity to the interactional context; attention to the patient's experience, feedback, and impact; and adjusting psychotherapeutic interventions to patient's needs are appropriate to achieve high healing effects, whereas, for example, misapplication of technique can adversely affect the working alliance (Hilsenroth, Cromer, and Ackerman, 2012; Lecomte, 2010).

These findings correspond with my conception of psychoanalytic competence, as a network of personal, relational, and conceptual capabilities and dispositions, which can only be realized in a learning-collaboration with the patient according to his or her manifest or latent evaluation of the psychoanalysts' interventions (Kahl-Popp, 2007). In general, the development of competence in the professional lifespan of psychoanalysts then oscillates between assimilative-learning directed to the person's inner world and applicative-learning directed to the interaction with the patient (Kahl-Popp, 2011a).

French's first investigations, as well as the modern psychotherapy outcome research results, suggest that psychoanalytic practitioners should be capable of mutative learning, as Szecsödy described the supervisee's learning process in psychotherapy supervision, which he investigated also empirically (1994, 2008). Mutative learning processes in treatment and in supervision should be differentiated theoretically and practically from a mere problem-solving attitude and action in clinical and supervisory learning situations. The latter seem to result in developing psychoanalytic pseudo-identity during psychoanalytic education (Tuckett et al., 2008). According to Szecsödy's findings, it is also essential to distinguish between learning problems and problems

of learning in candidates and in clinical and educational psychoanalysts. Problems of learning seem to be a serious limitation of the capacity to learn expansively and autonomously in psychoanalytic contexts (Lecomte, 2006). Those limitations could be connected with individual and situative states of feeling secure (Beland, 2011) and with individual narcissistic states of personal development (Poland, 2009). Shaw recognized at least four areas of professional narcissistic vulnerability with which analysts, teachers, and supervisors are struggling, and any one of which could lead to authoritarian control behaviors: the temptation to exhibit superior expertise and power so as to invite idealization and defend against anxieties about inadequacy; envy, competiveness, and the fear of being surpassed; the need to be admired and to feel indispensable and concerns about our reputation, especially in institutional situations (Shaw, 2006).

Nevertheless, clinical and educational psychoanalysts incur an ethical-based special responsibility (Buber, 1970; Kahl-Popp, 2007). From this responsibility arises the task for psychoanalysts to observe, reflect, and develop their mutative learning processes; to overcome resistances, self-deception, and emotional discrepant experiences; and to offer their patients and candidates helpful concepts and activities for expanding their capacities of mutative learning, gaining insight and adapting reality in a more satisfying way. From a general point of view, treatment concepts, as well as educational concepts, can be considered as didactics of treatment and education (Kahl-Popp, 2012). When clinical and educational didactics were not handled as an offer for patients and supervisees, but in a projective and manipulative manner, ethical basics especially respecting the autonomy of patient/supervisee will be violated. In psychoanalysis, practitioners know a lot about projective and introjective identification, indoctrination, and overvision in psychoanalytic education (Dorpat, 2006; Kahl-Popp 2005, 2007; Kernberg, 2013; Kirsner, 2000; Tuckett et al., 2008). Therefore, educational psychoanalysts can learn a lot from pedagogical knowledge how to offer psychoanalytic education without dominating the personalities of the candidates (Kahl-Popp, 2007).

Educational psychoanalysts, especially supervisors should realize their pedagogical responsibility and should develop pedagogical competence dispositions (Szecsödy, 2008). That means, for example, that supervisors should focus on the states of learning of their supervisees and should stimulate them to maintain an expansive learning attitude to develop their individual clinical concepts and styles of intervention. Supervisors should protect the supervisee against double traumatization of stressful and conflicting involvement with patient and supervisor on the same time (Ellis et al., 2010; Ronnestad and Orlinsky, 2010). The main target of supervision is to offer the supervisee situations to learn and develop his/her self-reflective supervision-function within a trustful and secure relationship (Lecomte, 2006). To serve this target and to meet the special complexities of supervision a context-analytical concept and methodology of supervision in psychoanalysis is necessary (Kahl-Popp, 2010).

PSYCHOANALYTIC EVALUATION OF LEARNING: INVESTIGATION OF THE INNER SUPERVISION FUNCTION

One of the central psychoanalytic paradigms is to make use of unconscious wisdom and knowledge for acting, intervening, and interpreting in psychoanalytic practice. But how can this special capability be learnt and how can it be taught in educational practice? More qualitative research about this delicate domain, as for example the investigation of psychotherapeutic change in

interaction by Leiman (2012), Peräkylä (2010), Voutilainen, Peräkylä, and Ruusuvuori (2011), is needed for illustration of how this paradigm works in clinical practice.

Reading and understanding the products of unconscious mental functioning is a special psychoanalytic learning target. For example, Meltzer (1988) pointed out the value of dreams as symbolized products of unconscious thinking, problem- and conflict-solving, and creative trial-acting, which could serve to realize meaning and to understand therapeutic conflicts. In the same direction, Casement (1989; 2002) described ways to learn from one's patients and from one's mistakes by decoding narratives and dreams, and to develop an inner supervision function. During some past decades, Langs elaborated a theoretical and clinical psychoanalytic approach of understanding encoded meaning in patients' communications during therapeutic interaction as evaluation of the therapist's preceding intervention/interpretation. Furthermore, he found out that the patient would only validate those interpretations, which are based on his unconscious evaluation (Langs 1978, 1992, 2004).

To read the patient's dreams, narratives, and symptoms, as well as to understand one's own dreams, associations, and symptoms from an evaluating perspective according psychoanalytic competence, can be a learning target for the professional lifespan of psychoanalysts. Developing this kind of internal part of psychoanalytic competence disposition (Kahl-Popp, 2009) means overcoming severe resistances, competence-illusions, and phobic anxieties (Zwiebel, 2007). Following are two examples.

Dream of the Psychoanalyst as Unconscious Evaluation of His Clinical Acting

The analyst had dreamt that he had a telephone call with one of his female patients while he was at a petrol station. She reproached him vehemently with treating her very badly and told him that she would be totally discontented with him. The analyst tried to justify himself and said to her, finally: "I cannot always behave therapeutically." The psychoanalyst's associations to his dream made him aware of a case that dated from 20 years ago. Reflecting on this case and its actualization in his dream brought him to a contemporary treatment situation. The female patient was complaining about his passivity, retention, and the lack of progress. With the help of the dream, the analyst could admit to himself that he submitted to the patient's pressure and answered her with justifications and recriminations. Then he could take up, again, his psychoanalytic attitude and could understand his and her patient's feelings of guilt (Zwiebel, 2007).

Dream of the Patient as Unconscious Evaluation of Her Psychoanalyst's Clinical Acting

A female patient told her female psychoanalyst the following dream: A group of people, who had been merged together enthusiastically like after a soccer match, had left. Everyone was on his or her own way. The patient was one of the people and now walking alone on the beach. She gathered stones. Some of the stones were extraordinarily beautiful. Suddenly, there was a finery salesman. He demanded to be paid for the stones she had found in the sand. He showed her that he polished some of the stones. He had hidden them in the sand to let them be found by passers-by to stimulate them into buying. She gave these stones back to him. Then she gathered her own.

The analyst investigated the dream contextually. The dream began with a separation situation after a successful match. The salesman had manipulated the patient, in that he imputed stones as "by herself found" to the patient, to stimulate her to buy them. But the stones belonged to him

and were used by him like a lure. The psychoanalyst regarded the salesman as a dream symbol of herself. Then she investigated the therapeutic interaction with the patient before the dream. She remembered that she had "invaded" the patient with a projective interpretation: She had imputed to the patient that she must be sad or enraged about the psychoanalyst's coming holiday break. Just after given this interpretation, the psychoanalyst had a feeling of gliding on a slippery surface. And the patient had accused her that she was not prepared enough to do an important work. After remembering that, the psychoanalyst understood the patient's hint according her work as a marker of the therapeutic interaction-context. With the help of the dream, the analyst had done her homework, meaning that she had found her emotional parts in the sand, the underground of the therapeutic relationship, which she had imputed to the patient.

After that process of understanding and learning, the psychoanalyst could take up, againm her psychoanalytic attitude and the patient communicated narratives about trusting herself and fulfilling her work with success (Kahl-Popp, 2011a).

To follow this understanding during clinical or supervisory interaction is especially at the risk of feeling competent and secure. Ambivalence with psychotherapeutic research (Protz, Kächele, and Taubner, 2012) and the unwillingness to audio- or video-record analytic treatment sessions in psychoanalytic communities could be also the expression of the fear to meet threatening knowledge about the effects of one's own clinical or supervisory acting in the patient's and supervisee's narratives.

Nevertheless, if one would define that a central psychoanalytic competence disposition would be the psychoanalyst's capacity to regard the patients unconscious evaluation of clinical interaction as guideline for clinical action, one would come to the central question of if and how would this disposition could be learnt in clinical practice with supervision.

Although supervision has become a field of empirical and conceptual research in the recent decades, there has been, until now, only little evidence of how supervision influences the learning process of candidates and the clinical acting of practitioners at all (Strauß, Wheeler, and Nodop, 2010; Watkins, 2011). Therefore, in 2011 I started a pilot study on supervision in and beyond psychoanalytic education, which is awarded by the IPA with a small grant (Kahl-Popp, 2011b). In the next section, I describe an extract of this qualitative investigation of mine.

EFFECTS OF SUPERVISION EXPERIENCE ON PSYCHOANALYSTS' CLINICAL INTERVENTIONS

Interaction-Evaluation-Analysis as Research Method to Investigate Improvement of Clinical Competence by Learning in Supervision

The findings previously mentioned suggest that patients continuously perceive and evaluate the psychoanalysts' interventions on a conscious and unconscious level of psychic functioning. Therefore, all psychoanalytic interventions are considered to be a possible significant context for the patient, which can trigger his manifest and latent evaluation of the therapeutic interaction. The result of this evaluation will be communicated to the psychoanalyst as manifest or, more often, as latent feedback shortly after the intervention. Within psychoanalytic interaction, the patient's narratives and communications underlie a context-related selectivity principle. Therefore, it is important to consider how the patient experiences psychoanalytic interventions. Any intervention

can contain special implications for the patient, which can trigger individual memories, phantasies, beliefs, emotional-cognitive states, resistances, and symptoms. If the intervention fits the need of the patient, the patient will validate the intervention in his feedback. If not, the patient will communicate rectifications or will falsify the intervention.

Patient's verifying evaluation can be categorized as followed:

- *Cognitive*: in form of diminishing symptoms; increasing mentalization and knowledge about the conscious and unconscious connections between symptoms, sufferings and maladaptive functioning; diminishing and correcting conscious' and unconscious pathogenic beliefs, etc.
- *Interpersonal*: in form of increasing confidence and feeling secure; emergence of reliable, mainly benign introjects; strengthening of the therapeutic alliance; change of projective/acting-out communication mode into a more symbolised communication mode.

Consequences for Supervision

The main task for supervision is to inspire and encourage the supervisee to keep an eye on the interactional context, to listen to the patient's feedback to his interventions, to decode the patient's evaluation, and to help him to adjust his interventions according to the patient's needs and rectifications. In case the supervisee will benefit from the interventions made by the supervisor, his feedback can be categorized with a resembling evaluation-concept:

- *Cognitive (verifying/falsifying) evaluation*, expressed by increasing or stagnating learning processes (expansive versus defensive learning), establishing new insights, overcoming and integrating emotional disturbances triggered in clinical practice, deepening, intensifying and linking the conscious and unconscious reflecting function, integrating theoretical concepts to creative psychanalytic acting.
- *Interpersonal (verifying/falsifying) evaluation*, expressed by increasing or decreasing of the supervisee's feeling secure in supervision and clinical practice, by handling the supervisory frame, by growing trust, sincerity and critical distance when depicting the clinical work with the patient.
- *Clinical (verifying/falsifying) evaluation*, arising from the development of the psychoanalyst's interaction with the patient and from the feedback of the patient (and the supervisee).

Research Project: Supervision In and Beyond Psychoanalytic Education

Hypothesis:

> I propose that supervision in psychoanalytic practice and education can improve or not improve the psychoanalyst's clinical competence. And I propose that the competence-improving effects and competence-nonimproving effects of supervision will be evident in the supervised treatment.

Research Plan

The supervised treatment shall be investigated in cross section, as well as in longitudinal section. By longitudinal section, at least three cross sections should be reported as sound documents: at the beginning of the patient's treatment, in the middle, and at the end of the psychoanalysis.

A cross section contains the sound record of the treatment session before the supervision session, the supervision session itself and the treatment session after the supervision session. In the cross section, the interrelation between the patient's feedback to the psychoanalyst's interventions, the supervisee's feedback to the supervisor's interventions, and the psychoanalyst's interventions with patient's feedback after supervision will be investigated.

With interaction-evaluation analysis interaction sequences will be investigated in transcriptions of psychoanalytic and supervisory sessions following a four steps model starting at the therapist:

1. Intervention of the psychoanalyst/supervisor (A)
2. Implications/answers of the patient/supervisee as his evaluation of A (B)
3. Intervention of the psychoanalyst/supervisor (C) concerning (or not concerning) the patient's/supervisee's processing (B of A)
4. Response of the patient/supervisee (D) as validation of (C)

Expectations

I expect that supervisory interventions influence the supervisee's development of psychoanalytic competence. I expect that there is a visible difference between the supervisee's clinical acting before and after supervision, which will be proved by the patient's evaluation and feedback of the interventions as more or less helpful. If this relation can be found again in the longitudinal section, then it could be considered as proved, that supervision changes clinical competence of the supervisee.

In this perspective, I expect increasing competence or stagnation on the side of the supervisee correlates with verifying or falsifying feedback on the side of the patient.

Possibilities and Limitations of the Method

Contemporary interaction-evaluation analysis is proved as a psychoanalytic clinical method to investigate how patients of various psychoanalysts process and evaluate, consciously and unconsciously, the psychoanalysts' interventions and communicate their feedback. If it is possible to apply this method as a scientific research method, the latent or between-the-lines dimension of clinical and supervisory interaction could be investigated in more detail, especially the question how patients experience clinical acting in psychoanalytic here-and-now-interaction.

The method is not yet proved as a reliable and valid qualitative social-scientific research method. So, the pilot study shall serve also the target, to prove interaction-evaluation analysis as a research method.

First Results of an Investigated Cross-Section: Treatment-Session—Supervision Session—Treatment-Session (Condensed Version)

With the participating candidates, psychoanalysts, and supervisors, an ethical contract has been made. They also make safe an ethical agreement with their patients and supervisors according audiotaping the sessions. For this research project, only the cross-sections of the treatments with supervision are audiotaped.

Treatment-Session Before Supervision

The female patient in her early 20s started the session with alluding to her married manager, whom she loves unworldly, and then with complaining her loneliness. She is looking on her mobile phone, controlling, if it is off, so that "nobody can listen to us." A little bit later, she mentioned that it had occurred more times in her therapy sessions that she had controlled her mobile in a "compulsive manner" at those moments, when she was thinking on her love for her manager. She would not allow herself to break into her manager's matrimony, as she had experienced in her childhood with her parents. When she was 8 years old, her father's mistress had called the patient's mother, to inform her about her existence. But she, the daughter, had been at the phone when the mistress called, and mixed her up with her mother.

Later in the session, she talked about the emotional disturbances and arbitrariness of her mother, so that she had to split off her own feelings and had to take care of her mother from childhood on. The patient talked about her suffering from a lack of closeness, from sleeplessness, and from fear of intrusion.

During this session, the interaction between psychoanalyst (candidate, female) and patient was, on the one hand, sometimes functional; for example, the therapist was opening the window when the patient was excited, or was counting sessions and planning the further proceeding numerically when the patient planned to interrupt her therapeutic process for half a year. On the other hand, the therapist acted very carefully in a granting and holding attitude. The patient was crying several times and seemed to be in a state of mourning, as if she had lost a loved person.

Toward the end of the session, the patient asked directly, alluding to the audiotape: "This will be listened to by another person?" Psychoanalyst answered: "Yes." Patient: "Okay, and does the listening person knows the whole context?" Psychoanalyst: "No. The sense is to understand supervision, if supervision is helpful and effective. The listening person does not know your whole context." Patient: "Okay." Psychoanalyst: "There is a woman, who listens to the audiotape. She will write it down and then will extinct the recording." Patient: "Okay . . . now I could sleep."

The patient calmed down. Sometime before end of session, the patient was counting her sessions. Then she said:

> I am feeling connected to earth . . . relaxed. . . . I do not think much . . . and now it is like waking up. . . . It is long ago, that we talked about my mother and my parenting her as a child; it took a long time weeks, months, and now I feel emotional solution. . . . I am sad about that, this is the main reason I am in psychotherapy, the lack of closeness. . . . it is just like after a cosmetic treatment, when you have listened to relaxing music and you have to wake up again, I am totally relaxed at the moment.

Patient and psychoanalyst are laughing together. Patient: "It is curious, that the insurance company will pay for that. . . . Oh, can I bring my dog with me in a case of need. . . . Would you allow me?"

Interaction-Evaluation Analysis (1)

Intrusion is a central subject of the patient according to her childhood experiences with mother and father. At the beginning of the session, there is an unconscious motivated enactment of intrusiveness: When she is thinking about breaking in the manager's matrimony with her love, she has to control her mobile phone in a compulsive manner, as if somebody would be intrusive to her by listening secretly what she is talking about in the treatment room.

On this biographically and actual background, one could hypothesize that audiotaping her session could be a trigger for her subject intrusion. Later in the session, the patient referred manifestly to the audiotape and seemed to be calmed by the fact that she is not in the focus of investigation and the recording will be deleted.

After that, the patient changed in her mood. She focused on her psychoanalytic frame and content and her inner world of feelings. Subject now is the emotional "lack of closeness," also with her psychoanalyst. Manifestly, she experienced feelings of well-being, like holding and containment. In her unconscious meaning analysis, she communicated that she felt like being treated in a cosmetic frame. On the one hand, the cosmetic psychoanalyst can be understood as an emotionally calming, in this sense helpful introject (interpersonal validation). But there seems to be a lack of understanding and development, a lack of cognitive validated interventions. Therefore, she wondered that, in a way, cosmetic psychoanalytic treatment would be paid by the insurance company and communicated her need on an enactment level again, how to live close relationships (for example, with therapist or with the dog), togetherness and separation, without being intrusive or cutting off the relationship.

Supervision Session

The psychoanalyst (supervisee) started her supervision session with reporting that her patient will interrupt the treatment for 6 months by travelling to another continent, and how she, herself, is handling the frame in a functional way by increasing the weekly session-frequency "to make the time full" (as a candidate she needs a certain amount of sessions in her psychoanalytic education). Then she reports about the patient's love-story with compulsive handy enactment. Mrs. S. (Supervisor) is listening. The supervisee is, furthermore, reflecting on her patient's biographical aspects and psychoanalytic theoretical connections like unconscious phantasies, incest-taboo and so on.

Neither the supervisee nor the supervisor was alluding to the research-context of tape-recording this supervision-session. But the supervisor seems to cling to a certain interpretation of intrusion at the beginning of the treatment-session. She repeatedly presses the supervisee "to strike off the patient, if she is in a love mania with her manager and if she believes that one could use her mobile-phone to listen secretly to the treatment session in reality." The supervisee repeatedly uttered that she did not agree with her supervisor and that there are no hints in a psychiatric direction. But the supervisor argued against her and gave her strict and intrusive instructions of interventions like questioning or confronting the patient with the "truth directly."

The supervisor alludes to her clinical experience in psychiatric surroundings. She seems to be subliminal anxious about the border between phantasy and reality. The supervisee tries to calm her supervisor down with defensive answers. Supervisor: "The patient is falling out of the norm variables." Supervisee: "Yes, but could it be the wish of the patient to reenact the situation from her childhood?" Supervisor: "Absolute, but you have to ensure, that there is no mania and no psychosis." Furthermore, she is insisting on her perspective filling it with her own phantasies. Later in the session, the supervisee was successful in changing the supervisory focus on the patient's wishes for closeness and relationship and her mourning and crying about the lack. Supervisor and supervisee shortly reflect on the patient's feeling relieved from a burden, when she cried. Supervisee: "The patient feels relieve like after a cosmetic-treatment, as she said."

Then supervisor and supervisee exchanged phantasies about what could have happened to the patient in her youth, like a beginning depression, sexual abuse, or another developmental frame break. Again the supervisor insisted that the supervisee should ask the patient for what had happened to her in her youth. Manifestly, the supervisee agreed with her: "I must ask, yes, and then the subject closeness and distance was coming up and anxiety that she (the patient) could feel dependent or destroyed." Again supervisor and supervisee are exchanging phantasies about the patient's biography. Then the supervisor reported case narratives from her own clinical experience. She ended this sequence: "It is hard, that there are such stories, which can destroy one." Supervisee answered: "I will listen in this direction, what occurred to the patient." Supervisor: "Yes, she is noncommittal, isn't she? Put [to] her a question, which is justified; for example, do you feel guilty . . ." Supervisee: "Okay." Again an exchange of phantasies inspired by former treatment-sessions about violation between mother and patient started.

Near the end of the session, the supervisee told a story about the patient's dog, but did not report the real interaction on it. Instead of that, she informed the supervisor about laughing together with the patient when focusing the further development of the dog. Supervisor: "And you have got the impression that the patient understands and takes over such stuff? And then the burden will be reduced." Supervisee: "Especially in the last session, the patient talked about her burden at the beginning, which she had gave away at the end."

Supervisor: "And this is the cosmetic treatment." Supervisee: "Yes." They were laughing together. Then the supervisor focused on the transference meaning of the cosmetic metaphor. She comes to a mixed meaning of relief, wellness, relaxation, but cosmetic only on the outside, artificial and superficial. Supervisor: "You are the cosmetic person, who is doing a wonderful wellness treatment. In this role, you avoid to come into the mother transference." Supervisee:" Okay, then I have to . . ." Supervisor: "You must prepare her that not everything is wellness; sometimes it is part of the cosmetic treatment to use electric power and to pick the eyebrows." Supervisee: "This will hurt . . ." Now the supervisor started, again, to talk intrusively, that the supervisee should confront the patient, if there is a trauma, a love mania, or an isolated hallucination.

Interaction-Evaluation Analysis (2)

The supervisee did not verify the supervisor's interventions. From a cognitive validation perspective, the supervisee increased a defensive attitude against some persecuting supervisory interventions. She did not gain new insights or develop ideas of creative clinical interventions. On the contrary, the connection between theoretical reflections and clinical interaction was lost. The supervisee was changing the supervisory focus defensively.

From an interpersonal validation perspective, the supervisee expressed decreasing feeling secure and decreasing sincerity during the supervision session. After a manifest agreement to the supervisor's opinion, she reported narratively emotional aspects of her patient according closeness and distance in relationships: feeling anxious, dependent, and destroyed. This could be regard as the supervisee's unconscious evaluation of the experience with her supervisor, who forced her again and again to follow her perspective and instructions. Now, with the question for the clinical validation in mind, I investigate the treatment session after the supervision session.

Treatment Session After Supervision

The patient started the session with complaining about her job situation, that she plans to leave and search for another job, because she cannot learn and develop herself there, because the work is too effortless. The psychoanalyst asked her if the reason would be her manager. The patient made clear that she would not like to try to realize her love for him and that she plans to leave this behind and to search for a new job and a man who is not affiliated. She said: "I have to learn to live on my own. . . . If I would be successful in living alone, then I would feel well but I am not yet so far."

The psychoanalyst said: "Let us see, which burden you are dragging with you. I remember when you were 16 years old you felt bad or what happened that time?" From this point on, the psychoanalyst started a series of questioning the patient in a persecuting way, like: "Did you want to be near to somebody?" Patient: "No, I found this dangerous." Psychoanalyst: "What did you experienced at that time, can we go back to those days?" Patient: "Mhm." Psychoanalyst: "Puberty, men, boys, how did you feel there?" Patient shut down: "I do not know". The psychoanalyst continued to persecute the patient with questions, speculations and suppositions.

The patient reacted latently annoyed, defensive, and told a narrative of running away or that intimacy is not possible "when the father is absent or had died." After some narrative communications, the psychoanalyst forced the patient back into answering her questions manifestly. The patient now commented on withdrawal with depressive expectations of bad life experiences and of being abandoned. A little bit later, she refused to answer the persecuting psychoanalyst's question about her stain: "I do not want to talk about it." Afterward, she questioned the psychoanalyst, asking if there is no sense in what she says. The analyst stopped persecuting her with her questions. Patient: "There is a black veil before my face—like a widow." Again, the psychoanalyst intervened, directing her questions into the past of the patient.

The patient came back to her thoughts, with which she had begun the session about her discontent with her job: "I started working there only because the colleagues were pleasant, the team is great and the people like me. But this had been the wrong reasons for the decision to work there. I need more input and more challenge . . . and more distance." Then she described recent meetings with her father, when he persecuted her with wishes of contact and with tenderly touching her and she marked him out: "I am not a little girl at the age of four years anymore; I am an adult woman." Then she mentioned her marking against the psychoanalyst's persecuting questions according her mole. Later, she told how she overcame a bad mood on her own and how the manager marked her off, when she had tried to persecute him with words she then regrets, that "all good men are already engaged."

Interaction-Evaluation Analysis (3)

The patient did not clinically verify the psychoanalyst's interventions. The patient's narratives about her work, at the beginning and especially at the end of the session, can be regarded as cognitive falsification of the psychoanalyst's interventions. Furthermore, there are rectifications like "I need more input, challenge, and distance." The patient communicated in an encoded way, that in a working frame (analogue to the treatment frame and working alliance), it is not sufficient to have a great team or the love of the colleagues (the psychoanalyst) for satisfying experiences which could trigger her learning and development.

Beyond that, the patient verified her own marking off the persecuting questioning of her psychoanalyst from an interpersonal perspective in the narrative about the experiences with her father. There is also a rectification in like being persecuted that she would like to be treated as an adult woman and not as a little girl.

CONCLUSIONS

On the basis of the analyzed treatment sessions and supervision session, it is visible that the supervisory experience of the supervisee did not improve her clinical competence in the following treatment session. The competence-nonimproving effects of supervision can be shown also quantitatively: In the treatment session before supervision, the psychoanalyst made 39 questioning remarks, indirect and direct questions. In the treatment session after supervision, she made 80 questioning remarks, indirect and direct questions. This fact could be the result of the supervisee's identification or introjection of her supervisor's persecuting and insisting instructions. One reason for being on a higher level sensitive as candidate for identification with supervisors' attitudes and convictions can be the candidates' search to become a better clinician and the search for recognition of their clinical preconceptions by supervisors as found out in the empirical investigation of Carlsson (2011) and Carlsson et al. (2011).

In the reported cross-section, supervisory interventions were not focused on the clinical interaction of psychoanalyst–patient relationship and working alliance with the patient and the clinical development of the supervisee. The supervisor seemed to be not pedagogically oriented. The supervisee did not verify the supervisory interventions on cognitive and interpersonal level.

Qualitatively, the patient's evaluation and feedback of psychoanalytic interventions express that interventions in the postsupervision treatment session were experienced as less helpful as in the presupervision treatment session.

This short cross-section investigation with interaction-evaluation analysis confirms the hypothesis of changing clinical competence as a consequence of supervision. The stagnation of the psychoanalyst's clinical acting correlates with the patient's falsifying feedback and her rectifications.

Further investigation is necessary (Watkins, 2011). The general necessity to prove psychoanalytic axioms with empirical investigation and research justifies the proposal to modify the conception of a psychoanalyst to include research competence as well as clinical competence (Safran et al., 2011; Schachter and Kächele, 2011).

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