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Knowledge in Psychotherapy Supervision: Derived from a Therapeutic Experience and about a Therapeutic Experience

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Abstract. This presentation describes two, often contradictory, types of knowledge of the therapeutic experience which influence the analytic supervision. One type is the primary, vague and intuitive knowledge about patients and therapist-patient interaction, derived from actual participation in the therapeutic relationship. The other type is knowledge derived from deductions, experience acquired outside of the specific therapy and dialogue with others. The presentation examines ways to manage negotiation between the different types of knowledge, which might each be represented by the supervisor and supervisee, or which might both be present within the supervisee's mind.

Keywords: Psychotherapy, Supervision, Knowledge, Negotiation.

1. Introduction

Many supervisors believe that their main task is to understand their supervisees' therapeutic experiences, impressions, feelings and reactions and to organize them all into general meaning structures, to advance the therapeutic process and the supervisees' development as analytic therapists. In supervision, the supervisees' therapeutic experiences are organized through their conceptualization, while making use of the supervisors' clinical experience and their rhetorical ability to tell a coherent, flowing therapeutic story.

The object of this presentation is to emphasize that supervisees have a unique type of knowledge. This knowledge is no less important than the clinical-analytic "facts" and theories, previously acquired clinical experience and raw material based on impressions that are not spelled out, which serve only as background data for constructing perceptions, attitudes and directions regarding the therapeutic process. I posit that supervisees have essentially different knowledge: unique knowledge about the patient and the therapeutic process, which has its own value and is no less significant than the supervisors' knowledge. Although not always clear or systematically organized, this knowledge has constant influence on their therapeutic actions.

2. Body

This essential knowledge usually remains concealed, even though it is what actually influences the supervisee-therapists' attitudes and actions, from minute to minute in the therapy. It is not necessarily related to a priori knowledge, but is created when the supervisee-therapist and the patient enter into a discussion that is as honest and meaningful as possible. It includes "procedural" information registered nonverbally in their consciousness, and is related both to learning "how to do something" and "how to be with someone else" [1]-[4].

It is this knowledge, referred to in this presentation as knowledge derived from the therapeutic experience, which guides the supervisee-therapists, both overtly and covertly, in their minute-by-minute responses as the therapy develops, in adopting therapeutic positions and deciding how to interpret and resolve clinical dilemmas. Supervisee-therapists' unique knowledge about their patients and the interactions with them is derived from their active presence in the therapy; from participating in the actual therapeutic

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experience and from being active witnesses and partners to meaningful intersubjective events in the therapeutic space and from registering these events in mind. This unique and not-spelled-out knowledge is generally ignored by supervisors, even though it is now more accepted than ever before that therapist–patient communication includes a large nonverbal element [5], [6].

In contrast, the knowledge brought by supervisors to the dialogue with supervisees, referred to in this article as knowledge about the therapeutic experience, is not derived from their direct participation in the therapeutic relationships. This knowledge is created from reading and listening, from dialogue with colleagues and from deductions regarding the therapeutic narrative that the supervisees bring to supervision. The supervisors organize this knowledge in a complex system of acquired concepts. They link this knowledge to their clinical experience and hold it in their minds both semantically and systematically, while remaining faithful to their clinical psychoanalytic positions and values.

Our acceptance of the belief in the supervisees' unique knowledge being no less meaningful than the supervisors' knowledge about the therapeutic process, and being more than a mere impression on which to base the concrete knowledge, has implications for the supervision and for how it is conducted. If this is so, we can outline one of the primary roles of supervision as extracting this indistinct knowledge from the supervisees, organizing it and spelling it out more clearly as meaningful knowledge, even in the absence of a clear source and of unequivocal evidence about its content. The other role of supervision, according to this article, is to create safe and facilitating conditions in which supervisor and supervisee can negotiate between their different types of knowledge regarding the nature of the therapeutic experiences and the intersubjective space created in the therapy. At times, the negotiation will take place not between supervisors and supervisees, but in the supervisees' minds, within different parts of the self.

Negotiating between these two types of knowledge can lead either to a rejection of one or both of them or to their complementary enrichment. This process, when sensitively managed and accompanied by the supervisor, will deal with the different explanations and meanings derived from each type of knowledge. However, it is important to note that if the supervisee-therapists' knowledge about the patient and the therapy, which is derived from the therapeutic experience, is perceived as no less important than the supervisor's knowledge, the authority structure and the perception of the power relations between them will change. This article examines and compares the supervisor's and supervisee's unique types of knowledge that they each bring to the supervision setting and through which they each establish their own position that has an impact on their relationship. A realistic examination of the encounter between these two types of knowledge in supervision may contribute to the understanding of supervision processes and to the supervisees' development as analytic therapists.

3. Conclusion

Accepting this division into two types of therapeutic knowledge can help to explain some of the difficulties that arise in supervision between supervisors and supervisees. Furthermore, the discrepancy between the two types can explain some of the difficulties facing therapists when they attempt to organize the therapeutic material in their minds, when deliberating an informed therapeutic action. Dissonance or contradiction between the two types of knowledge can sometimes cause supervisee-therapists to discard one of them, if unaware of the division. In the present article, I suggest that increasing the awareness of both types of knowledge will enrich clinical experience and enhance the value of the therapist's actions and reactions.

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