Supervision Of The Treatment Of Borderline Patients

Sandra Buechler, Ph.D. ①

ACCORDING TO MARTIN BUBER, Education worthy of the name is essentially education of character. For the genuine educator does not merely consider individual functions of his pupil, as one intending to teach him only to know or be capable of certain definite things; but his concern is always the person as a whole, both in the actuality in which he lives before you now and in his possibilities, what he can become. (1965, p. 104)

Using this broad definition, we would have no problem considering analytic supervision a particular example of the educative process. Ruth Lesser's (1984) question of whether the goal of supervision is primarily educative or therapeutic seems to evaporate. Both teaching and treating have as their aim the education of character.

But when we ask how we should educate character in analytic supervision, we are again thrust into the dilemma of how far to go in considering supervision akin to treatment. Is the essential task in supervision the resolution of those conflicts in the supervisee that might countertransferentially interfere in the therapeutic enterprise? Or is supervision the teaching of a method of doing treatment, leaving the resolution of the supervisee's conflicts to his or her own analysis? Is the supervisor something of a cotherapist? Roy Schafer suggests this: "there is only so much you can supervise if you don't have a reasonably orderly analysis developing. And that sometimes takes fairly active participation by the supervisor to see that that happens" (1984, p. 230). Is it the responsibility of the supervisor to get the treatment on the right track, or is this, in John Fiscalini's (1985) phrase, "analysis by ventriloquism," in which the supervisor attempts to treat the patient, using the supervisee as a kind of conduit?

Regardless of how we define the supervisor's responsibilities, if we assume that supervision is basically an educative process, with character change as its goal, what sort of character change is involved? It seems likely that, to some degree, this will depend on the type of pathology presented by the patient.

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If analytic supervision is considered to be any form of educative process, then the nature of the subject matter, that is, the kind of treatment being supervised, should play a significant role in shaping the supervisory relationship. It may be supposed that the subject matter always plays such a role in education. For both student and teacher, mathematics engages a different aspect of the mind, and a different emotional response, from abnormal psychology, for example. Perhaps individual factors other than the subject matter are more important in shaping the teaching relationship. The mathematics or abnormal psychology teacher may foster an authoritarian, collaborative, distant, or respectful relationship, to name a few possibilities. But each field of study probably taps into a particular combination of intellect and emotion, reason and passion, logic and curiosity. The mathematics professor is using mathematics-relevant parts of who he is as a person to connect to mathematics-relevant parts of who his student is as a person. Following Buber, one might suggest that the teacher of each subject matter uses a particular element of his own character to influence a parallel element of the student's character.

Applying these ideas to analytic supervision, it would follow that supervision of the treatment of a neurotic, analytically adept patient should call out, in the supervisee and supervisor, a different combination of intellect and emotion from supervision of the work with a more disturbed patient. This statement, of course, runs counter to an extreme classical position that analysis, as an unvarying method, can be applied unaltered to any analytic patient by any well-trained analyst. Bromberg (1982) cogently argues that analysis differs from activities whose rules can be taught and applied in this manner.

As with any other educative process, it may be that the patient being discussed in supervision, that is, the subject matter, is less important in shaping the supervisory relationship than other factors, but it is still influential. As the literature on "parallel process" in supervision attests, conflicts encountered in the treatment are frequently repeated in the supervision (Caligor, 1981).

Having in mind the relatively predictable pitfalls in the treatment of a borderline patient, what aspects of character is
the supervision of this work likely to evoke in both participants? The patient is often someone who harshly blames his analyst for past and present perceived empathic failures. Boundary and identity problems complicate all interpersonal connections. The patient is, in a way, too concrete and literal about his experience, insistent upon actions as expressions of caring, rather than words. He lives in a black-and-white world, unable to allow for ambiguity or ambivalence. He is unable to deal with separation, impossible to soothe or self-soothe when distressed. Thoughts, memories, ideas do not allay disappointments, injuries, or anxieties. In treatment, he often resists the isolation of the couch and inspects interpretations for their comfort value, rather than for their meaning. He is likely to act out frustrations in self-destructive and treatment-destructive behavior.

With such material, it seems likely that both supervisee and supervisor might feel especially drawn toward attempting to control what is only partly under their influence. The supervisee may feel compelled to modify the patient's acting out, destruction of the frame of treatment, and imperviousness to interpretations. The supervisee may feel especially vulnerable presenting this material in supervision, since it seems to advertise his weak points as an analyst. The supervisor, in the interest of getting an analysis going, might pressure the supervisee to create a treatment milieu in which interpretation is valued for its meaning, frustration and separation are tolerated in the interest of the process, and issues are examined rather than acted out.

Thus, in the therapeutic enterprise, the supervisee is attempting to control the uncontrollable, as is the supervisor in the supervisory situation. What is likely to result? Leslie Farber has studied what happens when we try to control, through exertions of will, that which cannot be subjugated. In The Ways of the Will (1966) he explains: My answer, then, to the question, what is the nature of the experience of the man who seeks to purchase with his will some semblance of those qualities of being that cannot or should not be willed, is that eventually it is will itself that increasingly becomes his experience, until the private voice of subjectivity and the public occasions from life that might raise this voice are almost stifled, if not silenced. To put the matter somewhat differently, what is in his experience gives way to what should be, as decreed by his will. (p. 25)

The supervisee often tries to make the borderline patient behave more like a neurotic, and the supervisor often tries to make the supervisee act more like the analyst of a neurotic. In each, the aspect of character that is likely to succumb to the temptation of trying to control what cannot be willed is increasingly engaged, as the patient continues to behave like a borderline patient. It seems likely that when the patient is borderline, whatever inclinations the supervisor and supervisee may have in the direction of obsessive-compulsive defenses are often increasingly in play. Defining these defenses, Fenichel (1945, p. 296) suggests that, "By a mere verbal statement, the compulsion neurotic, unconsciously, believes that he can coerce reality into pursuing the course he desires." Salzman (1968, p. 16) succinctly sums up obsessional tendencies by stating that, "The primary dynamism in all instances will be manifested as an attempt to gain control over oneself and one's environment in order to avoid or overcome distressful feelings of helplessness." What this suggests is that the supervision of the treatment of borderline patients is, in large part, an education in the handling of obsessional pulls toward attempting to control that which cannot be willed.

The supervisor must model the ability to withstand these obsessional pulls, in order to enable the supervisee to attain an effective therapeutic stance in the treatment. In other words, how the supervisor handles his wish to exert willful control will teach the supervisee how to deal with his own obsessional pulls in the treatment hour.

Typically, the supervisee feels incompatible pressures from the supervisor and the borderline patient. In the treatment, he feels he is not helping the patient feel better. Analysis is not improving the quality of the patient's life experience. The patient's troubles are urgent, and require immediate relief. What the treatment provides is too slow, abstract, intellectualized, removed from the patient's day-to-day crises to be of any help. With the supervisor, however, the supervisee feels equally inadequate, but for an entirely contradictory set of reasons. He feels he has been too concerned with the patient's life, and not sufficiently focused on the patient's analysis. He is too easily drawn into the patient's mood of urgency, too vulnerable to the patient's attempts to make him feel responsible for the quality of the patient's life. He has let himself be bullied, perhaps even blackmailed by the patient's implicit threat to leave the
treatment if the supervisee isn't more forthcoming with personally revealing, openly caring, concretely advising behavior. He is ashamed, with his supervisor, that he has not adequately analyzed the transference and resistance, that he has been unable to maintain a neutral analytic stance, that his anxious, frustrated, conflict-ridden countertransference is interfering in the development of an analytic atmosphere in the treatment. In short, with the patient, the supervisee feels he doesn't do enough to help, while with the supervisor he feels he isn't doing enough to analyze.

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This situation seems to be optimal for recruiting the supervisee's obsessive needs to exert an unrealistic degree of control. He is likely to feel that if only he could make the patient see that a "real" analysis would, in the long run, help the most, everything would be fine! If only the patient could be convinced to focus on the transference, to be interested in observing the interpersonal process in the treatment, instead of constantly complaining about events outside the treatment situation. If only the patient would see that interpretations can help, that they are not merely the supervisee's attempt to dodge a real encounter! If only the supervisee could get himself to be less anxious, in the supervision and in the treatment. If only the patient didn't throw him off balance so much! If only he could maintain a more disinterested, professional demeanor, instead of getting caught up in power struggles, irrelevant arguments, petty, humiliating interchanges with the patient. If only he could get the treatment on the right track!

The supervisor is likely to feel some similar frustrations. Why can't this bright, sensitive supervisee get the treatment going? If only this were analysis, instead of supervision, the supervisee's need to satisfy the patient's wishes could be more directly analyzed and controlled. If only the supervisee would sufficiently address his compliance issues, his needs to please, his fears about confrontation, his inability to be tough enough in his personal analysis. Then, the supervisee might be able to get his patient's treatment on the right track.

Depending on their characters, it seems likely that both supervisor and supervisee can easily become obsessationally controlling in this situation. The supervisor may attempt to make the supervisee take a more neutral, analytic stance. The supervisee may attempt to make the patient accept transference and resistance interpretations. Angry, exasperated efforts at control may be masked, in both arenas, with obsessationally indirect, overly wordy, unclear, manipulative interventions.

It seems that the supervisory task, in this situation, is to feel the pull toward controlling the supervisee without acting on it. This would make it possible to elevate the supervision to a higher level of abstraction than the treatment. As Levenson (1982) suggested in his article, "Follow the Fox, " supervision derives greater clarity than treatment from its level of abstraction. In supervision, the supervisor can address himself to the class of patients to which this particular patient belongs. The supervisor is able to conceptualize what is going on in the treatment more clearly than can the supervisee, who is caught up in its particular pulls. Thus, in

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the treatment situation, the analyst can hardly take an abstract position, since specific responses to a particular patient are called for, while supervision elicits a more abstract perspective.

The supervisor can be of most help if he or she can name, rather than act on, the impulse to make the supervisee behave as though he is treating a neurotic. If the supervisor is open to self-observation, is in touch with the need to "get the treatment on the right track" and, perhaps, with his own obsessional needs for a sense of mastery, he can use these inner experiences to clarify what is likely to be going on for the supervisee. He can then model a self-observing interpersonal stance, by exploring with the supervisee the pulls they may both be feeling to control aspects of the situation.

In conclusion, to return to Buber's comments on the educative process, analytic supervision can be considered a form of character education. Especially when the patient is borderline, I believe that this educational process concerns itself mainly with the obsessional elements in the characters of the supervisor and supervisee. The wish to control, through acts of will, what cannot be controlled, recruits obsessive defenses. A resulting sense of failure and disappointment can be predicted for all the participants. The supervision must model a different sort of response to obsessional pressures. By observing, accepting, and naming, rather than acting on, these pulls, the supervisor educates the character of the supervisee. This method, since it does not subject the supervisee to the supervisor's obsessional needs, will allow use of the supervisor as a model of self-observing participation. Paraphrasing Buber's words, the
supervisor has gone beyond an attempt to teach the supervisee some definite things, such as the proper analytic stance. The supervisor's concern has become the supervisee as a whole person, whose healthy characterological development will enhance his professional and personal life.

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