

Supervision Today

Throughout my clinical training, prior to my analytical formation, the meaning of this term “supervision” did not have such significance in terms of its implication and its function in the clinic. It was, rather, more or less equivalent to appointing someone who had superiority and maturity in carrying out a technique or transmitting knowledge. It was somehow literally having a “super-wiser”, with a super/mega vision of what we were doing in the clinic. One could carry out clinical work under instruction of a mentor-like professor. It is no wonder that the first few generations of psychoanalysts, who were mainly medical practitioners, had invented all sorts of supervision-related theories, in all of which the pattern of a transmittable set of theoretical and practical methods seemed to be both possible and necessary.

Studying some historical cases of psychoanalysis, it is indeed striking to find out that this approach to the question of training and supervision has not itself been questioned – or, even worse, has been copied, though we know that working in such a way has little or adverse effects in the clinic. The question of supervision and clinical training has always been a political question something that has to do with the politics of psychoanalysis. Wouldn't it be easier if Freud had had something decisive to say on the topic? He does not have any theories on this which seems to have led -to certain extent- to some confusion around the “mode of practice” with the concept of “supervision”. The first generation of psychoanalysts, such as Ferenczi and Helen Deutsch, tried to conceptualise a theory of supervision. Ferenczi's approach, for example, was to discuss a clinical case with a colleague, while Deutsch tried theorising the question of supervision and training. Her suggestion was to have a patient seen by a supervisor as well as the trainee analyst (Deutsch, 1935). The so-called “Deutsch style” was still in use when I started my analytical training under a group of psychoanalysts, and it made me question the place of the supervisor in clinical work.

Introduction

The 2016 movie *Dr Strange* is about the case of a super-arrogant neurosurgeon who loses the ability to use his hands while conducting surgery. In the search of a solution – to get him back on track – he ends up consulting a seemingly spiritualist mentor called “The Ancient One”. In the scene of their first encounter, there was not a single word which this maverick doctor said that I was not in agreement with. His belief in science as a guarantor against ignorance and superstition meant his argument with the Ancient One initially took the right approach – until he says that he can “see through” anyone, including the Ancient One. This is the moment that he is made to question his certainty and trust in given facts. Although I did not agree with a single word of the Ancient One’s dialogue in that particular scene, I approved of her approach to the “all-knowing” position which seeks to provide the single solution. Poor Dr Strange! His state of absolute shock over what had happened to him, or, perhaps, over something having surpassed his unquestionable abilities, reminded me of myself many years ago.

Now, by the start of my second analytical training, I had learned my lesson in terms of how to seek knowledge when in the clinic with patients suffering from either their symptoms, modes of being or excessive jouissance. I was also well-acquainted by now with a different style of supervision, which was far more cynical towards the idea of shedding light on a fact in order to bring out a piece of unconscious knowledge. However, Dr Strange’s moment of shock in the movie resonated with what I felt after leaving my second supervisor’s consulting room in the middle of a chilly day in late summer in London. I was truly doubting EVERYTHING! Worrying thoughts of all kinds were rushing at me, from “Am I myself mad or not?” to “Have I done something harmful to the patient?” and generating enormous anxiety in me. As I walked up a hill, I began to feel that I had perhaps wasted all those years since I began my journey towards formation. However, in the next few years, it was proved to me that I was wrong in that conclusion.

The main shift in my training cannot really be pinned down to a precise moment during my supervision or personal analysis; my position in clinical work was re-questioned and worked through again and again. This was a dramatic change in the way in which I originally perceived the concept of supervision in psychoanalysis; what was important was not the style but rather what was at stake for a supervisee to look for, in the clinic. It became hard to differentiate between an analytical session and a supervision.

History Revisited

The history of supervision in analytical training involved a means of ensuring “authenticity” within a practice which had been taking place since 1925. The IPA Congress that took place in Bad Homburg, Germany, was the starting point for establishing a set of standards for psychoanalytical training, and hence establishing the need for supervision as part of the pathway to qualification (Safouan, 1995). As a new concept, it was treated as an institution from the first; it became an integral part of training and has been so ever since.

The ITC (International Training Commission) was for 15 years chaired by Max Eitingon who had a clinic providing both therapeutic services and the training now considered as the inception of training standardisation (Moncayo, 2008). Before then, the supervision dynamic was far less formal. Two peers would share their thoughts, findings, dilemmas and wonderings about a clinical case. Regardless of how effective or restrictive this model of supervision was, it served the analysts of the time well. It also seems to be somehow closer to what we understand today, through Lacan’s teachings, of the desire of the analyst and of the place of knowledge in clinical supervision compared to many other schools of analytical or therapeutic thoughts.

Freud had started with Breuer as his mentor-teacher, before moving to Fliess as his confidante-colleague, to address something of his patients’ cases (Safouan, 1995). Until, eventually, he named one of his first patients as his great teacher. His desire for knowledge was continually

redirected; from gaining knowledge from a mentor, to gaining knowledge from a peer, then from the clinic itself. He ultimately made his bet on the subject's repressed unconscious in order to get to "a" knowledge. Furthermore, the agency of each clinical case taught him how to approach the unconscious. Obviously, as he himself did not go into analysis and did not experience the effect of supervision, he was not pushed beyond where he felt his limits to be. Before the 1920s, there was no such a thing as a systematic, institutionalised psychoanalysis. However, soon after this time, the idea of becoming a psychoanalyst became associated with being supervised often by at least two supervisors, while still placing emphasis on the analyst's "skill" within their career of psychoanalysis rather than discussing the position of the analyst in the work. It is still a common belief for analysts to think that discussing a case in their personal analysis would help them to become a more expert or mature clinician, by detecting their so-called "mistakes" or "shortcomings". In today's way of thinking about being supervised as an analyst, discussing a case in either analysis or supervision is interpreted as finding out about one's own desire in the work; the desire of the analyst, which, according to Lacan, is a desire to analyse (Lacan, 1964). It would certainly not be correcting the supervisee's technique; rather, it would enable her/his competence in analysing the unconscious knowledge of her/his analysand.

The supervisor's role is an "enabling role" in many different ways. When we listen to a patient's speech, regardless of her/his psychical structure, what is communicated during the sessions needs to be taken beyond face value beyond meaning. This involves a specific mode of listening, which is the end-point of supervision in analytical training. How this aim is to be pursued in supervision depends on the ability of the supervisor to intervene at the level of the supervisee's desire to analyse. The supervisor's technique and mode of intervention are supposed to be in accordance with the supervisee's desire. A supervisee's creativity to conduct an analytical act is nurtured in supervision.

Therefore, a supervisor within the supervision space does not occupy a teaching position and, nor are they supposed to treat the symptom in the clinical case. This leaves the responsibility of analysis entirely to the supervisee.

Such an idea was explored in detail in a 1963 paper by Daryl Debell, called: “Treat or Teach?” (Debell, 1963). The context in which this paper was written was a time in which the emphasis of training was focused on the concept of so-called “counter-transference”. The trainee analysts in supervision were invited to reflect upon their own feelings towards the patients. Needless to say, this incorrect focus in supervision reduced the analytical framework to a mind spa for the supervisee! As a result of such an approach, the work was faced with a limit in the form of unconscious resistance. At this time – and still in some approaches today – patients were targeted “objectively” rather than being treated as subjects. The supervisee was encouraged to focus only on her/his own ego and learning process, making use of the patient’s clinic to do this. In fact, they were pushed to keep the work between two egos, when all they needed to do was distinguish their own from their patients’.

The demand for detailed records of patients’ narratives in some approaches shows a strong tendency towards making the clinic of psychoanalysis an evidence-based, scientific practice. There is little questioning of the implications such recordings have, in terms of their function and effect on the direction of treatment. Speech is reduced to and treated only as a vehicle leading to the meaning of repressed materials. Bearing this in mind, it is no wonder that many clinical cases either stagnate or leave the work prematurely. Both supervisor and supervisee, in fact, are supposed to be detectives of ignorance. They look for what is said but not heard within the most primitive aspects of speech.

Setting many, rather rigid standards to control the clinic is an obsessional strategy for tempering the analysts’ anxiety in the work. The mentor or teacher whose role is to transmit knowledge or correct/modify a trainee analyst’s mode of practice (similarly to the medical

training model) acts in accordance with the structure of law and regulation referred to in master or university discourses rather than being concerned with each subject's circumstances, as in the discourse of the analyst (Lacan, 1970).

In contrast to the usual belief that institutional regulations serve to save and guarantee the quality of training for a member of the public, actually, right from the outset they ignore both supervisor and supervisee's ethical positions in relation to a subject. The position necessary to truly guarantee that each clinical case is treated ethically requires a radical disbelief in the "all-knowing" position,

In another vignette from *Dr Strange*, Strange tries to behave himself in relation to a master: a man who sits behind a desk, making Strange believe that he (the man) is the Ancient One. The way Strange was brought up within a grand, hierarchical institution of academical knowledge has taught him little of how to live life without such guarantors; he is surprised to see that he is actually served a tea by the Ancient One herself. All his learned standards evaporate in the face of a different kind of power, and he no longer needs surface appearances to prove his abilities to others. Throughout the plot, we see his unknowingness put into play. He has to unlearn the knowledge he has striven to learn. As an overqualified doctor, the qualities he learned were his allies in becoming a competent healer of the human body. After he realises his ignorance, he becomes more and more able to devise and master his own mode of conduct. The Ancient One and her crew made him come face-to-face with his ignorance, rather than allowing him to remain entangled in his illusions. He lets go of his understanding of given facts. Through his new training, he is strongly advised against copying or identifying with the master. He is pushed to question even his mentor in order to defend his own case. He is faced with more danger whenever he gets close to copying another mentor's position. He has to form and (more importantly) claim such a position for himself, which he eventually does. He understands such a position only when he gets there and knows how to treat it.

Such a model of supervision, which sits outside the standardisation of medical and health-related practices, reminds us of a dynamic in the Socrates - Alcibiades relationship. In Plato's symposium, which Lacan referred to throughout his 8th seminar, *Transference*, the mode of clinical training (of which a part would involve supervision) is depicted well in Socrates's approach to the question of teaching and mentoring while still maintaining the role of nurturing a follower's ability to question, rather than being focused simply on handling the transference (Lacan, 1960).

There is certainly a question of knowledge and experience involved in becoming a supervising analyst. However, what this "knowledge" and "experience" might be needs to be expanded upon here.

Why Supervision?

From Helen Deutsch's, calling supervision "controlled analysis", (Deutsch, 1935) to Lacan's choice to term it "pure analysis", the desire for knowledge changes in meaning and function when occupied within the position of a clinical supervisor. Both the above types of approach towards supervision, however, show the need to be aware of such a position in the formation of the analyst: the analyst who forms the desire to make sure that the clinical work does not serve the purposes of the analyst's enjoyment of given knowledge in a case, as well as the enjoyment got from knowing her/his own symptom – as the latter gets in the way of the direction of treatment. The desire to know reduces the function of the analyst to an agent of the inquisition – much closer to a perverse position – and gets in the way of analysis, as Lacan had pinpointed throughout his teachings.

The supervisory role is to protect the direction of treatment from being diverted, a diversion from the desire to know about one's symptom in order to create a specific way to treat it. In a supervision session, a supervisee might present a case when things have already gone wrong in the work. The first, fundamental rule is to avoid taking the position of a "fixer". Instead of

treating the case presented as a patient being handed over, the role of the supervisor focuses on searching for “why” and “at what point” the work had seemingly stagnated, come face-to-face with resistance, bungled actions or even acting-out. Such a goal cannot be obtained if the supervisor in question – for whatever reason – searching for the answers outside the realm of the unconscious.

When a supervisee seeks a supervisor’s view on a clinical case – most likely in order to double-check something – there could be a chance to elaborate on a symptom in the supervisee’s own analysis. It would be colluding with the analyst’s symptom if the supervisor does not suggest this to the trainee analyst. Then, it would be the analyst’s responsibility how to work through such an intervention by the supervisor. Such an approach in supervision does not mean that a supervisor functions in the same way as an analyst a supervisee’s unconscious material and desire. On the contrary, a supervisor pushes a candidate in clinical training to recognise the whys and wherefores of becoming an analyst. In other words, her/his desire to analyse is helped to burgeon and is nurtured. The place of knowledge, what is interpreted and why, are the real questions to be raised in the supervision.

What is Supervised?

This question opens the path to work through after there is a demand for supervision in the first place. Treating such a demand could potentially be a good start to punctuate the dynamic of a supervision session, as a way to enable a supervisee to get to her/his desire for doing analysis. In other words, how the supervision is to be used by the supervisee, and what is the aim in seeking another analyst’s intervention, are the two main questions to be worked on as soon as a supervisor is appointed. When someone wishes to polish her/his skill in a specific field of expertise, the contract between the supervisor and supervisee is quite clear, and the question of change and modification is also kept at the level of learning and knowledge. However, the

question of change in the work of analysis is supposed to happen at the level of the subject, which has surprising effects.

A while ago, a supervisee -a counsellor- doing his psychotherapeutic training outside the Lacanian orientation, consulted me about “repairing the patient’s aggressive transference” further to an interpretation he had made to his patient. Apparently, he had been anxious about losing the patient prematurely, so he had tried inviting the patient to talk about why he disliked his therapist, putting the focus of the work between the two parties into an Imaginary register. In the supervision, he was again putting the emphasis on his own feelings towards the patient, which were caused by the negative transference. I interrupted him at that point, showing my indifference towards what he seemed to have paid too much attention to – both in the therapeutic session and in the supervision – and asked more about the patient’s symptom and the implication of his interpretation regarding that specific material. Such an intervention in the supervision not only “surprisingly” brought up a significant piece of the patient’s early childhood history – which had been totally neglected in the work up until then – but also made the supervisee question his type of approach to treating his patient. He was so concentrated on his own discomfort that he was not able to listen, hence keeping the direction of treatment circulating around his own anxiety, making little attempt to question it. This was then worked through both in his analysis and in the supervision independently, but in the same fashion. He became more able to see the relation between his mode of intervention – at that particular moment in the work – and his own symptom. He was no longer trying to reduce the subject’s desire to a demand and the focus of the work bypassed the realm of two egos. Something changed in the clinic as soon as his position in the work was shifted to take a rather more ethical position.

Supervision Today

The focus of many contemporary approaches to the concept of supervision oscillates between either exploring the so-called “counter-transference” of the therapist/analyst, in order to make sure that a clinical practice is “pure” enough from any personal input of the therapist; or to transmitting a piece of knowledge and expertise. On the other hand, more emphasis is put on recounting the recorded narrative of a patient, leaving little space to question the implication and function of such recordings in the treatment. This understanding of the space of supervision in the clinic of psychoanalysis and psychotherapy reminds us of Lawrence Kubie’s strategy in the 1960s: to keep all speech recorded, under the illusion of capturing speech fully (Kubie, 1958). It also reminds us of a trend that started in the 1920s when the institutional politics of psychoanalysis began to come into focus. Establishing certain rules and regulations, under the motto of “public defence” against malpractice, sounds like a benevolent idea. However, such an approach brings of a more fundamental question: protecting what against what?

Before Lacan’s famous proposition in 1967, the “Proposition of 9 October 1967 on the Psychoanalyst of the School”, which shows his stance towards the politics of psychoanalytical training, little attempt seems to have taken place to elaborate the function of such a practice, at the level of the subject and her/his desire to become an analyst (Lacan, 1967). Supervision alongside personal analysis is already given an essential space in the training – in fact, being supervised as a trainee analyst is a *sine qua none* of training. According to this proposition, the question of self-authorisation – which can sometimes be misunderstood and misinterpreted – brings the position of the analyst into something beyond being the “subject supposed to know”. The analyst is a “destitute” subject, whose desire concerns only analysing. This proposition indicates that a supervisor supervises the framework of a clinic to make sure that such a position is in place for a supervisee who is in the process of formation. In other words, a supervisor oversees how the analyst is acting, from a non-existent position beyond a dogmatic knowledge of theory. Moreover, the narcissism of the analyst’s ego, which can keep the demand of an

analysis at the level of just demand instead of elevating it to a desire, is the target of a supervisor's intervention. An analyst is supposed to get satisfaction from doing analysis, and this would certainly not happen if the actions of the analyst come from an "all-knowing" place. An "expert" supervisor encourages such a desire to operate beyond the demand for a cure from a symptom. Such intervention from a supervisor would not be possible if s/he tends to be only the provider of a certain "supposed knowledge" about the case.

Therefore, what is "overseen" in supervision is ensuring that the supervisee analyst is the analyst of the work; and certainly not someone who entertains himself with the "meaning" of the material. The purpose of a functional supervision is to bring the Real out of the material provided; to keep the direction of treatment from stagnating, of being diverted, and from being fooled by the mirage of knowledge which will only give a "temporary fix". The subject will certainly acquire knowledge from her/his own symptom throughout an analysis – leading to a *sinthome* formation – but this differs from a knowledge coming from the Other. In other words, an analyst's work is under a supervisor's audition – Lacan used the term "super-audition" as instead of "supervision" in 1975 – to generate an effect on *sinthome*-formation, meaning that the supervisee does not occupy the position of the Other in the work (Lacan, 1975).

According to the above, the framework of analysis and supervision are similar in terms of their aim and function. Both a supervisor and an analyst operate from the place of producing a desire. A desire to search for – and hopefully find out about – the "not-yet known" material within the unconscious. Mustafa Safouan proposes that supervision is a process of "apprendre à apprendre", meaning "learning to learn".

Going back to the question of "public defence"; when a practising psychoanalyst is pushed this far to go through a journey of "destitution" to restore a new subjectivity and when her/his desire for analysis is put to all possible challenges, from personal analysis to supervision, which push her/his more and more to question the place of knowledge in the work, which institutionalised

state law can possibly operate ethically in relation to this? Furthermore, it would be the patient/analysand – at the front line – to realise and judge a clinical work when there is, for example, a so-called in that of malpractice. Within such a view of the supervision and psychoanalytical training, searching for a “guarantor”, for an Other controller – which is antithetical to analysis – would be unnecessary. The “destitute” subject of the analyst is the strictest critic of her/his own work.

Perhaps it would be helpful to mention at this point too that supervising a case – while having structural diagnosis in mind – raises a question regarding how the different structural clinics would be supervised. Do they differ from each other in terms of how the supervising analyst operates from the position of “causing a desire” to come about?

When a clinical case is presented to a supervisor, as we mentioned earlier, the reason for the request for supervision needs to be explored. Similar to the analytic setting, a period called “preliminary sessions”, which can last much longer than one might imagine, would be needed. The purpose of preliminary sessions – apart from gathering some general, given facts and materials about the patient’s past history and symptomology – would be to punctuate the narrative in order to get to the most basic properties of the language used, where a sort of truth lies – in both senses! Therefore, the main question to be formulated is: what is at stake in the supervision in this particular case? Through the preliminary meetings, a supervisee analyst finds her/his own way to formulate her/his question in a space of supervision that can sometimes be mistaken for her/his own personal analysis. This is a point to be emphasised for further elaboration in another space: one’s personal analysis. Within the realm of the unconscious, from where the analyst’s and the supervisor’s interpretation comes, any trace of a desire or the resonance of a drive is “overseen”. This makes the supervisee remain in the position of the analyst in the work. What mode of practice, how to interpret, or perhaps the style in which to conduct an analytical act, is not the focus of such a style of supervision. The

point of a supervisor's actions is to nurture a stronger desire "not to know/understand", on the part of the supervisee. This could be when, for example, a demand to "Give me an answer" is put to the supervisor; or when such a demand, coming from a patient, receives too much of the supervisee's attention. In a way, a supervisor is supposed to be attentive at two levels: trying of to occupy the position of the "subject supposed to know", but rather that of an agalma holder. In such a way, a supervisee would allow herself/himself to meet and form her/his desire of doing analysis. As such, regardless of the question of diagnosis, the position of the supervisor remains the same. Clarifying a diagnosis with a supervisor would be again in accordance with how to orient one's work to keep the direction of the treatment in place.

Conclusion

Supervision is more than a political theme in psychoanalysis and it should be part of the ethics of psychoanalysis. Theorising such a concept in Lacan's teaching is at the heart of the analyst's desire. This shows how such a concept needs to be approached and treated. The idea of setting standards becomes absurd due to the fact that the position of how and when to form them is within the power of the subject. Many people ask when does a psychoanalyst start practising as a supervising analyst? As soon as s/he is appointed by a supervisee of the school and s/he agrees to be a "super-audition" of a clinical case. There is no finishing line for learning to learn.

Bibliography

- Debell, D. (1963). A Critical Digest of the Literature on Psychoanalytic Supervision. pp.546-575. In: *Journal of the American Psychoanalytic Association 11*
- Deutsch, H. (1935). Control Analysis. In: *The Therapeutic Process, The Self and Female Psychology*. pp.239-246. New Brunswick: Transaction, 1992
- Kubie, L. (1958). Research into the Process of Supervision in Psychoanalysis. pp. 226-236. In: *Psychoanalytic Quarterly 27*
- Lacan, J. (1960-61). *Le Séminaire Livre VIII: Le Transfert*. Paris: Seuil

Lacan, J. (1963-4). *The seminar of Jacque Lacan: Book XI: Four Fundamental Concepts of Psychoanalysis*. Alan Sheridan (Trans). New York & London: Norton

Lacan, J. (1967). La Proposition du 9 octobre 1967 sur le psychanalyste de l'École. pp. 14-30, In: *Scilicet I, 1968*

Lacan, J. (1969-70). *Le séminaire XVII : L'envers de la psychanalyse*. Jacques-Alain Miller (Ed). Paris: Seuil, 1991

Lacan, J. (1975). Conférences et entretiens dans des universités nord-américaines. p.42. In: *Scilicet No 6/7*. Paris : Seuil, 1976

Moncayo, R. (2008). *Evolving Lacanian Perspectives for Clinical Psychoanalysis*. NY: Routledge, 2018

Safouan, M. (1995). *MALAISE DANS LA PSYCHANALYSE. Le tiers dans l'institution et l'analyse de contrôle*. Julien, P., Safouan, M. & Hoffmann, Ch. Paris: Les Cahiers d'Arcanes