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An Experiential Group Model for Psychotherapy Supervision

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ABSTRACT
This article presents an experiential group model of supervision constructed for both group and individual therapy presentations, emphasizing concepts from object relations theory and group-as-a-whole dynamics. It focuses on intrapsychic, interpersonal, and systems processes, and stresses the group aspect of the supervisory process. Its central thesis is that material presented in a group supervisory setting stimulates conscious and unconscious parallel processes in group members. Through here-and-now responses, associations, and interactions among the supervisory members, countertransference issues that have eluded the presenter can make themselves known and be worked through on emotional as well as cognitive levels. Selected excerpts from supervisory sessions demonstrate various attributes and strengths of the model.

This article presents a model of supervision that the author has evolved in a group setting and which has recently been described (Altfeld & Bernard, 1997). The model is heavily experiential and involves using supervisory group members’ interactions as the matrix out of which supervision occurs. Prior to formulating group supervision in this way, most supervision that the author was aware of involved a member who presents an individual case or group for consideration and a leader and group members who focus on understanding the case or group dynamics. From that effort, a picture of the therapy process is constructed that the therapist can use in future work with his or her individual patient or group. In the individual case, through hearing the patient’s history,
presenting problem, family relationships, outside life, and therapist/patient interactions, various supervisory group members and the leader construct a meaningful narrative that one hopes brings clarity with it for the therapist. Similarly for group, a traditional supervision of group therapy might emphasize delineating and understanding the many complex interactions occurring in the group. This is a perfectly good and legitimate way to do supervision and a time-honored way to proceed.

Nevertheless, aspects about this traditional procedure remain unsatisfying. The problems seem to be several. Too often group members’ critical responses to the presenting therapist’s work elicit reactions of shame, embarrassment, and anxiety that do not provide an atmosphere for optimal learning. Also, the amount of feedback offered by group members can be large, and presenters often feel overwhelmed. Finally, a moderately experienced clinician can formulate dynamics reasonably quickly. Given the theoretical ferment prevailing today, the occasion is ripe for disagreement as members advance their own closely held viewpoints.

Even when things proceed well, an issue of equal or greater importance is that the learning that takes place is often only cognitive. When the problem presented is an outgrowth of a countertransference issue, the kind of cognitive learning referred to is often not sufficient to transform the subjective state of the therapist to any significant degree. Too frequently, the case is brought back repeatedly until the unconscious piece is worked through. At some point it became clear that problems brought to supervision not of a technical nature or the result of insufficient knowledge are emotional, the result of countertransference blocks, and require a counteremotional experience for any internal shift to occur in the therapist.

The kind of process that would produce such an emotional shift, however, is traditionally reserved for the therapeutic hour and not the supervision room. How to accomplish this shift within a structure that traditionally requires one person to “undress” emotionally while other therapists in the group work with that person to achieve a result, was not at first clear. This kind of “hot seat” supervisory work often seems ill-advised in the context of institute training programs or a clinic staff milieu. The idea occurred that all members of the group could become as emotionally involved as the presenter. They could undergo their own meaningful emotional experience along with the presenter, who would then not feel alone, uncovered, and vulnerable, whereas all others remained comfortably “dressed.” By focusing each group member on his
or her own emotional response to the patient presented, as well as to each other and to their own internal states, while disallowing cognitive formulations of dynamics, it seemed that something else might occur.

What happened was interesting. Supervisory groups took on the therapist's problem in an emotional, personal, and interactive way, which spoke to some of the objections raised about the traditional model. The presenter, in consequence, often found him or herself more able to move emotionally along with the supervisory group to a different place. A frequent result was that the therapist felt able to and interested in returning to the patient or group to work with the issues that had been troubling prior to the supervision.

**DESCRIPTION OF THE MODEL**

What has evolved to date is an experiential group model of supervision constructed for both individual and group therapy presentations, emphasizing concepts from object relations theory and from group-as-a-whole dynamics. (It can also be employed in the supervision of supervisors who wish to present their supervisory work.) It focuses on intrapsychic, interpersonal, and systems processes. The model stresses the group aspect of the supervisory process, using the unique character of group processes to execute the group supervision.

The central thesis of the model is that material presented in a group-supervisory setting stimulates conscious and unconscious parallel processes in group members. Then, through here-and-now responses, associations, and interactions among the supervisory members, the countertransference issues that have eluded the presenter can make themselves known, and do so in a relatively nonthreatening way. This method provides a means for the presenting therapist through the course of the supervisory group to shift his or her ground, and to become more attuned to both his or her own feelings as well as the patient(s). It is proposed that the therapist will feel heard by the supervisory group, held by that group, and taken in and resonated with by its members.

**THEORETICAL RATIONALE**

How can one theoretically explain this phenomenon of material moving partly unconsciously "from one group to another," as Etting (1995) has called it? Concepts from ego psychology such as unconscious communication and primary process, as well as object relations theory using the
concepts of parallel process and projective identification, are all helpful in formulating this methodology.

An important theoretical component of the method is found in group-as-a-whole work developed by theorists grounded in object relations (Agazarian & Peters, 1981; Bion, 1961; Horwitz, 1977). In their systems, emphasis is placed on the group as container for the various affects, projections, displacements, or repressed material that emerge in sessions. A group can hold onto such material and assimilate it slowly enough for a member to see and understand what they have brought to group and have asked the group (or part of the group) to do for them. The power of the group to hold, frame, contain, and give back to someone in an assimilable form, that is, to accept the projective identifications and work with them, becomes the transformative medium of the group process. Ogden (1982) has written extensively on the process of projective identification in individual psychotherapy and this paradigm is easily transferable to group process.

Another important influence is that of Gestalt therapy theory (Perls, Hefferline, & Goodman, 1951), which particularly emphasizes here-and-now work, a therapeutic focus that is currently receiving wide acceptance across a broad range of theory and practice. Gestalt therapy theory also emphasizes play and playfulness in therapy as curative, and employs imagery, metaphor, and experiment in guiding therapeutic work. Other issues that Perls et al. stress are the willingness of the leader to share psychic contents and feelings, a regard for and emphasis on phenomenology, and the importance of existential issues in treatment. All of the above factors have been instrumental in guiding the development of this supervisory model.

METHOD

The method of this experiential group model of supervision is as follows. A member volunteers to present a case or group and the other members are instructed to take note of whatever images, fantasies, feelings, memories, associations and/or bodily sensations they experience while listening to the material presented. They are asked to report these inner data to the group, and to assume that their reactions are related to the case material, no matter how personal, bizarre, embarrassing, or seemingly unrelated to the task at hand they may at first appear. It is also stressed that these reactions will likely hold some key to the “puzzle” of
the case, providing a crucial piece in the group's process of discovery. Group members are thus urged to begin converting what might appear at first to be merely idiosyncratic internal wanderings into an understanding that such responses are meaningful countertransference material. Members are also asked to report responses they are having to one another or to the leader and to trust that such responses also belong to the material being presented and not merely to their own private world.

These initial group instructions are easier said than followed, however. Clinicians are prone to giving opinions, formulations, clinical insights, and so on, and it is easy for them to offer interesting dynamic formulations given a reasonable amount of information. But to reach inside and respond on this other level is not as natural and requires some training and experience. Typically, a member may begin a sentence with the phrase "I feel" and immediately convert it into a cognitive statement such as "I feel that you are angry with this patient and not admitting it," or some such interpretive statement, an assertion that has to do with the other and not the self. Such a statement, mostly characterizing the presenter and not the member, is responded to by the leader in the model being described, who says something to the effect of, "Yes, you could be right about this, we don't know yet, but that statement is about the presenter. Did you have some feeling inside related to that statement, or some feeling about what the presenter was saying?" By such questions, the leader begins to induct both that individual and the group into the work task. This early phase can take some time in an initial group meeting or consultation. Often, if the group is slow to respond, the group leader can offer his or her response and so model for the members, offering his own internal process and reactions. For example, in one instance, when a group did not respond, the leader said, "I was having an image of eating ice cream while you were talking." In another group, he stated, "I don't know why, the minute you started talking, I had an image of someone sitting comfortably smoking a pipe." In another instance, he described a farmer raking the ground with a hoe (and was subsequently told that the patient grew up on a potato farm). In still another, the leader told the group he felt an immediate dislike of the patient being presented. Frequently such images, associations, and feelings find some connection with the material, sometimes immediately; of course there are times when no such connection is made. What the leader's remarks attempt to accomplish if the group is slow to offer responses, is to relax the members,
and provide examples of the kind of input being asked of them, which can facilitate their entering into the process.

It is not always a simple matter for members to accept their subjective responses as actually related to case material. Understanding that subjective states can have a group aspect and can function as containers for group processes is an acquired understanding. To regard private responses, spontaneous associations, and feeling states as part of the public domain is often hard to accept. A recent session in an ongoing supervisory group that focused on individual treatment illustrates how important responses can get lost when the group instruction is ignored, and the leader does not follow up enough on the instruction:

It was the custom in this group for a member to present the same patient two weeks in a row, but for certain reasons it was decided that this presenter could switch and present a new patient for her second week. The presenter felt terrible about her work with this patient, expressing shame and embarrassment, saying she had been doing the patient harm. The group work proceeded normally and, by its end, group members felt satisfied with the work, or so it seemed. In the following week, one of the members who had been quiet the week before admitted that she had been upset with the change in procedure the week before, felt alone in her view and out of step with the rest of the group, felt inadequate in some way, and left feeling ashamed of her idiosyncratic and different reaction.

It became clear that regarding her reactions as private and different from everyone else, led her to hide them, unable to see that her feelings vividly mirrored those the presenter described. A better response by the leader the week before would have been to inquire of each member before ending the group about their reactions to what had taken place. This might have elicited how all of the group members felt, making it more possible for the leader to help the presenter and others to see how their feelings related to what the presenter was dealing with.

**PRIMARY PROCESS AND THE EXPERIENTIAL GROUP**

Primary-process activity is defined here basically as Freud (1900/1955) defined it, namely, the “thinking” of the unconscious. It is highly intuitive, employs the language of metaphor and imagery, is not characterized by (but can be influenced by) what its opposite is known as, namely, secondary-process thinking, or rational, logical discourse. It can be thought of as regressive in nature, governed by need systems, drive systems, and energies, and early relational attachments. It is also the place where artists find creative inspiration and draw material
from, what dreams are governed by, and what often characterizes psychotic processes.

The following example illustrates how, in this working supervisory model, simple primary-process imagery often furthers the group process, providing links to the emotional understanding of the case presented:

A suicide in a presenting therapist's family was preventing him from keying in on a major dynamic in his adolescent patient's life. Hearing the clinical material, a supervisory group member had the simple image of a blossoming rose being cut from a rosebush and falling gently to the ground. This image of a shortened life opened an unforeseen vista for the therapist, who stopped defending against the feelings of loss aroused in him by his patient, was able to talk about the suicide in his family, and then felt more empathic with what his patient was feeling.

When a therapist begins a presentation in the supervisory group, the leader often eases into a receptive state that allows a sitting back and observing of his own free-forming images, thoughts, and feelings. The state seems akin to what Freud (1912/1953) described as evenly hovering attention, an analytic method that has been discussed extensively in the psychoanalytic literature. Such inner data are viewed in this model as valuable, and are seen as often encapsulating an important aspect of the difficulty being presented, although the connection to the case may be ill-understood at the time.

A lack of such imagery or associative material should be equally noted. In the following example, the leader's lack of such internal imagery was taken as a clue to the countertransference difficulty in the case:

The clinical case presented to the supervisory group was that of an individual treatment of a 30-year-old woman who had been seen in therapy for several years. The patient, a go-go dancer, was an early victim of sexual abuse, and had as an adult been involved in a broad range of acting-out behaviors, sexual and otherwise. While the presenter was describing this, the leader became surprised that his mind, usually active and responsive, was a blank, described by him in the group as a "flattened empty space."

The therapist described the patient in detail but said almost nothing about herself. She spoke of the patient with great concern, but her presentation was devoid of information about the relationship or her feelings in it. A number of futile attempts by the group to gather such material followed.

As the group material developed, and the group played with the imagery and feelings produced by entering the world of go-go dancing, it became clear that important aspects of this patient's life and inner world were being kept out of the therapy space by the patient as well, in response to the therapist's suppressive tendencies. For example, the patient had not told the therapist how much
pleasure she took in behaviors that the therapist had outlined as self-destructive, bad, and that were holding the patient back from living a better life.

The leader believed that his "empty head" experienced in the beginning of the group was part of a parallel process, and represented the empty space in the therapy relationship that was not being used or filled in. A dream told by the patient just prior to the supervisory meeting suggested that this belief had some validity.

The preceding vignette emphasized the role of imagery and its absence, and its relationship to the parallel process that occurred during a supervisory group. This particular supervisory session also provided an example of how projective identifications can play out in an experiential supervisory group. Both therapist and patient experienced early sexual abuse, and their subsequent adaptational responses to that abuse were polar in nature. The therapist used repressive defenses, whereas the patient acted out the libidinally exciting aspect of the repressed material. Each was carrying an opposite piece for the other.

The therapist brought into the supervisory group that unconscious tangle, and group members interacted around the central conflict. They formed subgroups that identified with the two different aspects, with one subgroup becoming playful and sexy when working with the more sybaritic impulsiveness, which had been consciously shunned and avoided by the therapist. Such a group atmosphere can, in play, become a welcoming haven for dissociated material, allowing the therapist to repossess rejected parts of him or herself, and by doing so, to understand better what the patient is about.

Importantly, the model does not reject cognitive formulations. It regards them as important additions to the supervisory endeavor and believes they should follow after the working-through process. It is the author's belief that when cognitive understanding follows experiential or emotional understanding, the learning that takes place occurs on a deeper and more integrated level than cognitive learning alone provides. Thus, the last part of the method includes an attempt by the supervisory group to formulate theoretically what transpired on an experiential level in a supervisory session. The nature of the conflict or problem presented to the group, the parallel processes, projective identifications, and resolutions, if any, are all discussed and formulated where possible by group members and the leader.

A group-supervisory session quoted extensively in a previous article (Altfeld & Bernard, 1997), provides another illustration of how in an
experiential group-supervisory session, group members can, through identification, function as a holding environment for the presenter’s unacceptable affects, and help the presenter reown those affects. In that containment process, group members may also be helping themselves, insofar as they may be working with difficult parts of themselves:

A therapist was feeling devalued by a male group patient, feeling set up by him and consequently annoyed with him. The patient had been communicating dissatisfaction with the therapy and scheduled a family therapy interview at the time of the group session. He wanted more from the therapist than he felt he was getting and the therapist was feeling too tense and angry to help the patient with the issues involved. She directly asked the supervisory group for help with this problem.

The supervisory group took on the problem, interacting around it, experiencing its own anger, and its own sense of being devalued. Members spoke of experiences they had with patients leaving treatment, threatening “to leave, or breaking the frame in other ways. There was much interaction around themes of loss, threat of loss, and abandonment. Later in this group, the presenter began to cry, and said about the patient, “I feel how vulnerable and alone he feels.”

Useful imagery and metaphor abounded. There were many associations stressing the need for safety, a lack of feeling protected, many thoughts about weak boundaries, and also desires to flee the group. Remarks were made such as, “I want to leave, and am struggling with the door”, “I’m in the wrong place”, “I feel exposed”, “Oh God, I need to get out of here. How could I leave?”

As can be seen, the group moved to a primary-process level of work and identified with more unconscious aspects of the presenter’s unacceptable feelings. The group worked on what she had not yet worked on, each member in his own way identifying with her. Because of her resentment of devalued feelings stimulated by the patient and her unconscious identification with that devalued state, she had not been able to explore with the patient the meaning of his behavior with her, but by group’s end, she felt eager to return to deal with it.

Another interesting aspect of the model illustrated by this example is the relationship of the group energy to imagery and image building. Most frequently, imagery builds among group members as they influence and affect each other, and forms a composite that becomes eerily accurate as a rendering of the emotional dilemma occurring among patient, group, and presenting therapist. The statements and imagery this group expressed about their fears of disruption and abandonment illustrate this nicely.

If a presenter in the supervisory group wishes to follow his/her problematic countertransference response to patients as far as it will take them personally, there is invariably a resonance with someone
in his or her own family, usually parent, parent substitute, or sibling. No pressure is brought to bear on presenters to expose and explore their charged emotional histories, but when it is followed, and the pain reexperienced, the supervisee often leaves the group supervision in a much more positive state:

A therapist presented a relatively new group patient to his supervisory group, complaining of difficulty he was having connecting with this patient and helping him to become more integrated into the group. The patient had brought in written material containing life and marital history, as well as work accomplishments and history that he wanted group members to read in order to understand and help him. The supervisory group experienced the emotional flatness in the presenting therapist’s response to this patient, and their reactions and associations ranged from feeling annoyed with the therapist to expressions of feeling alone, hurt, and set aside by him. At an important moment in the process, the presenting therapist connected to both the patient and himself having had fathers who had been seriously absent in their lives, producing feelings of emptiness in both. The therapist realized he had been avoiding the patient emotionally. He had become resistant to empathizing with this obsessionally defended patient because it activated his own unresolved feelings for the father he had always yearned for. Expressing these longings in the supervisory group with their accompanying sadness led to expressions of greater caring and understanding of the patient’s own emptiness and a desire to reach out to him.

Sometimes the supervision does not seem to progress for the longest time. Although the parallel process may be at work, nothing coherent seems to crystallize. At such moments, it is important for the supervisory leader to stay with the process, keep the frame, tolerate his or her anxiety as well as the group’s in the face of potential failure, and wait. The following vignette illustrates this kind of endeavor:

The therapist felt uncomfortable and embarrassed about presenting this 40-year-old male lawyer. She had been seeing the patient for 3 years, but felt unclear about what, if anything, the treatment was accomplishing. A clear thinker, she felt unclear and twisted out of shape by the patient, who refused to play by the rules. Skipping sessions, dismissing the therapist’s insights, not talking about feelings, sleeping in group, trying to date group members, he nevertheless kept coming to sessions, sometimes arriving quite early, sometimes quite late, and at times, not at all. The therapist was often angry, and found herself feeling relieved when the patient was late, or didn’t show.

The therapist described herself as a warm and caring person, easily loving and empathic with patients, but uncharacteristically withholding with this patient. In the course of the supervisory group, a parallel process began, in which the members found it difficult to make connections with each other. Experienced therapists, they did not follow the task instructions, did not interact much with
each other, and remained primarily intellectual, staying within their professional roles. The leader also felt twisted out of shape, asking too many questions and making interpretations, a role unusual for him in this kind of supervisory group.

Hungry for love, the patient could not commit himself to any relationship that might provide it. Intellectualization, distancing, devaluing, acting out, and splitting were his major defenses, and the group employed some of these as well. The patient was a deprived child, the presenter a deprived therapist, the leader deprived of material, and the supervisory group deprived of each other. Group members occasionally had images and metaphors but they did not seem to build on or relate to each other. Then leader, presenter, and group allowed themselves to experience some despair, in effect to lose some heart. Finally an image emerged that focused the work, namely, that of the Tin Man in the Wizard of Oz, who desperately needed a heart. Heart damage, and disconnection in the face of continual devaluation were the motifs of this supervisory story. The therapist felt that if she pursued the lost-heart theme with the patient she would be mocked, rejected, and have to reexperience her own early family disappointments. Treating this patient demanded the highest order of sacrifice from the therapist, namely, exposing one’s heart in the face of potential mockery, risking painful rejection to infuse in the patient a sense of hope and authentic caring.

It was felt that the leader’s willingness to contain and stay with this difficult, anxious-making, and seemingly unrewarding process was ultimately helpful to the presenter and group process.

THE USE OF EXTRA-SUPERVISORY EVENTS

The supervisor in the experiential model makes an assumption that events occurring from the moment the door is open in such a supervisory group may be interconnected and carry meaning later for the supervision. That is, nonsupervisory events are also treated as primary-process material, as in the language and events of dreams. Such material may weirdly fit in with later events, may help in shaping later events, and also may retrospectively derive meaning from them. Examples of this abound. Someone being late, a misunderstood word, chair arrangements and seating, a locked door before the group meets, something that spills on the floor, a casual remark or joke prior to beginning the work are common examples. All of these minor, sometimes trivial, and seemingly unrelated behaviors and events often find their way into the primary-process work of the group as markers, elucidators, and confirmers, supporting the hypothesis of the power of the primary-process work in group. These potential meaning-connections between unconnected events are sometimes humorous, and
have the attribute of surprise. They also seem to show themselves so frequently as to make secondary-process thinking, that is, our orderly expectations about the progression of events through time and space, seem quaint at times. One can respect such synchronicity, be frightened by it, in awe of it, charmed by it, suspicious of it, disbelieving of it, or guided by it on the road to discovery.

GROUP SUPERVISION OF A SUPERVISION

Occasionally a supervisory group member who is also a supervisor may wish to present a problem he or she is having with a supervisee. The experiential model is able to work with these dilemmas as well. Because such a relationship is a step further removed from the therapist/patient interaction, it can contain additional complexity. The parallel process may be harder to decipher because of the added players involved. The following example illustrates a successful supervisory group handling of a supervisory dilemma brought by one of its members:

A member reported to the supervisory group that she had been coming late to sessions with a supervisee and was genuinely puzzled by it. She realized during the group process that the supervisee’s patient, a 16-year-old with severe acting-out problems, was raising issues from her own adolescence that she had not addressed sufficiently. This painful unworked-through material seemed connected to her acting out around the time boundary with a supervisee, something she would not ordinarily have done. In keeping with the format of this group model, she did not discover this cognitively. It was worked through in a parallel process by group members, who became interested in acting out against the group supervisory task and the leader. Interestingly, the supervisor’s mother, with whom she was never close, had been an acting-out adolescent, and the supervisor had also acted out against this mother. Getting in touch with her still-current resentment of her mother’s treatment of her, helped her to feel she could stop depriving the therapist she was supervising of the full allotted time they were designated to spend together.

RELATIONSHIP OF THE MODEL TO GROUP TREATMENT

The question has been asked whether and how this theoretical approach to supervision differs from the theory that governs the author’s approach to group treatment. The question is not a simple one as there are a number of differences and similarities between the two modalities. The most obvious difference is that the goals of the two are different, that people who attend do so for different reasons,
and that the service provided is therefore quite different. In addition, parallel process is a concept developed exclusively to explain phenomena that occur in supervision, and not treatment. In the latter, strictly speaking, there is no transfer of information unconsciously from one format or group to another. In that regard, then, the two are also structurally dissimilar. (Even here, though, one can view transference as the unconscious transfer of feelings from the early family setting to the treatment setting.)

Those important differences being noted, there are also a number of striking similarities dynamically. Much that goes on in the experiential supervisory group is not unlike the kinds of events one pays attention to and attempts to stimulate in therapy groups. For example, encouraging interaction between members as well as attending to group-as-a-whole phenomena are both therapeutic group leaders' tasks. In both therapy and experiential supervisory groups, members are asked to focus on their own processes in relating to others. Primary-process material is attended to, as are projective identifications, which members place into both the leader and other group members. In this sense, the approaches to both therapy and experiential supervision dovetail or overlap in terms of what is curative, life-enhancing and productive for people who are working on themselves emotionally in the presence of, and in interaction with, others.

**FURTHER DISCUSSION OF THE MODEL**

Not all of the author's group supervision employs the experiential model presented here. The model is not suitable for a group of beginning therapists. They do not have the background for it. They would probably not understand the theory if it were presented to them. Even more important, they usually have not done the therapeutic work on themselves to the degree that this method requires of people. Their resistances would usually be high and the levels of anxiety that such a group can stimulate may be too great to sustain the level of interaction and inquiry called for by the experiential model. More and more, clinicians are recognizing and writing about the deep regressive levels that seem required for transformations that free up energy for growth and creative living (Schermer, 1994). With beginning supervisory training groups, elucidating countertransference is not a primary goal. Rather, a good deal of time is spent on structural and boundary issues like establishing
the frame and making contracts. When such a group moves to more experienced levels, the focus shifts more to the kinds of events the experiential model provides. By this time, it is assumed that a basic level of personal analytic work has been accomplished by the therapists in their own treatment and that the anxiety that necessarily accompanies experiential learning is better tolerated, and in fact usable.

However, the model should not be viewed as an all or nothing proposition and can be used in less pure form. One can borrow from it, use parts of it, shift in and out of it. One can use it as a guide for the leader to titrate how much experiential learning is desirable at a given time. The model as a pure distillate is strong and potent in its intensity and power, but one need not use it only this way. It can lend itself to a mixed-model formulation. The leader, using his or her judgment, can shift the focus by introducing didactic questions into the process and shifting the supervisory group's focus onto theory or technique issues.

What does this kind of supervisory work attempt to accomplish? Starting from the negative place, it seems important to detail what it is not accomplishing. Clearly, it is not teaching the rudiments of group therapy, such as patient selection, making and forming contracts, dealing with initial anxiety, and building cohesion. It is not a "how to" method for the beginning group therapist in that sense. So it does not provide the kind of security that rules, guidelines, and structure do for the group therapist who sorely needs them in order to proceed amid what otherwise appears as an amorphous field.

Implicit in the model is some notion that an ideal experienced therapist who would maintain perfect contact with patients, and be in perfect resonance with their various interactions, cannot and does not exist. It is assumed that in the less than ideal state, impediments to the perfectly attuned therapist/patient interaction do not result from lack of technical knowledge or skill. Only internal problems connected to formative life experiences would disrupt the capacity of the therapist to understand and resonate with a patient and his fellow group members. In brief, disruptions, disjunctions, and communication problems are the result of countertransferential responses in the therapist that are not yet understood. When supervisory group members are asked to join in an experiential search for clarity, one is going to have an impact on the supervisees worked with. When the group runs successfully, group members
most often state that they feel moved and affected by the process. “Intense” is a word often used by participants to describe the process as well as “creative,” “different,” “freeing,” and “powerful.”

Ideal running time for such a group is about 1½ to 2 hours, depending on how often the group meets and the number of people in it. It can be structured as a one-time event, such as a consultation procedure, workshop, or institute at a conference, or as a central component in an ongoing supervisory group. When used in an ongoing supervisory group, it is probably important to also incorporate other more traditional models of supervisory work in order to provide an optimal supervisory experience. If the group meets regularly, the time can be reduced to an hour or an hour and 15 minutes, as the contract is understood, and the members are well acquainted with each other. It is important for the leader to make a contract with attendees, outlining what will take place, what is being asked of them, how the procedure will run, the crucial importance of confidentiality, and so on. The use of primary-process material, and the need for the leader to contain so much, makes it imperative that the group members have a frame for proceeding. As the method was developing, criticisms leveled against the procedure or leader included members feeling they were not well-enough prepared for what was to occur, it being a departure from their accustomed method of being supervised. These criticisms cut across differing levels of experience and also seemed related to personality variables of certain group members. The optimal number of members can vary considerably, from 4 to 20 or so, with the most comfortable number being between 12 and 15. If the group meets regularly rather than as participants in a one-time consultative experience, the number should probably be smaller, ranging from six to eight, so that members can have more frequent opportunities to present their work.

CONCEPTUALIZING THE MODEL IN SELF PSYCHOLOGICAL TERMS

Although the model employs object relations concepts to organize and explain phenomena focused on in this article, it is possible to conceptualize some of the methodology and results in other terms. For example, self psychologists stress maintenance of self-cohesion as a key theoretical concept and as a central goal in therapist/patient interactions. Just as in a therapy group, a supervisory group leader must be alert to vulnerabili-
ties and self-consolidations in group members. The method employed in our experiential model allows for a presenter’s vulnerabilities to be shared by group supervisory members, producing, one hopes, a nurturing holding environment, and enabling a high degree of self-cohesion in presenters, as well as other members. Members acknowledging their own internal states and identifying with the presenter’s feelings enable the presenter to feel heard and understood. This produces more self-cohesion and less defensiveness, enabling him or her to move to a more empathic listening position vis-à-vis a patient or group, a primary goal in self psychological work (Fosshage, 1996).

THEORETICAL OBJECTIONS

As noted previously, a basic working assumption of the methodology of this experiential model is that all responses that group supervisory members have to the clinical material presented is related to that case material. This working assumption is the most questioned aspect of the model. Could not a member’s response be a product of his or her own subjectivity rather than a response induced by the case material? Could not such responses merely represent a member’s own internal state, need, wish, or conflict unrelated to the task at hand? The model does not actively deny this possibility. A group member’s response may be highly idiosyncratic and even represent an attempt to veer the group away from its intended goal. What the model proposes is a layered or multidimensional view, in which responses are regarded as having an intrapsychic, sometimes interpersonal, but most definitely a group-determined component (Agazarian & Peters, 1981), and the model relies on all of these dimensions for whatever strength and power it has. People’s histories and psychic makeups are uniquely different and it is from this base that the individual will make his contribution to the group process and be affected by the material of the other within a group matrix.

In a sense, then, one can view the entire amalgam of group responses as variably group determined, in which, one hopes, those responses that are not related to the clinical material drop away, become neutralized, or if strong, and begin steering the group off course, be contained and limited by the leader’s skill and sensitivity.

Finally, Sullivan’s (1953) oft-quoted dictum, “We are all simply more human than otherwise” seems relevant to the issue under discussion, as it reminds us of our commonalities, the many existential issues all people
experience that allow one to understand in others the many joyful and painful experiences with which life regularly confronts us. This deep existential base becomes the crucible for the “ring of fire,” the resonance among group-supervisory members that encircles the presenter’s dilemma.

**CONCLUSION**

In conclusion, it is important to state that the method of experiential supervision described herein has been an evolving one. It began with supervision of individual treatment in an attempt to control as many variables as possible. The emphasis was placed on using the power and breadth of the group process itself as the key to understanding case dynamics. The more usually cited benefits of working in group were already in place, such as collegial benefits of hearing other therapists’ cases, sharing in their struggles, obtaining support from others, the idea that five or six minds are better than just one, and so on. What was missing was the kind of learning that experiential group process can provide. Once the method seemed workable and productive, it was an obvious move to include the supervision of group within its purview. The method is still evolving. It is the author’s hope that others will use the methodology, extend its limits, and open up its possibilities to areas not yet considered.

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