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THE SUPERVISOR AS WITNESS

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Adopting the role of witness can help supervisors to cope with emotional flooding and fluctuations in the supervisees' self-experience. Assuming the role of witness aids modification of the supervisors' tendency to hold the supervisees' in mind and to respond to their selfobject needs and provides the supervisees with a participatory yet external presence, which enhances the supervisees' creativity. The meaning and the uses of the role of witness in the supervisory context are explained and illustrated in the present article.

Keywords: witness, supervision, analytic therapists, developmental struggles

Many supervisors view their mission as accompanying supervisees in ongoing coping with clinical challenges and the developmental struggles that supervisees face as analytic therapists. These sometimes lead to emotional flooding and fluctuations in the supervisees' professional self-experience. Such emotional responses might disrupt the supervisees' clinical coping efforts and professional development, even if they are not as accentuated as those of patients, who, in the therapeutic space, reconstruct previously experienced developmental hardships and traumas. Therefore, supervisors try to stabilize the supervisees' emotional system and create a calming and reassuring space. They do so by responding positively to the supervisees' selfobject needs as well as holding in mind the supervisees' developmental struggles and the pains and gains encountered when meeting clinical challenges.

Supervisors who commit themselves to such a complex and sensitive role may help the supervisees to stabilize their self-image, self-worth, and the sense of going-on-being, similar to therapists' parallel role in aiding the patients who struggle with inner conflicts and with deficiencies and traumas experienced in the past. However, some differences between supervisors' and therapists' positions are evident: Supervisors witness a relatively moderate emotional flooding and fluctuations in the supervisees' self-experience, and the supervisors' role includes also teaching and evaluating the supervisees' clinical competencies and theoretical knowledge.

These differences call for a change in the meaning and use of the two analytic concepts of selfobject experience and holding in mind when applied to the supervisory context. It is proposed in the present article that supervisors assume the role of witness, like therapists

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who adopt the role of witness especially in the treatment of traumatized patients. This role, which is characterized by a somewhat external and reserved position, will help supervisors to give a different and better adapted interpretation to these two analytic functions: Supervisors will respond moderately and cautiously to the supervisees' needs for self-objects and holding in mind, thereby guarding them from deep regressive states and dependency.

The metaphor of the supervisor as witness helps supervisors to act and respond to the supervisees' professional and developmental struggles mainly by providing them with a calming and reassuring environment which encourages growth. The role of a witness who silently listens, observes, and participates provides supervisees with the sense of being seen and a greater sense of certainty in their existence, which enhances the supervisees' experience of creativity (Winnicott, 1971).

First, I examine how the analytic literature has addressed the role of therapists as witnesses to their patients' struggles and development. Subsequently, I outline the differences and the parallels that can be drawn between the role of witness among supervisors and therapists and the supervisors' unique functions vis-à-vis the supervisees' professional and developmental struggles. I will then throw light on the significance of this role and its possible contribution to theory and practice.

The Therapist as Witness

Witnesses observe the actions and reactions of another person or persons, out of the willingness to be included, to some degree, to hold the observed events in mind, and to reproduce them, if and when necessary. Nevertheless, witnesses are usually more than merely observers, and even if not actively involved in the witnessed events, their presence is significant and has an influence on the progression and development of events. This turns the witness into a significant emotional and ethical player in these events (Seiden, 1996). In the psychoanalytic literature, a considerable amount has been written about the role of the therapist as witness to the personal struggles of patients and to the processes that they undergo.

Most authors who dealt with this subject addressed mainly the role of the therapist as witness for survivors of trauma, which is reconstructed when these patients raise difficult personal stories in therapy and reexperience their past suffering (Boulanger, 2005; Davies, 1996; Akhtar, 2002; Shabad, 1993). In cases such as these, the therapist's primary function in the role of witness is to validate the patient's perception of world as unpredictable and potentially insane and dangerous, thereby combating the dehumanization experience that is part of the patient's reality (Peskin, 2012; Dimen, 2003). Therapists can testify that the difficult events and developments could not have been foreseen, especially in the patients' specific social, familial, economic, and political reality. In their role as witnesses, therapists can clarify the psychological and economic motives of different offenders, and can organize them and give them meaning in a manner that allows patients/victims to understand what they are facing and the evil in the patients' world (Ullman, 2006).

In therapy, posttraumatic patients experience the presence of another person, who is willing to be there for them and to encounter their story, listening not from a neutral stance, but clearly taking a side and validating the patient's burning desire to live in comfort and self-wholeness. The therapist does not, even momentarily, forget the identity of the players in the patient's story: He or she is well aware of the identity of the offender,

of who is likely to be harmed again and by whom, and of who carries the moral responsibility for the terrible events that occurred (Ullman, 2006).

Other writers discuss the role of therapists as witnesses who listen to their patients' stories from an external and participatory position when they treat patients who experience other types of mental distress. When patients tell their stories to the therapists in this position, they are more likely to adopt the stories as reality, leading them to organize the self-experience with additional clarity and order. Moreover, therapists as witnesses see patients in the same way as they see themselves, thus granting validity to the patients' self-perceptions and to the logic they use to explain phenomena. In this manner, patients gain something very important for preserving the self-experience: the continuous belief in their own beliefs (Eigen, 2002; Schafer, 1983; Seiden, 1996).

The function of the witness develops out of the parental function of holding, which includes emotional containment and instilling confidence in the patient through care and concern. It also incorporates the meaning of letting go for the patient, because while in this role, therapists maintain a clearly separate self (Poland, 2000). Therefore, at the same time, the function of the witness enables reassurance and strengthening of the patient and his or her release from dependence on the therapist. This dual paradoxical action may promote the mutual recognition of the otherness between the participants in the therapeutic dyad. Hence, the role of therapists as witnesses fortifies their patients' self-definition and experience of self-in-relation-to-others.

In the next section, I outline some parallels that can be drawn with the supervisors' and therapists' role as witness, as well as some differences that indicate a unique implication of the role of the supervisor as witness.

Some Similarities and Differences Between the Therapeutic and the Supervisory Contexts

Some important parallels exist between analytic therapy and supervision, which facilitates the mutual borrowing and implementation of terms between these two areas. Both in therapy and in supervision, one person helps another to organize his or her thoughts and perceptions, and has greater responsibility for the relationship between them, even when this relationship is mutual. In both settings, the participants aspire to broaden and deepen the understanding of motives, relationships, and other human phenomena, and develop their identities. In addition, in both situations, the more experienced participant creates an intersubjective environment for the other, in which he or she can advance personal growth processes.

Another similarity that is found when comparing the roles of therapist and supervisor is their respective attitudes toward regressive states with which the partner in the dyad experiences. Supervisors are becoming increasingly and cautiously open to their own and to their supervisees' regression in order to access important analytic material. This new stance further develops the belief that regression is inherent in the structure of supervision and is one of its natural characteristics— similar to regression in analytic therapy (Baudry, 1993; Gross Doehrman, 1976; Frijling-Schreuder, 1970; Sarnat, 1998; Glover, 2002).

The limited regression experienced by supervisees in the course of supervision, which is called "learning regression" (Watkins, 2013a), might appear similar to patients' regression and is characterized by "[A]ffectively intense, cognitively primitive, usually nonverbal experiences" (Frawley-O'Dea, 2003, p. 360). Moreover, Sarnat (1998) believes that regression in supervision is a controllable mental phenomenon and that supervisees

exercise some degree of unconscious or preconscious choice as to how much they will allow themselves to regress. Sarnat also believes that if the regressive experience does, at times, feel overwhelming to the supervisee, the supervisor's tactful and open response can help the supervisee to integrate the regressive experience in the service of learning without suffering undue feelings of shame or exposure.

However, some unique characteristics of the supervisory situation call for a modification in terms that have been borrowed from either therapy or supervision and implemented in the other area. One of the important characteristics described in the literature on supervision depicts supervisors as experienced and responsible colleagues who accompany the therapeutic process from a broad and somewhat distant observation stance, facilitating the development of the therapy and the development of the supervisees' professional identities. An external stance such as this is required to spare supervisees from feeling inferior in the shadow of the supervisors' expertise and to allow them to choose an independent therapeutic stance (Levenson, 1982).

Supervisors are advised to assume an attitude that is both supportive and empathic, but less involved and somewhat detached, located outside of the ongoing therapeutic process and with an external perspective (Ungar & de Ahumada, 2001; Zachrisson, 2011; Anastasopoulos & Tsiantis, 1999; Schlesinger, 1995). In the same vein, Crick (1991) likens the supervision relationship to the parent-child dyad and believes that the supervisor's role can be compared to the father's role in connection with the developing mother-baby relationship; protecting the mother-baby dyad from external intrusions and impingements, allowing them the liberty to develop close mutual acquaintance.

In addition, the analytic literature has identified various goals which divert the area of supervision away from that of therapy. These goals include working on parallel processes (Gediman & Wolkenfeld, 1980); managing the supervisee's narcissistic vulnerabilities (Brightman, 1984); processing and digesting the analytic material in the course of supervision (Ogden, 2004; Ungar & de Ahumada, 2001), and investigating the triadic intersubjective matrix of the patient, therapist, and supervisor (Berman, 2000; Brown & Miller, 2002), in which there is greater mutuality and partnership in responsibility (Frawley-O'Dea, 2003).

Thus, it appears that the existence of both similarities and differences between the two professional activities enables cautious borrowing of some basic concepts from one of the areas to be implemented in the other. However, this implementation necessitates some modification in the borrowed theoretical and technical concepts.

In the next section, I will describe two of the supervisor's functions amid supervisee-therapists' coping with the challenges in therapy and the development of the identity as analytic therapists. These functions are described in terms borrowed from the area of therapy and described in the literature as characteristic of the therapist's functions.

Holding Supervisees in Mind and Responding to Their Selfobject Needs

The goal of psychoanalytic psychotherapy training includes the evolution of a professional identity for therapists (Werbart, 2007), which entails developing the competencies to establish and maintain a psychoanalytic setting; to be attentive to unconscious processes as they unfold in the analytic relationship; to reflect on the dynamics and contents of these processes and transform their understanding into sensible interpretations (Zachrisson & Zachrisson, 2005); to form, endure, and end a relationship; to sustain a relationship while under attack; to tolerate hating and being hated without withdrawing or acting out; to take

risks and suffer the consequences, and to sustain intense feelings without always understanding what they mean (Wheeler, 2002).

To achieve these aims, supervisors work to establish a secure learning alliance that is founded and grounded in empathic attunement, mutual respect, and an ethos of empowerment (Watkins, 2013b); to develop and enhance the supervisees' analytic conceptualization and intervention skills, and to acquire and refine their analytic attitude (Jacobs, David, & Meyer, 1995; Lane, 1990; Pegeron, 2008; Rock, 1997). Supervisors strive to deepen the supervisees' understanding of unconscious processes and transference and countertransference dynamics, and of the appropriate interactive processes in relation to the patient's pathology (Wheeler, 2002; Driver, 2008). During their training, the supervisees develop these competencies and construct an "internal supervision". Internal supervision is a function in which therapists can hold a silent dialogue in their mind in the presence of their patients, with the aim of monitoring their own thoughts. This self-reflexivity contains, specifically, an attempt to listen to oneself by putting oneself in the patient's shoes (Casement, 1985).

The complex process of the development of a professional identity as an analytic therapist is often accompanied by painful moments, like any other developmental process (Waterman, 2002). Some writers, such as Bion (1970), emphasized the pains of growing: "Of all the hateful possibilities, growth and maturation are feared and detested most frequently. This hostility to the process of maturation becomes most marked when maturation seems to involve the subordination of the pleasure principle and the emergence of the reality principle" (pp. 53).

However, we need to keep in mind that the transformative road of professional maturation might sometimes be hard and at other times thrilling and also involves many moments of happiness and pride as challenges are overcome (Glick, 2003).

Thus, supervisors witness their supervisees' strong emotional vicissitudes in the process of discovering their professional strengths as well as their limitations while on the road to maturation as professionals (Brodbeck, 2008; Garza-Guerrero & Laufer, 2004; Kernberg, 2011; Wallerstein, 2011; Barish & Vida, 1998).

The sense of personal history may suffer greatly because of such emotional vicissitudes (Beebe & Lachmann, 2003; Ogden, 2004), which might damage what Winnicott (1971) called "going-on-being" and which others called a "temporal experience" (Ferraro & Garella, 1997; Meissner, 2008). These two concepts, which overlap and both deal with the sense of the passage of time or of the flow of life, represent a feeling that we take for granted as part of the existential experience, and that we sense mainly when it is shattered. When this experience is interrupted, we sense the undermining of our internal harmony.

Thus, supervisors register in mind all these developmental vicissitudes arranged along a time continuum as components of the incremental struggle for identity formation. The supervisors' role of *holding the supervisees in mind* resembles the parental role with children. Children who do not find themselves held in their parents' minds will grow up unaware of their own minds, and without the sense of an authentic, essential, personal self (Fromm, 2006). In contrast, children who are held in mind by their parents throughout the years will grow into human beings who are capable of understanding the states of mind of others and develop an intersubjective self-experience (Bromberg, 2012; Harris, 2009).

Similar to the parental role and the therapist's role of keeping track of the other's growth as a human being (Seiden, 1996; Ullman, 2006; Orange, 1995), supervisors also keep track of the supervisees' professional and personal development and register it in

their own memory. When supervisees are held in mind, they are capable of forming a perception of who they are as people and as professionals, who continue to develop and be capable of holding others in mind.

The supervisors' holding of the supervisees in mind is expressed through supervisors occasionally thinking about the supervisees, both in their free time and within the professional involvement. They might speculate about the supervisees as practitioners and as people, and wonder how they are coping with the complex issues that arise in supervision. Thus, supervisors remember therapeutic events on a time continuum and succeed in preserving within themselves the sense of the flow of time. The supervisors' ability to see the overall picture, the whole gamut of events and not only the most recent or most disturbing among them, prevents them from being carried away into disharmony within the supervisee's experience.

Another important aspect of the supervisor's role in coping with the supervisee's emotional flooding and fluctuation in self-experience, is providing him or her with *selfobject needs* (Pegeron, 1996; Crastnopol, 1999; Gill, 1999; Lhulier, 2005). Selfobject needs, which include mirroring, idealizing, and twinship needs, refer to the use of the other for the purposes of development, maintenance and regulation of the self (Fosshage, 1997; Kohut, 1984). This function which is assumed by supervisors is highly significant since supervisees' vulnerability arises in supervision when they are required to demonstrate clinical and emotional abilities and intuition, when they express regression following self-disclosure and when they idealize the supervisors (Mordecai, 1991; Gill, 1999; Mintz, 2006; Teitelbaum, 1990; Alonso & Rutan, 1988). Thus, the way that supervisees cope with both the therapy and the supervision in which they participate might undermine the narcissistic balance and threaten their sensitive, vulnerable self-image with experiences of embarrassment, humiliation, and threat (Brightman, 1984; Alonso & Rutan, 1988; Morrison, 1986; Fuqua, 1994).

Furthermore, the learning experience in supervision involves a necessary dismantling of psychological structures and the restructuring that follows (Fuqua, 1994). The process of structural change in supervision is similar to that of structural change in the treatment setting, which follows an inevitable "disruption/restoration" sequence and in which the supervisor attends to the supervisee's vulnerable self-esteem. These disruption of mismatches occur when it is difficult for the supervisor to understand the supervisee's approach, creating mutually frustrating and undermining scenarios (Fosshage, 1997). The supervisor's participation in such cases needs to include actively listening from "within" the supervisee's experience and validating it and the supervisor and supervisee must be able to recognize openly and discuss collaboratively any matters concerning their relationship's ruptures and to initiate reparative measures. Only then can the bond between supervisor and supervisee be further forged and fortified against future assaults (Watkins, 2013a; Wolf, 1988, 1993). In these processes, supervisors need to provide the supervisees with the selfobject experience, thereby helping them to preserve the excitement, vitality, and wish to grow (Lachmann, 2003; Orange, 1995; Seiden, 1996).

The two analytic concepts—holding in mind and providing a selfobject experience—are borrowed to describe the supervisor's position aimed at preventing disruption in the supervisee's sense of continuity and self-experience. However, it appears that these concepts need to be modified and adapted to the supervisory context. In light of this, in the next section, I propose that the metaphor of the witness, which seems to contain both of these concepts, enables this adaptation.

The Meaning and Use of the Concept of the Supervisor as Witness

In the analytic literature, the therapist as witness is portrayed as an observer who listens to a patient's story from a participatory yet external position. In this role, therapists are not actively involved in the witnessed events, but still have a significant emotional and ethical impact on the development of the therapy. It seems reasonable to assume that the role of therapist as witness is especially recommended in cases of therapy with traumatized patients, also because this role can protect therapists from secondary traumatization. This role may be protective for therapists because it keeps them at a safe distance from the storied traumas, thereby increasing the therapists' ability to help the traumatized patients' to cope because they themselves feel less vulnerable.

The role of the therapist as witness as described in the literature contains the two analytic functions of providing the patient with a selfobject experience and holding the patient in mind. It provides patients with the reassuring and calming presence of the therapist, who registers and holds in mind the patients' feelings, actions, and communications. However, the role of witness does not only include these two analytic functions, but it also changes them, by giving them an external and more reserved meaning. This change is well needed for supervision not because of a necessity to protect supervisors from secondary traumatization. It is mainly needed because supervisors do not only accompany and facilitate the supervisees' growth, but also need to evaluate them and to provide them with broad clinical and theoretical knowledge. It also seems to help supervisors to separate themselves from the metaphor of parents, which fits the therapists' role so well, when they encounter supervisees' emotional flooding and unstable self-experience.

Supervisors' role as witness provides an empathic presence, which helps to calm and reassure the supervisees and makes them feel seen by the supervisors. This experience of being seen by another enables supervisees to feel they exist, which in turn builds up in them an experience of "creative apperception" (Winnicott, 1971, p. 65). When experiencing such creativity, supervisees can experiment more freely with ideas and perceptions and can come up with creative solutions for clinical and analytic issues.

Supervisors' role as witness with beginner supervisees should apparently include clear demonstrations that they actually see the supervisees, such as mirroring interventions and clarifications. Inexperienced trainees facing the novelty of the psychoanalytic encounter with its multitude of interactive dimensions, and equipped with relatively poorer skills, are more likely to fluctuate emotionally and experience disruptions in their sense of continuity. They are prone to feeling anxiety because of the mixture of unconscious fantasy, high expectations, and personal vulnerability. This anxiety is aroused when they confront the relatively new complexity and ambiguity of clinical work (Rosemary, 2009).

Beginner therapists are also more likely to depend on supervisors and mentors to alleviate this anxiety and to provide reassurance in challenging clinical situations (Davis, 2008). At the same time, inexperienced trainees may be more inclined than the more experienced ones to respond with relief, a sense of achievement, and joy when overcoming these clinical-analytic challenges. Therefore, we may expect more threats to the sense of continuity and self-experience in the primary stages of the professional development than later, when supervisees have adopted analytic knowledge and clinical strategies. It is because of these reasons that beginner therapists need more concrete and clear demonstration of the supervisors' presence.

For the more experienced clinicians, the supervisors' role as witness is helpful mainly (a) in crisis situations in the course of the supervisees' coping and developing as

clinicians, which may be caused by personal issues or a combination of countertransference reactions and patients' crisis situations and regressions, when the functioning of experienced supervisee-therapists will resemble that of beginners; and in (b) ongoing supervisory work, when the supervisors' role as witness is characterized mainly by creating an intersubjective space in which the supervisees can be seen and feel more creative than when acting alone. The role of witness among more experienced supervisors provides mainly a marginal affirming presence without the need for clear evidence of the fact that they see their supervisees.

It is important to note that the witnessing role of supervisors can somewhat less effectively fulfill the supervisors' functions of selfobject and of holding the supervisee, in some cases. Thus, for example, when supervisees feel highly anxious in the role of therapist, they may need their supervisors to show more direct, active and explicit gestures of support than merely reassuring them by acting as witnesses. Similarly, when the supervisory relationship is not experienced as stable and solid, the witnessing role of supervisors may invoke further insecurities in the supervisee. In addition, supervisors who are less comfortable with the relatively less active position of observer may find the witnessing position somewhat frustrating and limiting. However, in most cases in which a secure supervisory relationship has been established and the supervisees feel contained by the supervisors, the witnessing role of supervisors is likely to strengthen and reassure supervisees in their coping with clinical challenges and their developmental struggles.

Vignette From Supervision

A supervisee brought a therapeutic process to supervision, which he considered to be significant for his development as a therapist and which strengthened his self-image as an analytic therapist. He felt that the patient was gradually learning to relinquish some of his social anxiety and to believe that he could create nondestructive relationships with men, the more constant and consolidated the patient-therapist relationship became. However, whenever the supervisee-therapist sensed a regression in the therapy, or when the therapy was not developing at the anticipated pace, he became despondent and sensed damage to his self-esteem as an analytic therapist.

The supervisee had been in the supervisory relationship for approximately seven months and felt that, to an extent, it served as a healing experience in relation to previous problematic supervisory relationships. In the past, he had felt hurt by the supervisors' lack of appreciation of him, and had felt unable to process this hurt in the supervision sessions because he lacked the self-confidence to ask for deep and honest clarification. In the current supervision, he felt increasing trust in the supervisor and in the honesty of her intentions, but still had difficulty in believing that he would not be hurt in the future. In one session, the supervisor and supervisee discussed their relationship. They identified a similarity between the process of gaining trust in supervision and the process undergone by the supervisee's patient, who had difficulty trusting the supervisee-therapist, just as he had difficulty trusting other men who had hurt him in the past. At the end of the discussion, the supervisor said, "Sometimes, I feel as though I am hesitating before reacting to the therapy story that you bring to supervision, because I am afraid that you will be hurt by my comments. It would be worth thinking together about how we can increase the trust between us."

In one of the supervision sessions, the supervisee described a recent therapeutic encounter with his patient, in which the patient explained that he would not be able to

attend a particular therapeutic session for family reasons. As this had come up toward the end of the session, the therapist–supervisee told the patient that he understood his difficulty in attending the session, but suggested that they continue to discuss this issue next time, because it evoked in him thoughts about the therapy, including how he himself had contributed to the situation as it was. He also said that he believed that the patient would have something to say about the recent developments in the therapy, which might be better expressed in a more relaxed atmosphere, when they would not be pressured by time or other factors. In the next supervision session, the supervisee told the supervisor the following:

I felt that the patient was not making a special effort not to cancel this session, and maybe even preferred that it would be canceled. I believe this indicates a regression in the therapeutic relationship, which gives me a feeling of helplessness. I thought that the patient was actually engaged with the therapy and would have made every effort to maintain it, and this incident disappointed me.

The supervisor tried to understand why the supervisee had reacted so strongly to this incident because it was not the first of its kind, and they had extricated themselves from previous “tumbles” in the therapy in the past.

The supervisee explained that cases such as this raised his self-doubt in his ability as an analytic therapist to release his patients from their ingrained long-term difficulties. He said that in order to sense his value as a therapist and to avoid becoming depressed as a therapist, he had to see his patients undergoing a process of improvement and constant progress, even if this progress was slight. A sudden regression to past schemas was an indication of no advancement in the therapy, which led to his feeling a sudden decrease in his ability to cope and in his desire to fight to advance the therapy. The supervisor replied as follows:

Continuous advancement in the therapy gives you the strength to invest emotionally and to fight for the development of the therapeutic relationship, but when this continuity is broken, it seems that you may be flooded by feelings of depression and a lack of strength.

This thought about how continuity in therapy was important for the supervisee brought the supervisor to mention another continuum, related to the supervisee’s experience, and which could apparently help him in those crisis situations when he felt despairing and helpless in the therapy: this was the continuum of the supervisee’s development as an analytic therapist gradually acquiring tools and capabilities. The supervisor reminded the supervisee of at least two similar situations in the past, in which he had been worried about the development in the therapy, but had not created a secure and inviting space in which he and the patient could deal with these questions as spontaneously and naturally as he had just done in the session they were discussing momentarily in the supervision. The supervisor reminded the supervisee that, in one of these instances, he had urgently sought complex analytic explanations to interpret the patient’s behavior. On another occasion, he had considered examining with the patient whether he believed that the time had come to end the therapy. However, in the last session brought to supervision, he had not acted on this, but had created a space to discuss the transference–countertransference issues.

The supervisor drew attention to the supervisee’s progression as an analytic therapist, when he had not disregarded the patient’s emotional regression, and had reacted appropriately and consistently with clinical–analytic values, despite being flooded by difficult emotions. He chose to invite the patient to perform a joint, relaxed observation in real

time, in a setting in which they would be able to process the difficulties in the therapy. At the same time, he hinted to the patient that he himself was also making a partial contribution to the problem in the therapy, which would be clarified in their future discussion, and which would certainly enable a more open and honest dialogue between them. The supervisor stressed the fact that the supervisee had chosen this mode of action despite his despair at the patient's return to his previous problematic schemas, and had implemented analytic tools to cope with the problem in the therapy. She added also that understanding the importance of the safe space in which he and the patient would be able to "play" with ideas, perceptions, and understandings was an important development for him. When his emotions plummeted and he had become depressed following regressions in the therapeutic relationship, he had not returned to the same place, but with each instance, he had returned to a more organized and safer position as a therapist. Hence the supervisee's developmental continuum as an analytic therapist was manifest by internalizing clinical-analytic values and stances and demonstrating greater ability than in the past.

The supervisee commented on this as follows:

Each time I fall into despair, when this kind of thing happens, it takes me back to my all-too-familiar negative self-image from the past. Nevertheless, I think that I am internalizing the analytic solutions more and more, as well as the importance of creating a potential space to speak openly about the relationship with the patient. Such a solution, even if it cannot promise an improvement, might be a way of coping with the despair that takes hold of me in these situations.

The supervisor spoke not only of the developmental continuum of the supervisee's clinical-analytic capabilities, but also of greater continuity in the supervisee's experience as a therapist because of his internalization of clinical-analytic concepts. It appears that strengthening the supervisee's sense of continuity in his clinical struggles and his professional identity helped him to avoid sinking into despair.

In this vignette, the supervisor chose to remind the supervisee of his developmental continuum, to lay before him a broad, historical view of his development as a therapist, as reflected in the supervision. The supervisee's professional-developmental history holds emotional vicissitudes for him as he experienced successes and failures when encountering serious challenges. Some of these experiences stemmed from emotional reactions to supervisory relations, but belonged mainly to his struggles with transference-countertransference issues. These oscillations in his self-esteem and his self-image as a therapist had apparently caused disruptions in his sense of going-on-being and undermined his vulnerable professional identity.

The supervisor could have addressed the countertransference schema displayed by the supervisee-therapist, of sinking into despair and depression, as a defense against the possible desire to blame the patient and to be angry about his emotional retreat from the therapy; she might have suggested different ways for the supervisee to cope with this complex situation in therapy, including intervention methods such as mirroring, confrontation, or interpretation of the patient's transference; she could have spoken about the supervision relationship and its parallel process to the therapy, in which issues of lack of trust and regression sometimes arose because of previous hurt.

Any of these possibilities appeared to be reasonable and feasible in the supervision situation described above, and they might have led to meaningful achievements in supervision. However, the supervisor chose to act from an active role of supervisor and

offered a broader perception of events, of which the supervisee was a part, and in which a developmental continuum could be identified. In this manner, the supervisor succeeded in assisting the supervisee to give a broader and more comprehensive meaning to the transference–countertransference events, which led to his despair and depression. This broader meaning changed the supervisee’s state of mind regarding the development in the therapy and was likely to have created within him a greater sense of wholeness and calm, which would accompany him in other therapeutic cases.

It is important to note that the supervisor’s memory and wording did not constitute a recording of the history of the therapy: She organized the events and told them in a way that reflected her beliefs and subjectivity as an analytic therapist. This unique organization was appropriate for the supervisee’s unique personality and, of course, influenced him differently than how it would have influenced others. This type of intervention by the supervisor encouraged continued identification with the supervisee and with his analytic therapy method.

Conclusion

If supervisors accept the tenet that the function of witness is important for the supervisees’ development and for their ability to cope with challenges in the therapy, this might reduce some of their pressure to reach insights about the supervisees’ therapy sessions and to find clear answers to dilemmas that arise. They are also likely to be more preoccupied with questions such as: How can current developments in the therapy be registered in one’s memory and how did this supervisee previously cope with similar therapeutic phenomena? Or, what is different about the supervisee’s experience at this point in time compared to the past? A perusal of documentation from previous supervision sessions can obviously be of assistance here, but cannot fulfill its purpose without the simultaneous effort for mental registration of the supervisees’ events and experiences.

The supervisor’s role as witness is also important in relation to supervisees’ pride and joy in their personal achievements, and in relation to the heights of personal and professional development that they have reached, as well as the ability for self-containment and recovery from the points of weakness and despair in the therapeutic experiences. Witnessing that sees, registers, and remembers such emotionally moving situations as these contributes to the creation of an important and advancing developmental-therapeutic experience for supervisees. The supervisor-witness holds the high achievements, capabilities and skills in mind, serving as testimony for the supervisees, who tend to forget about these merits when they are at critical points of their developmental struggles and crises. As such, the supervisor takes on the role of selfobject for the supervisee.

At this point, I wish to clarify also that the supervisor as witness does not preserve an objective picture of reality and does not eventually provide the supervisee with a precise and objective reminder of those points of reference and events. The supervisor’s perceptions are like those of any other person: influenced by his/her own unique organization of the experience, and are, therefore, subjective and biased. Supervisors’ biases are linked to the initial, automatic reactions, as with any other person, and to their own characteristic constructions; to characteristic anxieties; to the mechanisms of coping with these anxieties and to the compromises enforced by these mechanisms in the organization of their perceptions; to fantasies and to the wishes on which these fantasies are based; to their blind spots and to their own areas of trauma in different fields of experience, and so on.

The supervisors' biases and subjective organization will cause them to perceive and to hold in mind the specific events and milestones in the supervisees' development, and to present them later to the supervisees in specific and subjective manners. Nevertheless, the supervisors' perceptions and the way in which they organize the supervisees' therapeutic and personal material are derived from a stance that is involved and empathic, but simultaneously more distanced and broader because of their intention to serve as witnesses.

This perception of the analytic supervisor's role as witness emphasizes the relational perspective of the supervisees' development of a clinical-analytic identity. It clarifies that this is not merely a case of an internal-individual developmental process, in which the supervisee experiences internal developmental struggles between different internalized voices of his or her teachers and supervisors; it is an actual developmental process that occurs in an intersubjective context, in which the presence and the reactions of the participating other—the supervisor—are essential and contribute to the shaping of this process. Transference-countertransference developments and the mutual enactments that the supervisee experiences and conveys to the supervisor take on important additional meanings out of this unique intersubjective experience, even before the supervisor's interpretive involvement. This context has a similar influence on the supervisees' efforts to formulate and organize a professional identity as analytic therapists.

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