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ORIGINAL PAPER

Contemporary Trends in Supervision Theory: A Shift from Parallel Process to Relational and Trauma Theory

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Abstract This paper describes how relational theories of supervision and one aspect of contemporary trauma theory coalesce to offer a conceptual shift in supervision theory and practices. The paper gives a brief overview of the concept of parallel process in supervision. Following this, the paper summarizes current literature that questions the universal nature of parallel processes in supervision. Next, the characteristics of supervision, when framed in relational theories, are offered. Last, the paper describes how the understanding of trauma theory's triadic self of victim-victimizer-bystander is a useful construct in understanding impasses in supervisory relationships. Supervisory vignettes are utilized to illustrate the theoretical constructs.

Keywords Clinical supervision · Relational theory · Trauma theory · Parallel process

Introduction

This paper examines contemporary trends in supervision theory and practice, when framed in psychoanalytic and psychodynamic theory bases. Recognizing that these are wide-ranging theory bases, this paper focuses on the interface of three specific theoretical contributions to contemporary supervision theory. The parallel process concept has been a staple of the psychodynamic supervision literature for many years. However, this concept preceded our current views of relational or intersubjective perspectives. Critiques of the parallel process concept by relational psychoanalytic and social work authors may broaden our understanding of the supervisory process. In addition, the concept of a tripartite self arising in victims offered by trauma theory can inform our understanding of projective identifications in the client, supervisee, supervisor triad (Basham and Miehls 2004; Herman 1992; Staub 2003).

The following discussion is framed in the context of the shifting field of clinical practice from what has traditionally been thought of as a one-person psychology (modernist perspective in which the clinician is thought of as expert and the client is the passive recipient of the expert interventions) to a two-person psychology (relational and/or intersubjective perspective). Authors broadly referred to as relational clinicians (Aron 1996; Aron and Harris 2005; DeYoung 2003; Hadley 2008) clearly argue that all behavior is determined in an intersubjective field in which self and others are connected and exert a mutual impact on one another. Clients and clinicians are viewed as partners who co-construct the treatment process. Clinical relationships value authenticity and mutuality and the clinical relationships are seen as experiential, reparative and facilitating for clients and clinicians alike (Goldstein et al. 2009). This paper demonstrates how these general principles of relational theory influence a supervisory relationship.

Parallel Process

Miller and Twomey (1999) suggest that increasingly writers from different theoretical perspectives "have begun to reexamine parallel process in a way that calls into question some of the fundamental premises upon which the concept is based" (p. 558). Searles (1955) was the first

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author who identified a process in which a therapist unconsciously enacts issues he is experiencing with his client in the supervisory relationship. Searles called this a reflective process. Ekstein and Wallerstein (1958) further described this reflective processes a parallel process in their classic text on teaching and learning psychotherapy. Ganzer and Ornstein (2004) note that "social work's subsequent alliance with ego psychology helped to solidify parallel process as the primary diagnostic learning tool for identifying the supervisee's transference and countertransference transactions and working through therapeutic impasses" (pp. 422–423).

Doehrman (1976) studied parallel processes in supervision for her dissertation effort. She was the first to suggest that parallel processes can be bi-directional with either the supervisee or supervisor initiating a dynamic that is played out in the therapy relationship which is the focus of the supervision. Her work underscored that parallel processes were not necessarily a demonstration of difficulties in either the analytic or supervisory relationships; rather these processes were an expected part of every treatment. This notion has led to some difficulties with the concept. For example, Baudry (1993) suggests that parallel processes are descriptive by nature and not really explanatory. She suggests that it has become "somewhat of a fad, particularly among beginning therapists" (p. 611). There is a risk that clinical material may be made to fit into a parallel process if the supervisory dyad thinks that parallel processes occur in every treatment and supervision. (Miller and Twomey 1999). And there is a danger that the concept will be applied in a formulaic and simplistic manner if parallel process is thought of as a universal phenomenon.

Relational theorists add further critique to the concept of parallel process. Supervision literature has admittedly been somewhat slow in adopting the principles and epistemology of relational theory. Ganzer and Ornstein (2004) suggest that even though clinical work has moved to a two person modality, supervision literature has not kept pace. Gail Frawley-O'Dea (2003) had previously noted "that psychoanalytic supervision may just now be starting to be reformulated to fit better the great changes in psychoanalytic culture that have occurred over the past 15 years or so" (p. 357). Schamess (2006b) concurs; he notes "As contemporary treatment has evolved, ideas about therapeutic action have increasingly emphasized intersubjective and relational processes. Most of the supervisory literature, however, has not yet integrated those changes" (p. 428).

Relational Theory

At the most basic level, relational theorists critique the concept of parallel process as it tends to position the supervisor in an authoritative position. Stimmel (1995), cited in Miller and Twomey (1999) suggests that "attributing supervisory dynamics to a parallel process may be a resistance to the awareness of the supervisor's own transferences to the supervisee" (p. 564). Lesser (1983) provocatively suggests that the concept of parallel process is actually illusory and that "its use within the supervisory situation may suggest that important relational difficulties between the supervisor and supervisee are being avoided and displaced onto the therapy" (cited in Miller and Twomey 1999, p. 563). Baudry (1993) suggests that the supervisor uses the concept of parallel process as a resistance to identifying a transference reaction to the supervisee, independent of the particular case being presented (Miller and Twomey, p. 611). Miller and Twomey (1999) suggest that we need to question the occurrence and significance of parallel process "for not adequately taking into account the intersubjective field and the larger relational dynamics that influence all of the participants. An examination from a relational perspective of parallels that can occur in a supervisory situation may provide a deeper appreciation of the complexities involved in any clinical encounter, and thus serve as a caution in applying overarching theory to unwieldy facts" (p. 566).

The metaframework of relational treatment principles are now beginning to influence our understanding of the supervisory process. The paper now examines key components of supervisory relationships, when framed in relational theory. Rather than assuming the supervisor has objective knowledge that is conveyed to the supervisee in a didactic manner, the relationally based supervisor recognizes that she has a sanctioned position within the analytic community but the power and authority of the position is continuously evolving, in negotiation with the supervisee. Frawley-O'Dea (2003) suggests that the relationship is not symmetrical in that the supervisor does honor her advanced skill and experience; however, the supervisor also acknowledges the special talents and skills of the supervisee. The relational supervisor is "conscious of the necessary and ever present tension between assumed and authorized power that infuses the work of the supervisory pair" (p. 359). It is important to recognize the shifting distribution of power and authority and to be cautious when the supervisee radically shifts her views of her client. A supervisee may be trying to please the supervisor when she changes her own views of the dynamics of the client. Such a shift may lead to some incorrect understanding of the client issues and needs in therapy. A supervisor may consciously or unconsciously expect that the supervisee will defer to the supervisor's understanding of the client process and important information or dynamics may be missed by both the clinician and the supervisor if the sole "expertise" rests within the supervisor. Supervision that incorporates

relational principles would expect that both clinician and supervisor equally create the view of the client that guides the clinical process.

A second major shift in supervision practiced from a relational perspective concerns what data is relevant for processing within supervision. The issue of supervision as being separate from individual treatment of the supervisee is relevant in this discussion. Kron and Yerushalmi (2000) suggest that supervisees need to move from a modernist position of maintaining traditional frames in psychotherapy to a method of bringing themselves more personally and authentically into the treatment. There is no easy way to "teach" someone to practice intersubjective theory and technique but some authors suggest that the supervisory relationship is a natural place to model an intersubjective approach. Frawley-O'Dea (2003) suggests that "…the more fully and freely supervisor and supervisee represent the intricacies of their own relationship, in particular clarifying aspects of it centrally related to the supervised treatment, the more completely and effectively the supervisee can engage with the patient in identifying and speaking about the relational paradigms operating within the treatment" (p. 360). Supervision can be most helpful when supervisors and supervisees engage in an ongoing dialogue that explores difficulties and/or mutual transferences that occur during supervision. Schamess (2006a) also suggests that "listening attentively for transference enactments in supervision enriches supervisory conversations and communicates empathetic interest in the manifest and latent content of what supervisees communicate" (p. 424). He goes onto say that "…clinical supervision can and should be designed to achieve both educational and therapeutic goals" and "…the boundaries between cognitive and affective learning and those between professional development, personal growth, and personality change are permeable in ways the traditional supervisory literature has been reluctant to acknowledge" (p. 428). Tosone (1997) also previously noted that "…there is a general consensus that selective disclosure of (supervisor) countertransference to the supervisee can have a beneficial effect on the supervisee's treatment relationship with the patient" (p. 30). Here too, the operative process is to teach by example. This method of teaching, though, necessitates that the supervisor has the capacity "to tolerate and acknowledge his or her own anxieties and conflicts as they enter the supervisory relationship, rather than projecting them onto or into the supervisee" (Sarnat 1992, p. 401). Relationally based supervisors do not suggest that supervision is the same as personal therapy but some exploration of personal reactions to the client is appropriate. It is also important that the supervisee is able to explore her feeling responses towards the supervisor at certain times. And, the relational supervisor may choose to explore some of her reactions to the supervisee's clinical work and professional or personal interpersonal style. Exploring sociocultural factors such as race, gender and class may assist in a fuller understanding of the clinical process and the supervisory relationship. Relational clinical practice and relational supervision is always influenced by one's social identities and larger societal factors that permeate the work (Goldstein et al. 2009).

A relational model of supervision appreciates that some regressions in both supervisee and supervisor are normative and that affectively intense or cognitively primitive material does not need to be hidden in the supervisory relationship. Frawley-O'Dea (2003) suggests that the relational supervisor is "…open to considering primary-process material delivered into the supervision by dreams, somatic states, fantasies, and dissociative experiences" (p. 360). She encourages her supervisees to be alert to their own bodily sensations, affect, and transitory mental images when engaged with their clients and that this material is crucial to talk about in supervision as well. This is different than thinking about supervision as a cognitive process that relies exclusively on sound secondary-process and abstract thinking.

If a clinician was taught supervision principles or has been supervised in a more traditional approach one likely would expect that neurotic or characterological aspects of the supervisee would be taken up in one's own therapy. Relational supervisors view this somewhat differently. While certainly not advocating an "anything goes approach", a relational supervisor recognizes that supervision processes are enriched when supervisor/supervisee dyads try to understand the enactments of the treatment and the enactments in the supervision. A supervisor cannot ignore their supervisee's or her own reactions, personality style, or transferences if she hopes to understand the complexity of the enactments that are crucial to the work. Frawley-O'Dea (2003) says that personal transactions should not be pursued unless the needs of the client and the treatment are the primary focus of the discussion. She suggests that the boundaries and limits of the supervision should be co-constructed by the participants and the supervisee should retain the authority and decision-making about the extent of the personal issues that are open for scrutiny in the supervision. She also notes that a supervisor will take a more cautious approach if the supervisee has not had his own treatment. A clinician is less frightened of primitive content when it emerges in the supervisory relationship if the clinician has undergone his own therapy and is willing to explore the meaning of such content in the service of better understanding the processes of the clinical work being supervised. Citing Bromberg (1998) and Ganzer and Ornstein (2004) suggest that the "supervisor does need to be respectful of the supervisee's need for privacy,

and, as noted, to control the degree of exploration" (p. 446). They also note that "each participant needs to be able to walk the tightrope, not knowing whether the process will lead to clarification and insight or to increased complexity and even temporary confusion, but be willing to go either way" (p. 446). Supervisory vignettes will illustrate these concepts later in the article.

Trauma Theory and Supervision

How can trauma theory further inform some of the principles of relationally based supervision? Trauma theory has integrated many principles of feminist theories at its core. Numerous authors (Basham and Miehls 2004; Courtois 1999; Miller 1994) elaborate that clinical work with survivors of childhood trauma necessitates a partnership between client and clinician in which the client feels empowered and validated. Trauma survivors are encouraged to reclaim their own sense of agency and ability to influence people and events around them. The development of collaborative, working relationships with survivors of trauma echoes the mutuality of relationally based therapy. Trauma theorists and relational theorists and relationally based supervisors expect that clients and therapists and supervisors and supervisees will continuously be subject to enactments in the therapeutic and supervisory work. All participants compel each other to act out unconscious dynamics through a series of both complementary and concordant projective identifications. Clients attempt to have their clinician complement their views of themselves through the defense mechanism of projective identification. For example, trauma theory (Basham and Miehls 2004) suggests that a client who was victimized by a parent may try to have the clinician victimize them as well. They enact a relationship dynamic that is familiar and often powerfully experienced between the client and the clinician. This is an expected component of the clinical process. This paper suggests that supervisees and supervisors may play out unconscious dynamics of their clients and themselves during supervision that can also be understood by certain tenets of trauma theory.

The deconstruction of these enactments provides a fertile area of investigation and also potential for corrective experiences for the client, the supervisee and perhaps the supervisor. Relational and intersubjective theorists fully recognize the inevitability of these processes. There are particular enactments that can be expected when the client (or therapist) is a survivor of childhood trauma. Ganzer and Ornstein (2004) suggest that the therapy unfolds through the enactments of the therapist, client and supervisor—they also importantly point out the organization or broader context of the therapy may also influence the inevitable enactments. For example, supervision that is practiced in an inpatient mental health setting may see the dissociative experiences of a trauma survivor as pathological. Trauma theorists (Basham and Miehls 2004) would view these experiences as normative and signs of health within the survivor.

There are currently a few references in the literature that speak directly to supervisory issues when the client is a trauma survivor (Frawley-O'Dea 1997a, b; Hirsch 1997; Knight 2005). However, the concept of the triadic self in supervision is not developed in the literature and the paper now turns to this concept. Frawley-O'Dea (1997b) published an article in Contemporary Psychoanalysis entitled "Who's doing what to whom? Supervision and sexual abuse". In this article, she notes that supervision of trauma work is often characterized by unexpected, troubling experiences for both supervisor and supervisee. She accounts for this by suggesting that client and analyst enact dyadic constellations of trauma identity and she does recognize that client and analyst enact these in a "kaleidoscopically shifting pattern" (p. 12). She does not specifically refer to the triadic self although she does recognize that supervision becomes enhanced when the supervisee and supervisor expect some enactment between them during the supervision. She says "only then can all parties to the treatment—patient, analyst-supervisee, and supervisor—relax in a working assumption that relational patterns central to treatment, and thus to the patient's internal world, will be lived out, contained, processed, and ultimately spoken about within the relational matrices of the supervision and the therapy" (p. 13).

She raises another important point when she reminds us that dissociation processes, unlike repression, are the main defensive postures that a survivor of trauma employs in her adaptation to stressors. Dissociation is characteristically a vertical rather than a horizontal split and thus "dissociated ego states reveal themselves through emergence of intrusive images, violent or symbolic enactments, inexplicable somatic sensations, repetitive nightmares etc." (p. 15). Clearly the client is often inarticulate about these processes and as a result of enactments the clinician may also be subject to these same sort of dissociative experiences. She makes the argument that these sorts of dissociative processes will enter the relational field of supervision as well, complicating the particular transference/countertransference configuration of that particular dyad. She concludes this discourse by suggesting that "successful supervision of treatment of trauma survivors may require the supervisor to enter into the dissociative experiences of the supervisee in ways that invite symbolization and elaboration of the currently formless and unspeakable" (p. 15). A supervisor may gain valuable information about the clinical work being supervised if she is open to

exploring the nuances of the supervisee's behavior. It is important to understand the insidious influence of trauma dynamics when one's usually verbal and insightful supervisee seems helpless and unable to articulate the clinical process between her and her client. This may be a sign of some dissociated experience of the client and the clinical work will often be improved when the supervisee and supervisor can understand the origin of the supervisee's behavior as being (partially) related to the client's trauma history and her defense against the history.

Davies and Frawley (1994) discuss the complexity of transference and countertransference manifestations when the clinician is also a survivor of childhood trauma. They note that supervisors of these clinicians need to be alert to the possibility that the survivor/therapist may "assume a persistently masochistic position with patients, provoking ever-escalating sadistic attacks through their patients' self-destructive or abusive acting out" (p. 166). They note that a therapist may also turn a blind eye to escalating transference or acting out, enacting the caregiver who may have been a bystander in their own history. Clinicians may also adopt a rescuing attitude towards their client and may not allow themselves to become bad objects for their clients who limit a full range of frustration or rage to emerge in the transference relationships.

Additionally, Hirsch (1997) in his paper entitled "Supervision amidst abuse: A supervisor's perspective" recognizes, in hindsight, that he became an invasive abuser in the relationship of his supervisee and her client. He candidly acknowledges that he tried to impose his views or treatment suggestions on his supervisee. Hirsch does make the point, however, that "…the abused patient is usually victimized by a perpetrator and by another family member who chooses not to see what is happening" (p. 355). He did not extrapolate this dynamic to the supervisory relationship even though he says that he understands that these themes get played out in the transference/countertransference interaction.

The triadic self refers to the well-documented clinical concept which describes that trauma survivors internalize all parts of the victim-victimizer-bystander/rescuer dynamic (trauma theory suggests that the bystander role may also be played out by becoming a zealous rescuer of the trauma victim). Trauma survivors often enact the triadic self through projective identification interactions. The survivor does not stay fixed on one aspect of the triadic self; rather, he shifts between the identities of victim/victimizer/bystander (Basham and Miehls 2004; Herman 1992; Staub 2003). Basham and Miehls (2004) elaborate a couple treatment model for survivors of childhood trauma. They write about the importance of the victim-victimizer-bystander triadic self and how this becomes manifest in the triangle of the two partners and the clinician while engaged in couple therapy. It is common to experience the pull of projective identification (trauma enactments) and to be pulled in the direction of taking on the roles of one of victim-victimizer- bystander (rescuer) when conducting couple therapy with survivors of trauma. Clinicians who work with survivors of trauma have long recognized the powerful pull of projective identification in the relationship dynamics of transference and countertransference with their clients. Chu (1988) referred to these dynamics as countertransference traps and other authors such as Davies and Frawley (1994) and Pearlman and Saakvitne (1995) agree that there are typical interactions characterized by complementary positions such as (1) helplessness/rescuer; (2) victim/victimizer; (3) seducer/seduced (4) aggressive/frozen dyads, to name a few. Trauma literature recognizes that these unconscious dynamics inevitably get activated in treatment. This literature speaks to the dyadic nature of the enactments but it is important to recognize that the complementary positions are influenced by the third part of the triadic self, that being the bystander/rescuer.

This paper proposes that aspects of the triadic self get played out in the supervisory process as well. This is particularly true when observing "stuck" supervisory dyads that are in some instances embroiled in trauma scenario enactments. The client/supervisee/supervisor triad offers fertile ground to examine how the supervisory relationship falls prey to the victim-victimizer-bystander triadic self. These conceptualizations are particularly helpful in understanding impasses in the client-clinician dyad or the supervisee-supervisor dyad.

Consider the following example in which the student clinician and supervisor were clearly embroiled in an enactment based upon a repetition of the triadic self.[1] I became privy to the interaction in my role as a Faculty Field Advisor for a clinical program in a graduate School. Susan, a student intern reported to me that she and her supervisor were having some difficulties in the supervisory relationship. Susan recounted that the two had different ideas about how to assess and treat adolescents and Susan thought that Linda (the supervisor) was not all that helpful in assisting her to set limits with her adolescent clients. This was particularly true of her work with 15 years old Stephen, who was a mandated client to the agency; his therapy was meeting a probation requirement that was secondary to a charge of violence at his secondary school. The student clinician reported to me that she felt apprehensive about her individual sessions with the client as he was increasingly defiant and angry during the individual therapy. Linda dismissed the student's concerns saying that

[1] The student and supervisor identities are disguised so as to protect their anonymity. The process of the supervision experience accurately portrays the "stuckness" of the dyad.

non-voluntary clients were difficult to engage in treatment. The supervisor thought that the student was exaggerating the severity of the client's behavior.

The author had the benefit of bringing new eyes and observations to the interaction between the student and the supervisor. I noted that the student certainly felt immobilized, apprehensive, and frightened of her young male client. She acknowledged that she dreaded meeting with him and she described that she felt "beaten up" by his sarcastic and caustic comments in the interviews. The supervisor suggested that the student needed to toughen up if she was going to be an effective adolescent therapist. Linda suggested that a reasonable outcome in working with these sorts of clients was to keep them engaged—that change would come later. Linda reported that the student seemed helpless in the interaction and that she needed to look at this issue in her own therapy. I observed that the student indeed did seem somewhat helpless in both the interaction with her client and with her supervisor. The client did appear to be highly critical and devaluing of the student clinician and the student clinician was having a difficult time placing limits on the acting out behavior.

I also noticed that the supervisor seemed somewhat unalarmed by this treatment relationship. I knew Linda to be a compassionate, sensible and responsible supervisor and I noted that she seemed to be somewhat disinterested in the student's dilemma. Linda agreed that she found the intern's interaction with this student problematic and that she had a difficult time thinking that the client's anger was all that difficult to manage. I observed that the client was victimizing the intern from my vantage point. I also noted that the supervisor seemed to be playing the role of bystander in this particular supervisory process. I tweaked the curiosity of the intern and the supervisor when I clearly said that I thought clients, interns, and supervisors can fall into the enactment trap of victim-victimizer-bystander. I spoke briefly in a didactic sense about trauma theory's understanding of the triadic self and how these powerful roles can get played out both internally in the trauma survivor's intrapsychic world and also in the interpersonal interactions of triangular partnerships. It is here that there is an interface of relational theory and trauma theory. She may have been able to assume a less authoritative stance if she was supervising within a relational model. She may have become curious about her lack of interest (or empathy) with this young intern's dilemma had she been alert to the possible enactments when supervising cases in which the clients are traumatized. Had the student clinician been familiar with trauma's theory of the triadic self, she may have been able to understand the enactment of her client, placing her in a victimized role. She would have been able to understand the enactment and not be immobilized by it. And, had the supervisor operated from a relational stance, she may have understood that the experience of the student was being altered by the agency and supervisor attitudes about the relative ease of working with non-voluntary clients.

The author shares the following example so as to illustrate how the supervisory relationship could have been different if the supervisor (and clinician) were aware of the triadic concept of trauma theory and/or principles of relationally based supervision. I draw from this clinical experience of some 20 years ago. In this example, I was working as a clinician on an in-patient mental health facility. I was responsible for conducting individual psychotherapy as well as some traditional case management functions. My supervisor was the consulting psychiatrist on the unit and she had the responsibility of making decisions concerning the patient's leave of absence requests and/or discharge requests. My client was Ron, a 30 years old single man, who had been admitted to the inpatient unit after a suicide attempt. He was initially enraged that his suicidal act was unsuccessful and he was extremely bitter that he was once again in the domain of the mental health system. He had been certified on two previous occasions and his medical record indicated a very strong push towards suicidality. He met the criteria of both Axis I (major depression) and Axis II (narcissistic personality disorder) diagnoses (American Psychiatric Association's DSM IV-TR 2000) and he had a horrific history of tortuous physical abuse at the hands of each of his parents. Ron also had physical difficulties—walking with a pronounced gait and he was also functionally blind. He and his family had been in a severe automobile crash when he was aged 17. My client was the driver of the single car accident and both his parents and his three younger siblings all died instantly in the accident. One previous therapist speculated that Ron had intentionally caused the accident and her speculation was that he wanted to kill all of his family and himself. I thought this hypothesis was plausible as I got to know him.

Ron's interpersonal style on the in-patient unit was provocative. He was known to stir the other patients up and then sit back and observe the chaos, with a sense of detachment and what some perceived as satisfaction over his omnipotence and power among the others. He presented one main theme with me in his individual sessions. He wanted to be discharged; when I would report that his discharge was premature, he would "pretend" to be engaged in the therapeutic work. He would explore his anger by telling me countless and horrific details of his parents' physical abuse towards him and his siblings. He seemed to report these details, with little affect. I often felt nauseated during these hours and I dreaded hearing the detail of his abuse history; I often wondered if I would have to leave sessions to avoid any attack of emesis. I would become light-headed and literally have to plant myself

firmly in my chair to stay in the room with the client. I also was aware of wishing that the client would be discharged from the hospital, in spite of his continued risk of suicide. I was aware that I felt my supervisor was being overly cautious and I was angry with her for making me continue to see this client. There was no doubt that I was feeling victimized by both my client and my supervisor. In retrospect, I realize that my adaptation to this clinical dilemma was to act out my aggression. I started to victimize my consultant psychiatrist supervisor.

In my supervision hours, I started to detail my client's abuse narratives to my supervisor. I could tell that she was also repulsed by the graphic imagery; I had some sadistic satisfaction that she had to withstand some of the torture that I felt that I experienced with this client. She continued to suggest that further treatment was necessary before she could discharge the client in spite of how uncomfortable we both were while working with this client. She seemed helpless in offering any treatment guidelines. This was a clear example of trauma theory's triadic self in action. While my supervisor and I played out the victim-victimizer roles our client developed a detached, smug, and remarkably astute observation of our tyranny of each other (bystander).

Beyond supervision, our customary way of communicating information about patients and making team decisions about patients happened in morning ward rounds. Our colleagues sat in uncharacteristic silence as I openly challenged the consultant psychiatrist-supervisor. The other team members seemed to be identifying with the bystander part of the triadic self—they seemed mostly relieved when our discussion moved onto other patients. Ron had a remarkable capacity to catch me or the psychiatrist (or both) in the hallway of the in-patient unit and would calmly ask if we had settled our differences—at one point, he asked if we had finished beating each other up. I did not understand it then, but I know think he was playing the part of the observer in the triadic self. He had so often observed his parents' abuse of his younger siblings and his parents' abuse of each other. He had me and the supervisor/consultant playing out the victim-victimizer roles with each other and he was the passive observer. His calm, detached manner signified the success of his projective identification of two parts of the triadic self, that being the victim and the victimizer. I also recognize that his detachment was aggressive and he would continuously shift his stance. At other times, he would again victimize and at other times, he felt like he was the victim. In the supervision relationship, my supervisor and I played out the various roles of the triadic self as well. We stayed stuck for some time in that impasse as neither I nor the supervisor had the benefit of understanding the triadic self enactments with survivors of childhood trauma. If this scenario was current, I think my physical responses to this client would be a clue to me that I was enacting part of the triadic self representation. As noted earlier, a good relational supervision would facilitate an exploration of my somatic symptoms and would likely understand them as reflective of a dissociated part of my client that was getting enacted in the treatment relationship and in the supervisory relationship.

In this last example, the author became the complicit bystander in a series of behaviors between a client and supervisee who were caught in an impasse in which the clinician felt increasing helplessness, allowing her client to sadistically punish her. There were two important contextual factors that contributed to the enactment of the triadic template. I was a supervisor of psychotherapists and medical social workers in a large teaching hospital during an era of restructuring and amalgamation of health care settings. The hospital administration assigned an additional ten clinical staff to me and suggested that this workload change was not negotiable. In addition to my previous responsibility, I was given responsibility of managing the clinical work of four clinicians who worked in a large H.I.V. outpatient program. One supervisee in this group was known to be a difficult staff person and I did not welcome the addition of her into my supervisee pool.

A second important contextual factor was that another of the supervisee's clients' had recently committed suicide; she felt tremendous guilt and remorse about the client's death. The client with whom she brought to me for supervision was a friend of the client who had committed suicide. Worse, the current client knew that his deceased friend had been in therapy with the current clinician. The supervisee seemed to feel powerless in the treatment relationship. She met with her client weekly but it seemed decidedly clear that the therapy was at an impasse. Her client would often berate and belittle the worker and he noted her incompetence, citing his friend's suicide. The worker appeared to be unable to set appropriate limits and allowed herself to be humiliated by her client. Her client was apparently very loud and he would rage towards the worker in the common waiting area of the H.I.V. clinic. The worker described her somewhat feeble attempts to contain the client's rage in the supervision hour. In retrospect, I realized that I was inappropriately displacing my frustration with the administration to this worker and other supervisees. It is clear to me that I stood by and witnessed the client victimizing the worker. I recall thinking to myself that the client had read the personality style of the clinician well and I was surprisingly unalarmed at how the client humiliated the worker. In addition, I seemed somewhat detached from the clinician's response to the suicide of her other client—this is not my usual response as I generally am quite effective in assisting supervisees with processing such painful events.

The impasse clearly involved the triadic victim/victimizer/bystander dynamic. Fortunately, I was able to move out of the bystander role when the H.I.V. clinic director contacted me to express his concern for my supervisee. His compassion towards the worker disturbed my response sufficiently and I became mobilized to escape the bystander role. I then became attuned to trauma theory and recognized how I was being complicit in observing the client's sadistic interactions towards the frightened, guilt-ridden clinician. Consequently, I was better able to effectively offer the worker some opportunity to work through her reactions to her client's suicide and to also begin to appropriately set limits with her current client. I became more pro-active with the hospital administration and initiated some discussions that ultimately led to further staff reassignment and the eventual hiring of an additional clinical supervisor.

Conclusions

This paper has addressed three inter-related themes. First, the paper questioned the universality of parallel process in supervision and suggested that an over-reliance on the concept may lead to simplistic explanations of complicated dynamics. Second, the critique of parallel process led to an articulation of how relationally based supervisory practices are influencing the supervisory process. Catching up with the psychotherapy literature broadly labeled relational or intersubjective, supervisory literature now suggests that supervision relationships are most meaningful, when co-created, and where supervisor and supervisee anticipate a reciprocal process that may reflect enactments of treatment scenarios. Legitimizing some relational principles in supervision permits a more expansive interaction between supervisee and supervisor. This is especially true while problem-solving relationship impasses of the supervisory dyad. While not individual therapy, supervision does offer an opportunity for psychological growth for both supervisee and supervisor. Last, the paper suggested that trauma theory's description of the triadic self can be a useful tool in the supervisory process. When understood, this concept can be utilized by both supervisor and supervisee to disentangle enactments in the supervisory and treatment relationships. Supervisors will continue to improve their craft when they integrate aspects of relational theory into their practice and when they expect relational enactments as the cornerstone of therapeutic action with trauma survivors and others. An application of the victim/victimizer/bystander dynamic to the supervision process can contribute to a resolution of impasses in the treatment and/or the supervision relationships.

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