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The vision in supervision: Transference-countertransference dynamics and disclosure in the supervision relationship

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The centrality of the supervision experience in the development of the supervisee's personal and professional capacities is addressed. The supervision relationship and process are explored in light of the potential effects of transference-countertransference configurations of supervisor and supervisee. Parallels between supervision and treatment are highlighted. The importance of developing and utilizing the capacity for reflectivity is reviewed, as is the impact of supervisee nondisclosure to supervisor. The direct use of countertransference experiences in the context of supervision is explored, and the centrality of self-disclosure is highlighted. It is recommended that supervisor and supervisee remain receptive to exploring these experiences in the service of developing a shared subjective sense of the patient, of increasing the supervisee's capacity to treat his or her patient, and of providing the supervisee with a novel, growth-enhancing relationship. (Bulletin of the Menninger Clinic, 61[4], 481–494)

In the tradition of psychoanalysis, the vital supervision experience is second only to treatment itself in developing the knowledge, skills, intuition, and self-organization of the professional clinician. The *natural application** of

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*By *natural*, I mean the quality of those relations and interactions with the patient that are not artificial or manufactured, but that emerge from within the therapist as a logical result of his or her essential being-as-therapist, in contrast to acting-as-therapist.

psychoanalytic art and science seeks to meliorate psychopathology and to develop and enhance one's personal freedom, meaning, and authenticity. The potential for realizing this natural application originates, in order of importance, from one's own treatment experience,* one's supervision experience, and one's academic experience. I wish to focus on the second of the three domains, examining more closely those processes inherent in the supervision setting that can further enhance the clinician's effectiveness with patients.

Parallels have often been drawn between the therapeutic relationship and the supervision relationship (Searles, 1965), even though tradition has maintained the need for their diversity in character and separateness in application.† In some instances, one is antithetical to the other. In others, distinctions between the two evaporate.‡ Examining the similarities and parallels of the two types of relationships can deepen the supervisor-supervisee relationship, as well as expand the supervisor's and supervisee's subjective sense of the patient.

In that vein, the value of the supervision relationship resides not just in the enhancement of the supervisee's clinical effectiveness, but also in its potential for providing a developmental or "new object experience" (Shane & Shane, 1989) for the supervisee, vis-à-vis his or her professional identity, self-experience, and self-organization. Shane and Shane (1989) address this developmental dimension in the context of the analytic relationship, stating that "it is always a case of the messenger being assimilated along with the message" (p. 335). Alternatively stated, "the here-and-now unique analytic relationship *in itself* has developmental power, stimulating development via the patient's experience of the analyst" (p. 334). This dimension of experience is present, optimally, in the context of the supervision relationship as well.

The supervision relationship

The essential dynamics and experiences in the supervision relationship often determine the character and direction of the therapy of the patient

*I would like to include in this category those general life experiences, not necessarily associated with treatment, that have been instrumental as well in the development of the personal self and the professional self.

†See Lewin and Ross (1960) regarding "syncretic dilemma."

‡I am not espousing a merger of the two types of relationships, in contrast to the "Hungarian system" associated with Kovacs (1936), in which it was recommended that one's analyst also function as one's supervisor. Rather, I wish to highlight their similarities from an experiential and dynamic viewpoint. At a given moment, the ambiance of the supervision relationship could assume the *experience* of psychotherapy when, for example, a supervisee is exploring and illuminating his or her countertransference configuration in relation to the patient under discussion.

under consideration. The supervisor and supervisee continually grope and explore the proverbial elephant, and considerations of who has hold of the more accurately representative part are often controversial and debatable, if not political. The more pluralistic, contemporary supervisor may tend to assume a higher degree of sophistication and vision in his or her supervisee, as a function of his or her *experience*, and may convey a greater sense of parity by eliminating notions of final authority and arbiters of the "truth" (i.e., two-person model). Conversely, the more singular, classical supervisor may tend to feel that the "truth" about the patient is primarily fixed, static, and discoverable (archeological model) and that in light of his or her respectable and advanced level of training, education, and experience, he or she (the supervisor) is ultimately the determiner of the shape of the elephant.*

I would like to posit three fundamental tenets of the supervision experience: (1) that the primary—though not sole—subject matter of the relationship is the "unfolding, illumination, and transformation" of a third party's (the patient's) subjective world (Stolorow, Brandchaft, & Atwood, 1987, p. 9) and the way in which the therapist may be instrumental in promoting that process; (2) that the relational phenomena between the supervisor and the supervisee that arise out of continued contact and discussion—including the convictions about the patient that are mutually developed, shared, and maintained—are determined by the natural and complex transference-countertransference configurations and interplay among the three participants; and (3) that the exploration and examination of the nature of these relational phenomena comprise what is potentially most valuable to the supervisee's—and the patient's—development and progress. It is the second and third dimensions especially that I wish to explore.

Intersubjectivity theory

In examining and conceptualizing the supervision relationship and process, the utilization of an intersubjective framework is particularly conducive to understanding more clearly the vital, transformative characteristics inherent in this setting. This specific application of intersubjectivity theory has not been widely discussed. Fosshage's (1996) revealing paper regarding self psychological and intersubjective perspectives on supervision provides a notable exception. Fosshage clearly delineates the potential "listening perspectives" of the supervisor and

*The foregoing characterizations are of course generalizations based upon stereotypes and are used only to help define a spectrum of possible perspectives.

highlights the theoretical and clinical utility of listening from "within" the perspective of the subject—that is, the centrality of adopting an "empathic mode of perception" when attempting to illuminate the perspectives of patient and supervisee. This experience-near approach contrasts significantly with the more traditional orientations toward supervision and emphasizes how transference-countertransference configurations and experiences of the three participants are codetermined by all three intersecting subjectivities, not just primarily the patient's transference dynamics.

Another informative exception is found in Ricci's (1995) treatment of the supervision process through the use of an "empathic, affect-attuned, intersubjective model" (p. 60). He addresses the concept of parallel process viewed through the lens of affects, motivation, and intersubjective phenomena. He also underscores the centrality of tracking continually the self-state of the supervisee and of being mindful of his or her current particular foreground motivational system. The promotion and maintenance of self-cohesiveness in the supervisee, as with the patient, afford the supervisee experiences characterized by exploratoration and openness in contrast to aversion and withdrawal in which the danger exists of "the [supervision] process, thus vitiated, becom[ing] an 'as if' learning situation" (Ricci, 1995, p. 64).

In general, intersubjectivity theory, as addressed by these authors, helps structure the use of an experience-near perspective and a two-person (or, in this case, a three-person) model to understand and enhance the supervision process. Stolorow (1995) states that "the trajectory of self-experience is shaped at every point in development by the intersubjective system in which it crystallizes" (p. 394). Continually focusing on the nature of each participant's contributions to the tripartite system and the corresponding self-experiences of all three participants encourages a deeper illumination of those factors that are responsible for the development of the patient and, ideally, of the supervisee as well.

Capacity for reflection

Research in psychology and psychoanalysis underscores the salience and need for reflectivity in both the supervisor and supervisee (Neufeldt, Karno, & Nelson, 1996). Here reflectivity refers to an "internal process of attention and thought" (p. 3). This term, for me, also implies a process of internal dialogue in which varied configurations of self-experience (e.g., affect states, thoughts, imagery, and so on) are creatively played with and tested out for the purpose of discovery and of making sense. One of the functions of the supervision relationship is to help facilitate this process. Neufeldt et al. (1966) address this from a more

behavioral perspective: "Instead of immediately telling a supervisee what to do next, for instance, [the supervisor] can model a reflective stance and encourage trainees' own openness, active inquiry, and vulnerability" (p. 9). This process clearly involves a willingness to encourage exploration and a susceptibility toward meaningful interpersonal exchanges. This contrasts with the familiar syllogistic, lockstep approach to clinical "problem-solving." It invites creativity, novelty, reorganization, and of course, learning.

Searles (1955) focuses on the centrality of the reflection process in the supervision relationship and emphasizes that the supervisor's wide range of emotional experiences vis-à-vis the supervisee may often reflect countertransference reactions that help illuminate the patient-analyst relationship. Hora (1957) elaborates upon this phenomenon: "The supervisee unconsciously identifies with the patient and involuntarily behaves in such a manner as to elicit in the supervisor those very emotions which he himself experienced while working with the patient but was unable to convey verbally" (quoted in Grinberg, 1970, p. 380). While useful regarding potential phenomena in the supervision relationship, this "parallelism" perspective tends to rely upon a one-person model in which the patient and his or her transference comprise the primary contributions to the dynamics at hand (Fosshage, 1996). According to Fosshage, this perspective alone eliminates other vital, intersubjective dimensions to the supervision relationship, namely, the contributions of the supervisor and supervisee as well.

Mollon (1989) feels strongly about the capacity for reflection in the supervision setting and speaks about it as a *state of mind* "which is receptive and reflective, one which is open to impressions, perhaps somewhat akin to dreaming" (p. 120). He posits that the supervisor's task is correlated with Bion's (1977) description of how the "mother's reverie, her capacity to be emotionally receptive and thoughtful, which he terms 'alpha function,' may transform the raw elements of her infant's experience into material which has meaning, which can be thought about, dreamt about and communicated to others" (p. 120). Mollon also states that the "supervisor's task is to help create a *space for thinking*, a space for reflection with a toleration for not knowing and not understanding.... Ultimately the space for thinking must be internalized to form the capacity for internal supervision" (p. 120). One of the central aims of supervision is to foster this type of cognitive-affective experience in the supervisee.

An additional, although particularly crucial, consideration regarding the reflection process resides in the supervisee's experience immediately prior to embarking upon the supervision relationship: That is, it is instructive for the supervisee to reflect upon his or her cognitive-affec-

tive predisposition or subjectivity in approaching the supervisor and the supervision relationship in general. Unlike many patients at the outset of treatment, the supervisee, who is perhaps a patient as well, may be better situated and more inclined to reflect on this question. Due to previous experience and training, the supervisee may consider more readily questions such as, "What transference propensities do I sense as I embark upon this new relationship?" Reflection in this domain can help clarify one's needs, expectations, and fears in relation to the supervision relationship; it can help clarify how one might organize external stimuli and consequently how one's subjectivity will contribute to the supervision experience. This in turn helps develop an understanding of the way in which the supervision experience will influence the nature of the patient's therapy.

What follows is a more specific view of the potential for reflection in this area: A male therapist initiates supervision with a highly experienced and accomplished female clinician. The therapist asks himself: How do I feel about this person? How do I experience her? Do I trust her? Do I feel safe with her? How authentic and self-disclosing can I be with her? How comfortable do I feel with disagreeing with her? Is there an arbiter of truth here? If so, who is it? And if so, do I want there to be one? What is the outcome if, after extensive reflection, I continue to conflict with her perspective about my patient? What role do the exploration, examination, and discussion of countertransference play in this professional relationship? What is her perspective on countertransference, theoretically and practically? Where is the dividing line between supervision and treatment? The answers to this inquiry—and there are a multitude of additional questions to consider—will determine how this therapist ultimately will interact with his supervisor, and equally important, *in what manner he will present and explore his case.*

Presenting a case

The specific manner in which the therapist will present his case material is multidetermined; its origins are complex. First, consider the impact of the therapist's own transference propensities, his current treatment experience, the affective and interpersonal pressures placed upon him by his patient, the interpersonal impact of his supervisor, and in general his relative sense of safety in the professional setting. Then consider the impact of these variables upon the supervisor in conjunction with her (the supervisor's) own transference organization. Essentially, a complex network and interplay of transference-countertransference dynamics and resulting experiences will coalesce through the convergence of three (not two) unique psyches. This *convergence* has been addressed in

different, captivating ways, but usually so in the context of the more traditional *parallelism phenomenon* alluded to earlier. Gediman and Wolkenfeld (1980) highlight the notion that

> *therapists manifest major psychic events in supervision, including complex behavior patterns, affects, and conflicts which parallel processes that are prominent in their interactions with their patients in the treatment situation.... A supervisor often discovers these parallelisms when certain of his emotional reactions lead him to realize that his supervisee is engaged unconsciously with him in a "tension system" which is similar to that occurring in the therapy situation. (pp. 234–236)*

In addition, Ekstein and Wallerstein (1958) note that what the therapist reports in supervision about the patient's sessions may often parallel difficulties the therapist is experiencing in supervision.

Doehrman (1976) underscores the tendency of therapists to behave with their patients in concordance with or in opposition to their supervisor's behavior with them. She sees this as an enactment of or reaction against their supervisor's essential transference configurations. This is an aspect of the parallelism phenomenon, according to Gediman and Wolkenfeld (1980), and emphasizes even more the need for continual "recognition of the complex interactions among patient, analyst, and supervisor, which bond them in a systemic network" (p. 241). In addition, Dombeck and Brody (1995) discuss the "principle of system parallel reflection [in which] the emotional process in the relationships of the client-family, the client-therapist, and the therapist-supervisor systems mirror each other" (p. 3). They state that "changes in the emotional process in each system are reflected in the other two" (p. 3).

It seems to me that during the course of an intensive, ongoing supervision regarding one particular patient, the participants will benefit from reflecting upon how their subjective and constructed convictions about the patient have developed and continue to evolve. After all, I can imagine a multitude of ways in which to present a single patient to a supervisor, much of which is dependent upon many of the factors outlined earlier, including my affect coloration, my general health and energy level, my specific countertransference predisposition (in relation to my patient, as well as my supervisor), the presence of any still unrecognized unconscious communications from my patient, and so forth. In that regard, Gediman and Wolkenfeld (1980) note that "as supervising psychoanalysts we recognize that the therapist's report [of his or her patient] has been edited unconsciously and that through empathic identification the therapist

has absorbed more than he can readily verbalize" (p. 251). One perspective about and presentation of the patient may not be any more "correct" or "accurate" than another, but one may potentially be more temporally salient and relevant than another. Reflecting upon how I "choose" (usually an unconscious decision) to present my case might reveal valuable and helpful information.

Willingness to disclose

First and foremost, the potential value and utility of examining the foregoing supervision concerns hinge upon the relative willingness of both supervisor and supervisee to address these processes openly. This naturally could include a mutual, reciprocal, verbal exploration of both parties' countertransference experiences in relation to the patient at hand. What primarily differentiates this potentially "treatmentlike" process from a treatment context is the continued and persistent focus upon the intended subject matter of supervision outlined above.* A facet of this exploration should extend to the supervisor's ongoing invitation to the supervisee to reflect upon how the supervision experience is impacting the supervisee from a cognitive, affective, theoretical, and/or practical standpoint. This facet, if left unattended, can alter the manner in which the supervisee presents his or her clinical material and potentially complicate, and perhaps obscure rather than illuminate, the vision of the elephant.

One area of informative research centers around the phenomenon of supervisee nondisclosure to the supervisor and the salience of what is not disclosed. Ladany, Hill, Corbett, and Nutt (1996) note that

> *an implicit assumption in most psychotherapy supervision models is that for the supervisor to facilitate the development of therapeutic competence in the supervisee, the supervisee must disclose descriptive information about the client, the therapeutic interaction,* the supervisory interaction *[emphasis added], and personal information about himself or herself .... Nondisclosure would presumably interfere with the supervision process and thus inhibit trainee learning.... "[I]t seems plausible to suspect that much of what is not disclosed in supervision may be as salient as, if not more salient than, what is disclosed. (p. 10)*

*Fosshage (1995) poignantly addresses the concern about supervision becoming treatment. He states, "The 'teach or treat' dichotomy is no longer a meaningful distinction, for 'treating' corresponds with illuminating the analyst's experience, a necessary process for 'teaching'" (p. 202).

The results of Ladany et al.'s (1996) study reflect that 97.2% of supervisees do withhold information from their supervisors. The content of the nondisclosures centered around "negative reactions to the supervisor, personal issues not directly related to supervision, clinical mistakes, evaluation concerns, general client observations," as well as issues revolving around countertransference (p. 17). Grinberg (1970) shares that a supervisee's anxiety can occasionally be intense enough that he or she will lie about the clinical material, which the supervisee "reconstructs to accord with his fantasy of what the supervisor prefers" (p. 377). It seems reasonable to consider that one significant source of supervisee nondisclosure revolves around an experienced lack of safety and potential for shame, devaluation, and perhaps political suicide.

Nondisclosure in this arena suggests the potential for there being at least *two* treatments with *two* patients, figuratively speaking: One that is conducted in the supervisee's office with his or her patient and another that is idiosyncratically constructed and discussed in the supervisor's office. As Fosshage (1995) recommends, providing the supervisee with a nonconfrontational, relatively safe environment in which he or she may illuminate his or her experience of self and other helps facilitate a better integration of the various facets of the elephant, or the "two treatments" for that matter, into a more cohesive, intelligible whole.

In that vein, Ladany et al. (1996) rightly recommend that supervisors "inquire about supervisee reactions and strive toward relationships that have didactic, supportive, and collaborative components ... if supervisors are going to improve the therapy provided by their supervisees, they may want to engage in an ongoing evaluative process of their work with their supervisees" (p. 22). This process has been referred to by Fleming and Benedek (1966) as the *learning alliance*. Gediman and Wolkenfeld (1980) define this concept as "the acceptance of a mutually shared educational goal involving expectations of giving and receiving help and initiating a bond of trust without which the work cannot proceed" (p. 249).

Nondisclosure on the part of the supervisor can be equally stifling and stagnating. Lederman (1982) contrasts the perspectives of Searles (1965) and Reich (1973) regarding the supervision experience. He notes that, from Searles's standpoint, the essence of the supervisor's armamentarium lies in "his experience and his emotions, particularly the emotions the supervisor experiences in the course of a supervisory relationship" (p. 424). Also, Black (1988) suggests that *supervisor* self-disclosure is an equally vital component in a successful supervision experience. Gitelson (1949), Ekstein and Wallerstein (1958), and Gediman and Wolkenfeld (1980) all observe the necessity of self-exposure to effect the learning process.

Clinical material

The following vignette (regarding a 30-year-old female patient with a history of depression) illustrates how the subjective vision of a patient might unfold between supervisor and supervisee and how the delineation of the transference-countertransference configurations of all the parties contributes to this development. It also illuminates the importance of self-disclosure in the supervision setting.

Following some discussion about the supervisee's impressions of and countertransference to his patient, the supervisor inquired of the supervisee how he was experiencing this recent supervision process. This inquiry was initiated by the supervisor in response to her (the supervisor's) feeling rather tight, constricted, subdued, and inhibited during the hour. These feelings were accompanied by a vague impulse and image of being angry with the supervisee and shaking him by the shoulders. She wondered whether this reflected her own affective predisposition at that moment, whether it was a communication of an idiosyncratic aspect of the supervisee, or whether it was originally a part of the patient's affective experience and simply conveyed through the medium of the supervisee's cognitive-affective presentation (or, of course, a combination thereof).

The supervisee reflected upon his supervisor's question and responded that, while the recent supervision was helpful, he did not feel that she was actually "getting" a real sense of the patient at hand and that he consequently felt "more alone" in working with this patient than on previous occasions. He conveyed that the patient had been particularly challenging and difficult recently, and he felt that he needed substantial help right now. In effect, he felt that she was being somewhat subdued, almost withholding, in contrast to other occasions. The supervisor stated that she *was* feeling unusually constricted and that this was unfamiliar to her. She then inquired further as to how the supervisee thought these experiences might relate to the patient at hand. He responded that, on reflection, his personal experience of her, right now, was strikingly similar to how he had been experiencing his patient recently and that, in fact, this was the very quality he found so irritating and burdensome about the patient.

After further contact with the patient and continued reflection and discussion in supervision over the weeks to follow, it began to emerge that the patient's feelings of isolation and aloneness, of having to manage "all the burdens and terror on my own," coupled with the patient's experience of the therapist as sometimes withdrawn and constricted, frightened her into her own defensive withdrawal and constriction. This was ultimately conveyed and responded to in the

context of supervision. The therapist further realized that he felt frightened, alone, and constricted as well in response to his own sense of helplessness with the patient. He speculated that his feelings originated from his patient's unconscious communications of her affect state and from his own transference configuration in relation to the patient. He later stated that among all of his fantasies about his patient, he often imagined shaking her and forcefully coercing her into assertiveness, openness, and independence. He had previously felt that these feelings and fantasies were of little importance, and they remained just on the periphery of his awareness until his countertransference exchanges with his supervisor. He later interpreted these experiences partly as a complementary identification (Racker, 1968), engendered through the medium of an unconscious communication, and partly as his own transference-based response to a frustrating interpersonal exchange.

Ultimately, the supervisor, in the context of the countertransference interplay between her and her supervisee, was able to experience the defensive, threatened component of both the patient and the therapist, as well as the complementary component of hostility and coercion. In addition, the supervisor was later able to disclose, after more reflection, that she herself felt somewhat withholding toward the supervisee—not unlike the way in which the supervisee had felt and sometimes behaved toward the patient. This, she concluded, was in response to her own experience of the supervisee as not behaving assertively enough and as indirectly communicating his feelings of dependency on the supervisor. The supervisor assimilated aspects of the supervisee's presentation in this manner, due in part to her own transference organization, and responded with resentment and ultimately withdrawal. This experience of withdrawal combined seamlessly with the patient's unconscious communication (via the supervisee) of a defensive affective withdrawal and search for greater safety.

Discussion

The reflection, exploration, and discussion by supervisor and supervisee significantly augmented the sense and depth of the shared, subjective vision of the patient, as well as their shared experiences of their own subjectivities. This was largely based upon their susceptibility and willingness to engage in the countertransference and experiential portion of their relationship. This, in turn, facilitated a greater willingness on the part of the supervisee to examine ongoing countertransference experiences in relation to the patient and to take a broader, empathic step into the subjective world of the patient. In effect, each individual

seemed willing in this instance to say, "Here—let me *show* you what I think this patient is like, what I am like when I have contact with this patient, and further, how my patient might experience me." This is an excellent example of what Windholz (1970) refers to in the supervision experience as the "unusual empathic processes which move from the student to the supervisor and back, leading to the anticipated changes in the patient" (p. 394).

In addition to the clinical, utilitarian value inherent in these exchanges, the supervisee was able to reap the benefits of a "new object experience" (Shane & Shane, 1989) in a professional setting. He experienced his supervisor as an affectively curious and reflective professional being, who was willing empathically to immerse herself in the process—that is, admit some degree of her embedment in the relationship—and to demonstrate working with countertransference in a practical manner. For the supervisee, this was a powerful source of identification and internalization, of supervisor containing, reflecting, and relating functions. It generally aided continued development of his capacity to enjoy a wider range of cognitive-affective experiences in a professional setting. Stolorow (1993) observes that "if an interpretation is to produce a therapeutic effect, it must provide the patient with a *new experience of being deeply understood*" (p. 47). This is similar to what ideally the supervisor conveys to the supervisee, if the supervisory "interpretations" (based on the supervisor's affective attunements and cognitive intuition regarding the supervisee and his or her patient) are to produce an identifiable and enduring set of developmental experiences.

Conclusion

Clinical research and experience point to the need for close examination and exploration of transference-countertransference configurations in the supervision relationship. The continual unfolding and illumination of the experiences of all three participants and the clarification of the supervisee's direction with his or her patient center around the willingness of supervisee and supervisor alike to address verbally these processes and events. In addition, this willingness fosters the potential for a developmental experience that may greatly contribute to the supervisee's continued self-awareness and personal growth.

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The unbearable agony of being: Interpreting tormented states of mind in the psychoanalysis of sexually traumatized patients

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This article focuses on the clinical importance of the disturbing transference-countertransference matrix in the psychoanalysis of patients whose ego development was decisively influenced by early, traumatic sexual abuse. Dissociative defensive operations and "automatic" identifications are emphasized in accounting for the sadomasochistic and other characteristic features of the "traumatic" transference-countertransference ambiance. Two clinical vignettes depict the analyst's need to take his or her own disturbing experience as an object of analytic examination, while illustrating how "here-and-now" transference cues are used to interpret the patient's efforts to cope with overwhelming, traumatized states of mind. (Bulletin of the Menninger Clinic, 61[4], 495–519)

***What an abyss** of uncertainty, whenever the mind feels itself overtaken by itself; when it, the seeker, is at the same time the dark region through which it must go seeking. (Proust, 1928/1970)*

Early childhood sexual trauma creates the "abyss of uncertainty" described by Proust, while dramatically impacting the nature of the violated child's attachments, identity formation, and developing psychic functioning (Steele, 1994). Adults who were subject to such early

My title paraphrases Milan Kundera's (1984) pithy expression. Since originally choosing this title, I have learned that Stolorow and Atwood (1992) have coined a similar phrase, referring to "the unbearable embeddedness of being."

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The vision in supervision: Transference-countertransference dynamics and disclosure in the supervision relationship

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The centrality of the supervision experience in the development of the supervisee's personal and professional capacities is addressed. The supervision relationship and process are explored in light of the potential effects of transference-countertransference configurations of supervisor and supervisee. Parallels between supervision and treatment are highlighted. The importance of developing and utilizing the capacity for reflectivity is reviewed, as is the impact of supervisee nondisclosure to supervisor. The direct use of countertransference experiences in the context of supervision is explored, and the centrality of self-disclosure is highlighted. It is recommended that supervisor and supervisee remain receptive to exploring these experiences in the service of developing a shared subjective sense of the patient, of increasing the supervisee's capacity to treat his or her patient, and of providing the supervisee with a novel, growth-enhancing relationship. (Bulletin of the Menninger Clinic, 61[4], 481–494)

In the tradition of psychoanalysis, the vital supervision experience is second only to treatment itself in developing the knowledge, skills, intuition, and self-organization of the professional clinician. The *natural application** of

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*By *natural*, I mean the quality of those relations and interactions with the patient that are not artificial or manufactured, but that emerge from within the therapist as a logical result of his or her essential being-as-therapist, in contrast to acting-as-therapist.