

Group Supervision in a Retreat Setting: The Continuing Process of Becoming a Psychotherapist

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Supervision has long been regarded as essential to the training of psychotherapists, but is usually not required after qualification. However, we are convinced that it is also essential for senior and experienced clinicians.

Group supervision is often difficult and painful, but with trusted colleagues it can facilitate growth and improvement. This paper describes the 'supervision retreat', an innovation in which a group of senior clinicians satisfy their supervisory needs on a regular and systematic basis: eight psychotherapists, all of whom have known each other and have worked together previously, travel once a year to a place far removed from their usual domiciles to meet daily for group supervision.

Literature Review

Much has been written about individual supervision as essential to the training of therapists practising either individual or group psychotherapy. Group supervision of therapists, being a recent development, has been described by only a few writers. Larkin et al. (1969) explored the importance of group supervision as a facet of the group therapist's training. A strong case for the use of the group process in supervision was made by Glatzer (1971), describing the value of transference, resistance, and defence mechanisms as 'illustrated *in situ*'. Elizabeth Mintz (1968) noted that since the supervisory process can be biased by personal limitations of the supervisor, group supervision decreases the likelihood of such bias.

Although group supervision is not a substitute for personal therapy, it is a valuable form for examining the emotional reactions of a therapist towards a patient. We agree with Mintz (1968), when

she says: 'A difficulty with a patient which appears to involve only a lack of clarity in theoretical understanding, or a lack of technical skill is usually based on an unrecognized emotional reaction of the therapist towards his patient; that is, a counter transference, but counter transference in a far broader sense than is used in classical analytical terminology, involving the full realistic and unrealistic spectrum of the therapist's reaction.' Another principle discussed by Mintz (1978) is the emphasis on the experiential component so that the therapist can 'demonstrate' *in vivo* what problems belong to him and what belong to the patient.

This paper goes beyond what has been described in the literature as useful in the teaching and training of psychotherapists. It applies the basic principles of supervision to a ten-day retreat with senior clinicians: the 'full realistic and unrealistic spectrum' of the therapist's character as seen throughout the retreat becomes open for scrutiny. We think the retreat setting allows a depth and intensity of supervision not possible in previously described settings.

The Development of the Retreat Model and its Rationale

Since the first retreat in 1977, most participants have been colleagues working in the same private practice. This group has consisted of a psychiatrist, social workers, and a psychologist. While the number of therapists working in the practice has varied, its general character has been constant. Each patient is seen individually at least once a week and in an on-going psychotherapy group twice weekly. Two or more therapists are present in and conduct each group. The psychiatrist is additionally involved intimately with each patient since he rotates as an active therapist among the various groups. Each patient is well-known to all of the therapists who meet together regularly before each group and at the end of the day to discuss each patient's experiences. Although every patient works with one main therapist, a team approach is the model applied. All the therapists know all the patients and are directly involved with them. This has fascinating and useful implications in terms of the vicissitudes of the multiple transferences, as well as in terms of the real relationships among group members and the therapists.

Because the psychotherapeutic theoretical model used in this practice demands constant self-reflection, the therapists have as a routine met in two-hour weekly group supervision sessions for many years. Any difficulty in the treatment of a patient is initially regarded

as probably indicating an unrecognized problem of the therapist, rather than faulty technique or patient resistance. We have recognized throughout the years the necessity of exposing our own difficulties to the supervision group members, despite the anxiety and embarrassment which cannot always be avoided. Since we have all agreed in principle that nothing should be left out of these sessions, such supervision is similar in many respects to the psychotherapeutic process. A crucial difference lies in recognizing that the therapist's needs are secondary to those of his patient. While the ground rules encourage openness, regression and expressions of transference feelings are strongly discouraged.

Over the years we began to see a need for additional supervisory experience and finally it was decided to meet in a distant location for several days to examine clinical and supervisory issues. This useful experience has continued yearly since 1977, each retreat lasting seven to ten days with morning meetings of three-and-a-half hours. There has been no designated leader, but each day one participant presents a case with which he is having difficulty. The afternoons, reserved for informal discussion and recreational activities, provide a setting for working through issues stimulated in the morning meetings. Why meet in a remote location? Why could not the group rent rooms in a local hotel, or even return home after each session? The intent of the retreat is to live together intimately as if under bright spotlights so that nothing is hidden and all aspects of the therapist's character are open for scrutiny. Physical removal to a place distant from one's usual external support systems tends to bring out the best and worst in one's character. This is revealed not only in case presentations, but also in how one lives with colleagues, behaves on a sight-seeing excursion, eats and sleeps, or drives a car. As we ask our patients to expose and examine every aspect of their lives so too must we.

Supervisory Examples

In the first two examples, the focus of supervision is not on technical considerations, but on how the character of the therapist has an overriding influence on treatment. The case material therefore becomes relatively unimportant and is at times almost ignored.

Edited for clarity and brevity, the following excerpts from our retreats in Spain in 1983 and in Arizona in 1984 convey the flavour of this sort of supervision, illustrating the depth of exploration which can be experienced in the retreat modality.

Supervisory Example A

In his one-page case summary, the Supervisee (S) recognized that despite various attempts to mobilize Mr R's anger, psychotherapy was at a standstill and in danger of premature termination. Early in the session, S was able to speak frankly and with pain of how important it had been for him to be loved and accepted by others. It became increasingly clear that he did not welcome his patient's anger, and might be unconsciously discouraging it. As this excerpt begins there had already been more than one hour of work which highlighted S's character traits. His halting speech and long pauses had been addressed by several of the participants as passive demands. Several times it had been pointed out that S, like his patient Mr R, was a 'nice' man who was not comfortable asserting himself or openly demanding. Just prior to this excerpt there had been general discussion of the way S and some of the other participants tended to protect themselves from fear and disappointment by isolating themselves from others, living inside their 'own little worlds'. This was the same character defence upon which Mr R relied. S was silent and somewhat withdrawn as the rest of the group, refusing to cater to his passive demanding, engaged in a lively, somewhat lighthearted but nonetheless serious discussion on the importance of firm fathering in helping someone to leave 'his own little world'. S's reaction was a marked departure from his usual ways, and was an example of one step towards the character modification which would help him to deal more effectively with his patient:

B: There is a story about God who came to a nation with the Ten Commandments. He said what was written in them: 'Thou shalt not steal.' The people of the nation said, 'We cannot live like that.' He came to another nation and He said, 'Thou shalt not kill', and they said, 'Sorry, we can't accept it.' He came to a third nation and said, 'Thou shalt not commit adultery.' They also said, 'Sorry God, we cannot live this way. Why don't you give these rules to the Nation of Israel?' But when He did, they also refused. So God got angry and said 'Listen, you take it or else I'll cram it down your throats!' 'Well, okay! Okay!' they said, 'If you force us, we'll take it! We'll take it!' (General laughter.) So, that's why the Jewish Nation got the Torah. They didn't say, 'Oh God, please give us the Ten Commandments!'

J: They had no choice.

P: I'm sure that's literally true, though. Moses forced it on them.

N: That's right and he broke the calf . . .

B: Little kids, the Israelites. (Multi-conversation while S sits passively. Finally . . .)

S: Goddam it! (He is indignant. Then he pauses, like many pauses earlier in the session.)

J: Again you wait expectantly!

S: I don't like what is going on! (He is hurt and angry! Again he pauses, expecting others to alter their behaviour.)

T: (Sarcastically confronting S's narcissistic expectations.) Look at him, with the big blue eyes. 'I don't like what's going on!' So? What do you expect us to do?

B: (Encouraging S's nascent efforts to overcome his passivity.) So? Continue.

T: (Serious, but lightheartedly addressing how B partially plays into S's system.) And you tell him what to do!

S: It's very — I mean, it sticks in my throat when I say, 'I don't wanna!' I don't wanna leave my withdrawn position.

P: I think that you have just now proved you have a strong wish to stay there because rather than joining us where we happen to be at the moment, you wanted to . . .

S: (Adamant) I don't want to!

P: I know. You don't want to! That's exactly right. You want to stay in your own little world. I'm like you in that respect.

J: It stuck in my mind, why does Mr R stay in his apartment all by himself?

H: I wouldn't hesitate to guess that he must identify with his mother: pull down the shades and stay in the house.

B: Oh, yes.

J: That's his little life and he is willing to settle for that.

B: There is so much confusion about you and him, him and you. If you don't want to leave your favourite helpless spot, then surely you wouldn't want to push R beyond that spot yourself because it endangers the spot where you live. You say here on the write-up, 'Although I have a good relationship with him.' I don't think you have a 'good relationship' with him, you have had a honeymoon. It is coming to an end and there is no 'good relationship' to replace it. In a good relationship there's no honey; there's reality, there's sometimes anger, there's sometimes love. Whatever there is, is! I also wondered how you know he has

a good relationship with his children. When a man is damaged in this way, what is the likelihood that he has such a good relationship with his son and daughter as you claim? Perhaps that is also a projection in that you would like to see yourself having a good relationship with your own children. Maybe it is not as good for you as you hoped, and therefore you protect both yourself and R from a painful reality. For all I know, your son is angry at you if you are so much less smart than him as you said earlier.

S: I think some of it is true. (His voice sounds matter of fact, as if B's words have no emotional impact.) I think that the struggle I'm having at the moment is that what B said is partly true; that my relationship with my son — (He stops, trying to evade the painful issue.) But it's also how I present it, you know. I present it in a different way than it actually is.

N: We all unconsciously present things exactly the way they really are. That is the nature of this process we're engaged in. By writing so much about Mr R's family, you write about your own.

B: That's exactly what I said. But I don't think he heard it yet.

S: I did hear it! I DID HEAR IT!

A major shift in the process occurred at this point as S went on tearfully to speak candidly about his worries and disappointments regarding his own family in a way none of us had heard before. He had clearly left his 'own little world' and was more intimately involved than usual. The mood of the group shifted from confrontive to supportive as S was encouraged to go further. The implications regarding the treatment of R were obvious as he continued.

Discussion. The highly confronting, painful work just illustrated could not be usefully undertaken without a supportive environment and trusted colleagues. S had known and worked with the other participants for many years, and had attended several previous retreats. Having had previous but useful experiences with this same group of people, even knowing that he had just had breakfast with them, served to support the fact that he was among friends even when the going got rough. Clearly Mr R needed to do in his own therapy what S had just done in his supervisory session.

Supervisory Example B

The following example does not illustrate the process of a group supervision session as did example A, but instead reflects the quality and intensity of the retreat process as an entity. On the day before example B, another participant had a difficult supervisory session which troubled all of us. Becoming anxious within the early minutes of the presentation, he had become silent and remained so for many minutes. Because others had observed this tendency in him on previous occasions and knew that it was intended to elicit coaxing and cajoling, they had been reluctant to join this system and said almost nothing during the long period of silence. In fact, several of the group had resolved that at a certain time, they would leave the session and tend to other matters. This session will not be discussed further except to say that eventually the man had acknowledged his acting-out and its influence on his work with patients. It is mentioned here because in example B reference is made to that troubling session. In what follows, the presenter seems to need very little help as he explores the issues at hand, apparently making excellent use of the safe environment referred to throughout this paper:

S: Before I talk about the patient, I would like to say that this time with you people has been very, very important to me. I find myself to be in a very comfortable place. I feel safe. I am not guarded, like I have to watch over my shoulder to see what is going to happen.

The issue I want to deal with is how I am sometimes soft-hearted, soft in my mind, soft in my ideas as to what is proper in terms of doing the right thing. Earlier, I told you I know that my patient, C, will not pay me the \$1,400 she owes. I saw her once a month and now once every two weeks when she pays me for the individual sessions. I was thinking of reducing her individual fee so she could have more sessions, but I think it would mislead her. Perhaps my thinking is soft.

B: Well, why not reduce her fee? Let's start here. You assume there's something wrong with it.

S: I can explain why it is the right thing to do. Things have been rough for her and now she has gotten a job and wants to stay in therapy. She thinks that therapy is literally life-saving to her and I also think so. I think that if she is out of therapy, it is like shutting the door on her grave. So in that sense, to continue her in therapy would be the right thing to do. On the other hand, to reduce her fee would be

fostering this pathological system in which she sucks like an infant from the world, from society, and from her father and mother. From everybody. That is how she survived in the world and then she would be doing the same thing with me.

B: But that is not the point. You're not trying to talk about why a reduced fee would be wrong for her dynamics. In your write-up I got the impression that you wanted to explore the possibility that your judgement may be faulty because of your wish to be a helper, whether it makes sense or not. These are different issues. You shift from one to the other because you're embarrassed.

S: For the last year or so I've been aware that I have been embarrassed to talk about some fantasies I've had. When I get angry with my wife for example, I imagine she will go into the bathroom and cut her wrists. Same thing with others. I express my angry feelings and they kill themselves. When I talked to J yesterday, I thought about how my mother had actively attempted suicide several times. She talked about it in relation to the death of my uncle when she became very depressed and was taking some medication. I don't have any other information and don't know how to find out more.

T: Isn't there someone in your family who would know?

S: Maybe an aunt.

T: I'm asking the questions because I wondered why you never tried to find out if it's find-out-able.

S: I've never tried to find out. It is an issue that kind of comes up. I didn't even remember I told you the issue. It just hit me again when I talked to J. And I have never thought it through or talked about it, not even in my therapy. I've treated it as my mother did. For a long time, she kept everything away from everybody. She wouldn't share with relatives anything that would happen inside our family. (He continues for a few minutes, recalling how it was to be his mother's son.) So I saw the family through her eyes for a long, long time. I'm just free associating or just telling you stories about . . . I'm a little bit embarrassed about it and I don't want to go on.

T: About being a helper?

S: Yeah. (Pause) Well, being a helper has been sort of my rôle in life. I remember that it was my job, when I saw my grandmother walking, to go grab a chair and run towards her so she could sit down half way across the courtyard if she got tired. She was the queen of the family. And you see, I prided myself in being her helper.

H: Being an excellent servant.

S: To come in so quick. My father would love me for taking care of his

mother. (He is in pain, embarrassed.) I'm getting hot, I'm boiling inside. (Pause) It was a nice thing to do. So, I was a good helper. Excellent, not good.

B: So, what is implied is that to be your father's son, you have to be your grandmother's servant.

Discussion. As the material continued to unfold, S saw clearly the sources of his 'soft-heartedness' and began to separate archaic wishes to be a 'helper' from the clinical issue of helping C with her illness.

Later in this session, references were made to everyday examples of S's characteristic tendency to 'bring a chair' to others. For example, on the previous day he had stopped his car to buy a bag of oranges for the others. It was a nice gesture, but in the context of what had just been discussed it was clearly conflictual. Someone else noted that S was often the one to pay when we had coffee or wine before dinner. Another participant suggested that he make a conscious effort not to buy drinks, oranges, or gifts for the rest of the retreat. With embarrassment, some of the other participants spoke about their tendency to wait for someone else to pay the bill, as if expecting a 'chair' to be brought up to them. Also related was an incident in which three of the participants got lost driving around the old section of Seville. Temporarily overcome by their anxiety, they had expected others in the car to 'bring a chair' by pointing the way out of the traffic maze they were driving through for two hours. While this may seem humorous on the surface, it was coldly sobering because we knew that this kind of mindlessness could be destructive if occurring in a patient's treatment.

Supervisory Example C

Unlike examples A and B, the following is an anecdotal account of how an issue arising in supervision may thread its way through the whole week, resolving itself in a recreational activity. The account attempts to convey the spirit of camaraderie which helps to make those retreats so useful. Participants push one another beyond what are experienced as comfortable limits, but within an atmosphere of deep respect. There is a certain joy as participants find themselves attaining goals they had not thought possible, and a pleasure in supporting one another in their struggles, although each must — in the

final analysis — do it by himself.

Some of the participants had brought along boots for hiking in the mountains, while others had moderate or little interest in this. H had very little interest. When five of the group left early on the first morning to climb a small mountain nearby, H and the others remained behind. By midmorning, the hikers had reached the peak of the mountain and were sitting together enjoying the beauty of the countryside. Then they walked back to the cars, relaxed at a patio breakfast, and returned for a shower before the supervisory meeting.

Later, as H presented his case, he related a difficulty with his patient which touched a number of difficult personal issues: the recent loss of his father after a lingering illness, his recent discovery that he had troublesome physical symptoms of unknown aetiology and his growing dissatisfaction with his current work situation. Sounding like a defeated man, he spoke of his fear that he might have an as yet undiagnosed fatal illness. Calling attention to his lifeless mode of speech and fixed gaze, several participants noted that H looked like a 'dying man' who had given up struggling for life. 'You may indeed be dying', said one participant, 'but you should be out there on the mountain hiking with us in any case! You should be fighting for every moment of life you have!' H's passivity was addressed again in later meetings. Despite constant encouragement and confrontation by the others, H still did not attempt the climb, although as the week drew to an end, all the others had done so. However, on the last day but one, H yielded to the pressure and decided to climb with the rest of us. He gave himself a head start, slowly moving up the trail. The rest of us caught up with him, passed him and later saw from above that he had turned back. Some of us were angry with him, some sad, but we continued on our way.

As we sat on top of the small mountain watching some hot air balloons flaunt their gay colours in the brilliant morning sunshine, a shadow was cast on our mood by our realization that H was missing this glorious sight because he had given up. Perhaps he had given up on life as well, much as patients are tempted to when therapy becomes difficult.

On our final day in Arizona, we all rose early to climb. As soon as we arrived in the parking lot, H headed up the mountain. The rest of us did our routine stretching, and then started off. Ahead, we could see H slowly plodding along. His stooped posture and hooded outfit suggested to some of us the image of an old monk travelling through a medieval countryside. Soon we overtook him and lost

sight of him and when we were all on top of the mountain except for H there was speculation as to whether he had turned back, or would make an effort to reach the summit. After enjoying the view and resting, we began to think about heading back down the mountain. But should we be waiting for H? How much is appropriate when trying to help someone? Then, one of us spotted a stooped figure far below, looking like a pilgrim struggling towards his goal. Several of us yelled encouraging words, but the wind carried our voices off to the desert. We waved, but he was so bent over, as if studying each footstep intensely, that he could not see us. Yet he kept going! As he approached the final stretch, one of us went down to meet him and encourage him to come to the top.

As H rested at the foot of the final steep stretch, we could see N talking to him, although we did not know what he was saying. Soon they both started to move up the mountain, dropping from sight as they reached the steepest sections. When H's grey, wavy hair and smiling countenance popped from behind a rock we let out a cheer. A moment later, we were all together again. We stood together on the peak of the mountain we had struggled independently to conquer.

Conclusion

Examples drawn from daily life on the retreat abound, from one participant's difficulty in sleeping to another participant's tendency to eat too much. Everything we did, everything about us, was 'fair game' for scrutiny, and we looked at these issues no matter how seemingly insignificant. 'That's just the way I am!' was an unacceptable position in this group. There were many important hours of conversation unrecorded by our audiotapes, as issues were discussed driving from city to city, or sipping a cool drink on a verandah, or shaving while a room-mate showered. The group process did not begin at the start of a three-and-a-half hour session or end when that time elapsed, but was always in motion.

The supervisory retreat enables scrutiny and self-examination and there is good effect in consistently keeping one's self whole. The therapist is refreshed as hidden corners of his own personality are exposed for exploration. Each time this occurs, there is an increased capacity to see, to understand and to empathize. It is like discovering new and recessed parts of the lung so that breathing becomes easier. Such experiences are like a surge of energy which gives enthusiasm and

vigour to the task of treating patients. Joy comes from being with trusted colleagues who are thoughtful, respectful and honest: this is a good way to be with fellow human beings. Joy also comes from good times, which are experienced together outside the regular sessions: there is a sense of togetherness and camaraderie.

Refining is the process of making something more pure. Group supervision may be seen as a method of refining the psychotherapist. In order to treat emotionally ill people the therapist must be as free as possible of his own conflicts, otherwise the patient's therapy is impeded or threatened. The process of refining is never finished, but must be continued regularly and consistently. The retreat model offers a unique and unusually effective way for therapists to continue the refinement process.

References

- Glatzer, H. (1971) 'Analytic Supervision in Group Psychotherapy', *International Journal of Group Psychotherapy*, 21, 437-43.
- Larkin, M., Lieberman, M., and Whittaker, D. (1969) 'Issues in the Training of Group Psychotherapists', *International Journal of Group Psychotherapy*, 19, 307-25.
- Mintz, E. (1968) 'Group Supervision for Mature Therapists', *Journal of Group Psychoanalysis and Process*, 63-70.
- Mintz, E. (1978) 'Group Supervision: An Experiential Approach', *International Journal of Group Psychotherapy*, 28, 467-79.
- Pettes, D. (1967) *Supervision in Social Work: A Method of Student Training and Staff Development*. London: Allen and Unwin.

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