WORKING TOGETHER, WORKING AGAINST EACH OTHER, AND WORKING PAST EACH OTHER IN THERAPY AND SUPERVISION. A GESTALT PSYCHOLOGICAL VIEW ON STRUCTURE AND DYNAMICS OF THE THERAPEUTIC RELATIONSHIP

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Abstract

Crises in therapist-patient relationship can also become a challenge in clinical supervision. However, success and failure in establishing and maintaining constructive relationships in therapy and supervision is not only subject to a lucky fit of personal characteristics (therapist A gets along well/badly with client B; supervisee A gets along well/badly with supervisor C). Rather, we can identify determining field conditions in the overall therapeutic and supervisory situation for this outcome. We do not only focus on the persons involved, but also on their environment, the task to be accomplished together, further framework conditions and the power relations resulting from their mutual influence - in the supervised case of therapy as well as in supervision itself. We want to examine the structure and dynamics of these relationships from a genuine Gestalt psychological perspective. What contributes to a cooperative atmosphere? When do goals get out of sight? What can make the atmosphere hostile? How do such developments become accessible in supervision?

Key words: Gestalt psychological perspective, clinical supervision, psychotherapy

1. INTRODUCTION

Understanding psychotherapy and clinical supervision as the mere application of certain techniques and interventions and largely excluding the effects that the persons involved have in the process, contradicts in essence what psychotherapy and clinical supervision are about [1], especially within the framework of humanistic/ hermeneutically oriented approaches. Whether psychotherapy or supervision is helpful or not depends largely on the persons involved and the nature of their encounter and relationship.

What makes alliances in psychotherapy and clinical supervision strong or fragile is an important question. Even more crucial seems to be the question of what´s happening in moments of crisis. In their meta-analysis about "alliance rupture repair", Eubanks, Muran & Safran state (referring to therapy alliance): "Alliance ruptures present research challenges because they are both obstacles and opportunities: Unresolved ruptures are associated with poor outcome, but repaired ruptures are associated with good outcome" [2, p. 516]. They refer to Bordin's conceptualization of the alliance "as composed of (a) agreement between patient and therapist on the goals of treatment, (b) collaboration between patient and therapist on the tasks of treatment, and (c) an affective bond between the patient and therapist." [3, p. 509].

This understanding of "alliance rupture" seems to us to imply the notion of a kind of continuum extending from one pole of intense alliance to the other pole of completely "ruptured" alliance. We do not deny that such a notion may be helpful for some cases involving fluctuations in the intensity of an existing alliance at different stages or in certain respects of cooperation. However, in our view, the notion is not helpful in those cases where it is not a matter of gradual changes in intensity, but of a more or less sudden *turnaround in the quality of the relationship*. We are talking about those cases where the alliance turns into the opposite: into an openly hostile and destructive relationship of *working against each other* or into the less dramatic but no less obstructive form of *working past each other*. This is no longer a gradual change in the intensity of the relationship, but a flip or switch into a qualitatively different kind of relationship. We think it might be fruitful to look at this turnaround or flip in the relationship analogous to the „Gestalt switch" in the "reversible figures" known from perceptual research (see a well-known example in fig. 1).

In this paper, we will investigate which conditions have to be fulfilled for such a Gestalt switch to occur in therapy and supervision and provide suggestions to prevent this.

Fig. 1: reversible image young girl / old woman

We try to integrate these aspects in identifying certain field conditions in the overall therapeutic and supervisory encounter and relationship. What constitutes this encounter and relationship, which laws it follows and which framework conditions it is subject to, has always been the focus of the Gestalt theoretical approach to psychotherapy. In this respect, this approach has been based primarily on the specific "characteristics of working with living beings and processes", elaborated by the German Gestalt psychologist Wolfgang Metzger [4].

In therapy and clinical supervision the focus is on the relationship. The consideration of the relationship has fortunately strongly increased in the recent past, as the increase in corresponding publications show [5]. However, another level comes into play when we look at supervision. The challenges that arise for the supervisees in the relationship-centred work with their clients become the object of reflection and learning in supervision in another relationship constellation, that between them and their supervisors. We are convinced that this constellation should also be considered as a relationship-centred one, even if at first glance other aspects (such as the supervisor's lead in terms of experience and knowledge and other competencies) seem to be dominant. However, the challenges are not simply the same as in the supervisee-client relationship because the tasks, power fields and interpersonal dynamics are different. Nevertheless, there are definitely interrelations between the two realms that deserve attention.

Let's start with three main different meanings of relationship-centring in the psychotherapeutic context:

In therapy, attention and activity can be centred on different relational spheres:

1. The patient's relationships with others in everyday life that become a topic in therapy;
2. The patient's relationship with her or himself;
3. The patient's relationship with the therapist.

These different relational spheres are in close interaction with each other: For example, if a person has repeatedly had unpleasant experiences in relationships in his life, this will have an effect on his self-relationship [6]. If this person enters psychotherapeutic treatment, these experiences will inevitably flow also into the relationship with the psychotherapist. As is well known, this is also a therapeutic opportunity: If this transfer is noticed and worked on, negative experiences from other relationships can be processed constructively in the relationship with the therapist.

When, in what form, with what effects these various relationship spheres may appear and become effective in the context of therapy is neither random nor arbitrary: It depends on a great many conditions and not all of these conditions are subject to potential therapeutic influence. Often centring shifts are unnoticed: For example, patient and therapist may repeatedly analyse the subject of the patient's difficulties with a colleague at work, which may be about envy, inferiority, helplessness, or the like, and thereby fail to recognize that similar ways of experiencing have long determined the relationship to each other in the therapeutic relationship. However, the patient and the therapist can also deliberately and consciously determine whether one of the above relationship spheres should be addressed and worked on in a certain situation and in a certain phase of the therapeutic process.

Here, too, we have two global spheres (and on both sides, that of the supervisee as well as that of the supervisor, although with certain differences): The processes and problems in the work of the supervisee with his client and the processes and problems in the work of the supervisee with his supervisor. In regard to the supervisee's work with his client, the focus of attention may be directed, for example, to the following questions:

What causes a fruitful therapeutic relationship? What predicts a desirable or undesirable development? Progress presumably occurs not only when things are permanently harmonious, but sometimes precisely when „tensions" arise. Certain heightened states of tension as components of a dynamic therapeutic process are not only unavoidable, they are helpful and sometimes purposefully induced, e.g., in certain feedback or confrontational interventions. However, there are also moments or phases when the whole atmosphere of the therapeutic relationship can „turn", e.g. from a cooperative to a hostile mood. When does this happen and under what conditions? Is it always bad and has to be avoided?

The following questions arise specifically for clinical supervision related to the second sphere mentioned above (between supervisee and supervisor): What obstacles must be expected in bringing up and working on problems of this kind in supervision? How can the relationship experience in supervision between supervisee and supervisor be linked to the processing of such relationship problems arising in the therapies of the supervisee?

2. WHY AND WHEN DOES THE THERAPEUTIC RELATIONSHIP BECOME CENTRE STAGE?

We begin with how this issue manifests itself in therapy and then move on to supervision. The possibility that what is going on in the relationship between therapist and client may become the focus of attention without being noticed or unconsciously has already been addressed. This can have far-reaching and unpleasant consequences if it remains unnoticed by both parties and is not thematized. The patient may unconsciously idealize the therapist, for example, and the therapist may permanently „bask" in the glow of this recognition. In this case, the relationship dominates unnoticed the foreground, the actual therapeutic task is only a „side show". We will come back to this constellation later under the term „therapeutic juxtaposition". In the following, we will deal with the variant of conscious, intentional centring on the relationship.

The therapeutic relationship should service to overcome or improve the patient's state of suffering; it is not an end in itself. If instead of the immediate life problems, which were and are the reason for therapy, the relationship between patient and therapist becomes the focus, then this can arise from different constellations.

First possibility: ***relationship centring as a resource of interpersonal solitary community***

In dealing with the immediate problems of life, the patient may have reached a state (exhaustion, despair, helplessness, feeling of loneliness, etc.) that makes it necessary for her to reassure herself that she is not alone in all this, that there is someone who can give her room to "catch her breath" before she can go on with her life again. In this case, centring on the relationship is a momentary occurrence; it is a kind of pause for recovery and reassurance. Such an approach largely corresponds to what Kästl [7], following Metzger, means by „nurturing." "This nurturing form of relationship will be necessary above all when the client is strongly emotionally involved in a topic to be worked on and only needs noticeable sympathy, time and patience from the therapist in order, for example, to be able to expose herself to stressful feelings and live through them, in the best case to be able to conclude unfinished business and reorient herself" [7]. Any intervention of the therapist beyond the nurturing accompaniment and care could have a disturbing effect in such a situation and hinder the necessary development process. As a rule, the relationship in this case is not particularly discussed or reflected upon between client and therapist; it is supposed to have a supporting and sustaining effect. The general orientation towards the therapeutic goal is maintained in this phase, even if there is no explicit movement in this direction.

Second possibility: ***relationship centring as a therapeutic tool***

The therapeutic work may have revealed that the patient's life problems are essentially rooted in relationship problems. Both client and therapist have (more or less) consciously decided to take a comparative look at their relationship experiences in the therapy situation and also to use these experiences „experimentally". This approach is based on the fact that no relationship is completely „reinvented" in every new situation; both client and therapist develop their relationship to each other influenced by previous relationship experiences or relationship experiences they make at the same time with other important people in their lives. This assumption is explicitly used in this constellation to understand and possibly correct one's own way of shaping relationships in a real-life situation, with the intention of then being able to implement these insights as fruitfully as possible in everyday life. Also in this constellation the general orientation towards the therapeutic goal is maintained.

Third possibility: ***relationship centring with abandonment of the goal***

This third constellation is characterized by the fact that the therapeutic process has lead to a relationship-centeredness in which the actual goal is (at least temporarily) abandoned. The working on the immediate life problems has (at least for one side) come to a standstill or crisis, or substitute goals (e.g., appearing attractive to the other person or finding someone to blame) have come to the fore in such a way that the entire therapeutic process revolves around the relationship.

It is precisely this latter possibility which obviously runs the risk of rendering the entire therapeutic process unfruitful, namely if it is not possible to understand and constructively work through these processes. But critical courses are also conceivable with the first two variants: In the first, when the reassurance and nurturing does not come about (because, for example, the patient cannot trust anyone or the therapist proves to be untrustworthy); in the second, for example, when the pendulum movement toward the therapeutic relationship leads into the same dead ends in which everyday relationships are already stuck.

3. ON THE CONNECTION BETWEEN THERAPEUTIC TASK AND RELATIONSHIP

The therapeutic relationship should be a conductive condition in terms of goal achievement. In the sense of a first approximation, it can be stated that a perceived progress, a progress in terms of goal achievement will usually strengthen the relationship: Both sides are successfully pulling in the same direction. The reverse may also happen: If both (or even only one side of the therapeutic couple) feel stagnation or deterioration in terms of goal achievement, this will probably lead to a strain on the relationship.

Some remarks on the therapeutic task may be useful here: Even the simplest definition of a therapeutic goal, namely that the patient should somehow get better, can be questioned, e.g. in the sense of a pessimistic critique of society, that as long as conditions make us sick, there can be no real recovery. Also, from the point of view of different therapy schools very different goals are aimed at: they oscillate between a strict symptom orientation up to a comprehensive personality development (e.g. in the sense of Carl Rogers' „fully functioning person"). In addition, the patient and therapist may strive for different goals. Moreover, the goals may change in the course of therapy. In this respect, the discussion about the goals will usually be a (recurring) part of the therapeutic process.

For the purposes of this paper, it is assumed that the patient is suffering or has a problem that has led her to seek therapeutic help, and that a perceived reduction in suffering or a perceived approach to a solution to the problem or a better way of dealing with the problem is considered a therapeutic success. This already shows how inseparably goal attainment and relational events are interwoven.

This interweaving becomes particularly clear in a classic research work from the Lewin's school, Tamara Dembo's "The Dynamics of Anger" [8]. Therefore, this experiment is briefly outlined here:

The experiment puts the subject in a situation where a certain goal should be reached but the experimental conditions are manipulated in a way that goal attainment is almost impossible. This constellation leads unavoidable to a point, where the focus of the subject's attention increasingly shifts from the task to the experimenter and a struggle between the subject and the experimenter takes centre stage. This has a certain "advantage" for the subject: she can – at least temporarily – withdraw from the frustrating task; moreover, she may no longer feel weak and inferior, but in the new situation of the struggle with the experimenter at eye level.

Dembo's classic research analyzes an experimental task, so one should be cautious of making overly simplistic transfers to the therapeutic process. Nevertheless, analogies can be found with all due caution:

A patient who enters therapy may also experience the task she faces as difficult to master (bumping up against the inner barriers of her life space as the Gestalt psychologists conceptualize such a constellation). Her life situation in general and the therapeutic situation in the narrower sense form the outer barrier. Bumping up against the barriers increases the state of tension. But what is experienced in particular is the dependence of the task on the relationship: the difficulties in overcoming the problem direct the focus to the relationship and have a clear influence on this relationship.

4. THE INITIAL SITUATION

Whoever goes into psychotherapy enters into a (new) relationship. This relationship develops, however, not from a kind of point zero or neutral state, but it is from the first moment in a describable state of tension: Both, patient and therapist, experience a certain given relationship constellation, namely that of help-seeker on the one side and helper on the other: suffering and pressure of suffering, helplessness on the part of the patient, expertise and the promise of help on the part of the therapist. These unequal starting conditions lead to further characteristic aspects in practice: the therapist can ask, judge, prompt, criticize, encourage, reject, and refuse the patient. In principle, this also works the other way around, but in the patient's experience, these characteristics of an active and controlling relationship are more likely to be located with the therapist, at least in the initial phase of therapy, especially because of the different starting conditions of the help-seeker and the helper described above. In addition, there is the flow of money from the person seeking help to the helper with corresponding requirements and demands on the helper in terms of training and certification, which reflects not only an economic and legal factor, but in essence a debt settlement: the knowledge of payment relieves the person seeking help in this respect.

On the one hand, this shows how much real problem potential and which tensions are hidden in this constellation, even beyond an analysis of the therapeutic relationship in the narrower sense of a psychodynamic event. On the other hand, it is precisely this constellation of being mutually dependent on each other that forms the basis for the further development of the therapeutic relationship.

5. WORKING TOGETHER IN THERAPY

It is not the case that the supportive flows quasi like a medicine from the helper into the person seeking help, but the idea of therapy is (outspoken or unspoken) that collaborative work is done increasingly over the course of therapy. In other words, both throw their skills into the balance and work together to improve the situation for the patient. For severely traumatized, deeply depressed, highly anxious patients, this is a complex challenge and a high demand. To be able to deal with this and to move the patient to a creative cooperation despite her stresses is certainly part of the therapeutic art (here we refer to Metzger's characteristics of working with living beings and processes: described by Metgen [9] e.g. in Walter [10], Kriz [11], Kästl [7], Stemberger et al. [12, 13, 14, 15]).

In principle, a dynamic development in therapy will usually take the form of the patient working shoulder to shoulder, so to speak, with the therapist on the problems. Both are united by the task of therapy to bring about an improvement in the patient's situation. The therapeutic constellation successively induces a change in the patient's perspective: She initially experiences herself primarily as a suffering person whose task is to describe her suffering and the situation from which she suffers and to make it accessible and understandable to the therapist. The therapist tries to empathize and think herself into the phenomenal world of the patient. This process is accompanied by communication, both exchange what they see and feel and make sure that, if and how their view of the patient's experienced world matches sufficiently. If this succeeds, the patient will feel "seen" and understood.

However, this process is not a one-sided procedure, even if the focus of attention of both participants is naturally directed to the experienced world of the patient. For the patient will also engage with what she experiences of the world of the therapist, and ideally precisely in relation to the parts of that which become "visible" to the patient in the course of therapy: Namely, the specific way of encountering the patient, what the therapist emphasizes in the process, in which language that was is seen and sensed is expressed, how it is evaluated or not evaluated. In short, the entire therapeutic attitude is not only passively perceived by the patient, but can also be successively "adopted", at least partially, sometimes also "on a trial basis", for example in the sense of: "Aha, this is a new or interesting or helpful way to look at me and my world!" In Lewin's terminology one could formulate: The therapist`s power field [13] induces in the patient an endeavour that is initially foreign to her, namely to look at herself in a self-caring and interested way, while her own original endeavour is directed differently. As soon as she has left the therapy room and thus, (in this assumed case) also the therapist's field of power, the induced striving may lose ground and her own striving may come to the fore again. In the long term, however, this could help the patient to deal with herself in a more self-caring way even outside the therapist's immediate power field. Galli means something similar when he speaks of „love that compels love in return" [16, p. 58] with reference to Dante.

In this sense, the therapeutic relationship can be understood as a process Gestalt that follows certain regularities, primarily praegnanz tendencies. In this context, Stemberger [14] also refers to Galli and emphasizes that, on the therapeutic side, what matters most is the social virtue of „devotion" - devotion in relation to the task and in relation to the therapeutic concern. This, in turn, does not only apply to the therapist, because the patient will also, as a rule, surrender to the task at hand, intensified by her psychological strain. The relationship takes now on the excellent praegnanz form of common devotion to the task at hand. The tendency to praegnanz can be understood as a superordinate active principle in the therapeutic process; it can contribute to the fact that the participants have the

experience of „pulling together" or also „being pulled" (pull of the goal) [9]. This shared experience can be described in an approximate way as a certain conducive, creative "atmosphere" that "carries" the relationship, much in the same way that one can sense and describe different atmospheres in groups (families, school classes, clubs, etc.). Whatever words can be used to describe these atmospheres ("stimulating, challenging, exciting, interesting, calming, horizon-expanding" etc. will probably be more conducive than "boring, threatening, constricting" etc.): They are co-determinants of what constitutes the atmosphere of the therapeutic situation in the respective experience, which either strengthens the bond or makes it appear fragile.

The potential of therapy lies in the collaborative atmosphere just described; it provides a supportive framework so that crises that arise can be overcome. It may also be necessary to overcome longer phases of conflict. This can succeed if both participants are aware of the necessity (insofar as it makes therapeutic sense) of phases of struggling to move on [7]. In the sense of the field-theoretical model of the therapeutic relationship outlined at the beginning, it must even be regularly expected that such phases arise. The therapist's task is to support this process, to accompany it compassionately, to endure the problem (often also the suffering and pain) together with the patient. As described above, there is already potential for conflict in the supposedly harmonious cooperation between patient and therapist. In addition, the therapist must successively intervene in such a way that a "position can be taken", e.g. by inducing a change of perspective, encouraging the patient to adopt other points of view, "holding up a mirror" to the patient in the sense of confrontational interventions, etc. This will put a strain on the relationship, but can be successful if, despite all the conflicts and struggles, the feeling of working together "shoulder to shoulder with a view to the task" is not lost, i.e. that a common direction and the feeling of pulling in the same direction is maintained. This is promoted by a differentiated perception of different parts and aspirations, methodically supported by the induction of different perspectives (internal view/external view) and the joint effort to endure (as yet) unresolved issues, "shades of gray".

5.1. WORKING AGAINST EACH OTHER OR: WHEN DOES THE RELATIONSHIP "TIP OVER"?

Up to this point, it should be clear: It is not conflicts per se that endanger the relationship in the long run, but the loss of a sense of community that supports the relationship. The immediate experience of an effective togetherness in the sense of the praegnant process Gestalts described above, the experience of being part of the whole of the relationship dynamic, turns into a feeling of distance or even that of "against each other". The patient will then no longer experience the therapist (and/or vice versa) as a partner, but increasingly as an opponent. The "shoulder to

shoulder" constellation will dissolve. This 'tipping event" can be very different. It may happen suddenly and escalating or very gradually and subtly progressing. It may be obvious to both parties involved or only to one of them, but it is also conceivable that initially hardly perceptible processes may cause the relationship to tip over.

The term "tilt" for this has been borrowed from the studies on shape perception. Many are familiar with the classical tilt figures (vase/faces, old woman/young woman cf. fig. 1, duck/rabbit). Here applies: Among the perception figures, tilt figures or ambiguous figures are a rare special case. They are characterized by the fact that it is already the special structuring of the visual material that enables not a single but two praegnant ways of viewing the picture. What makes them tilt figures or ambiguous figures is therefore not the relationship of the viewer to them, but their special nature or factual suitability for this phenomenon. The tilting process itself, i.e., the emergence of the second concise figure/ground structure embedded in the material itself, is an involuntary or arbitrarily brought about process of restructuring, primarily of re-centring. The role of the subjective side in this process has several aspects. 1) there must be enough interest or a special occasion on the part of the viewer to look at the picture long enough or repeatedly enough for there to be any chance at all of tilting; 2) his "attachment" (sic!) to the figure/ground constellation seen first must not be too strong (although this attachment can certainly be imagined as having something to do with his given state of tension of needs and strivings).

Even if this special perceptual phenomenon cannot simply be transferred one-to-one to the much more complex processes of change in a relationship, it is worth taking a look at it: Just as not every picture is suitable for a tipping figure, not every relationship is suitable for a "tipping relationship". In the tipping figures, the two possibilities are present from the outset in roughly equal weight; such an antagonistic, dichotomous view of the counterpart can also be present in a therapeutic relationship, as the following examples will show:

- The patient is supposed to open up to the therapist, trust her - but has the impression of being attacked again and again;
- The therapist makes a lot of effort for the patient, but at the same time has the feeling that her efforts are not valued at all;
- The patient appreciates the therapist for her cleverness and verbal skills, but repeatedly feels "cornered";
- The therapist empathizes with the patient's world, but believes she is being manipulated in the process.

These are all brief excerpts from possible "tipping moments" that can be overcome within an overall framework of a sustainable bond. However, relationship constellations are possible in which such "tipping moments" can actually change the entire picture, transforming a hitherto communal atmosphere into a hostile one. In analogy to the perceptual phenomenon, it would then have to

be assumed that the ambiguity was inherent „in the material" from the outset, i.e. the psychological field of the patient or the field of the therapist (or both) are structured in such a way that they are "tiltable" in the sense that a simple change in the centring permanently transforms the entire picture of the other person and the relationship. This is conceivable if, for example, there is a tendency to think and act in a primitive-praegnant way, in primitive dichotomies like black or white, right or wrong, good or evil. Nuances, "shades of gray" are not allowed or are not bearable.

At the moment of the "tipping event" there must then be - as described above - an interest on the subject side to look at the picture long enough for there to be a chance of tipping. This could be the case, for example, if a patient (or also the therapist) has had many disappointing relationship experiences - perhaps especially with people toward whom she has found herself in a weaker position - and has therefore developed a fundamental scepticism. This patient (or this therapist, too) will keep checking the relationship continuously for possible "breaking points". On the other hand, the attachment to the originally seen figure/ground constellation must not be too strong, otherwise it can no longer tip over. Binding thus prevents tilting. This explains why especially the beginning of a therapy is prone to tipping: no attachment could develop yet. If a therapeutic relationship tips over into a "against each other", although it has existed for a long time, one has to ask what constituted the fragility of the therapeutic situation, although it seemed to be superficially stable.

5.2. THE THERAPEUTIC „WORKING PAST EACH OTHER" AS A SUBSTITUTE ACTION

The atmosphere does not always have to tip over into hostile opposition or confrontation. A possible alternative variant is a kind of "side by side", a "working past each other" of patient and therapist, kind of a hidden withdrawal. This juxtaposition may initially be experienced quite similarly to the "shoulder to shoulder" constellation described above, but with the significant difference that the achievement of the goal has been lost sight of. Both participants (possibly also just one of them) feel comfortable in the therapeutic situation, enjoy the perceived togetherness, but avoid dealing with the issues and problems at hand. In the sense of Dembo (mentioned above), this can serve as a substitute action. The relationship becomes an end in itself, a substitute goal; it loses its function with regard to the achievement of the therapeutic goal. The therapeutic offer of relationship (see above) is on the one hand "powerful" (in the moment of the encounter usually intense, personal, devoted), but on the other hand it has narrow limits (temporal, spatial, economic, legal). This ambivalence must be accepted and endured by both sides. Here, too, there is a "tipping alarm", namely when the offer of a relationship mutates unnoticed into an all too "sweet" promise and

meets unmet needs, so that the limitations (and the therapeutic goal) are faded out. If such developments remain unnoticed in the long run and are not addressed and worked on, they lead to variants of a therapeutic "juxtaposition": a permanent idealization of the therapist (or the patient), a permanent "victim role" of the patient, a possible eroticization of the therapeutic relationship, a common intellectualization (one has intellectual discussions), and so on. A danger may also arise from certain therapeutic techniques with high suggestive power (speculative interpretations, body exercises, family constellations, cathartic exercises, etc.), which are used without being embedded in a supportive relationship. The therapist becomes a kind of "miracle worker" and thus undermines progress and further development on the part of the patient by virtue of her own insights and efforts.

Under certain circumstances, there is a greater potential danger in all variants of therapeutic „side by side" than in „against each other". The permanent „tipping" into hostility will sooner or later lead to a rupture of the relationship, so that the patient (if she has not been completely discouraged by the rupture and has finally resigned) can take new paths to reduce her state of suffering. However coexistence will possibly extend over a long period of time and prevent alternative ways of achieving the goal.

5.3. WHAT MAKES „TILT-RESISTANT"?

The therapeutic relationship as a form of development in the excellent form of shared devotion to the task at hand (see above) allows us to expect stability; primitive attitudes and expectations on both sides make the relationship fragile and "prone to tipping over". It must therefore be a matter of moderating such attitudes and expectations. In the immediate relationship event, especially those moments will be precarious in which openly or covertly, consciously or unconsciously, evaluations are made or criticism is expressed. Henle [6] emphasizes the close connection between the ability and the way one deals critically with oneself, and how one deals critically with others and receives criticism from others. A severe inner critic – whether on the part of the patient, the therapist, or both – will cause the relational process to be more fragile. It will therefore depend on the abilities of both participants to deal sensitively and carefully with evaluations and criticism or to be attentive to all forms of exchange in which evaluation and criticism are hidden.

In principle, this is consistent with a therapeutic approach that is cautious about exerting any kind of direct influence on the patient, and instead sets boundary conditions to promote self-organization processes. A simple example: To ask the anorexic patient again and again to eat more is an encroaching, essentially aggressive intervention, which does not lose its primitive character even if it is dressed up in therapy contracts or the like. A conducive therapeutic cooperation will only develop when the patient feels free to explore her

experienced world together with the therapist, in order to be able to name the conditional situation herself (at best with therapeutic support), which has made the starvation necessary. The individual symptom will thus lose its "crazy" character, because it can be understood in its integration into an overall system of effective forces. The therapeutic process will dynamically develop in the sense of the praegnanz tendency to a higher order on a more complex level. Processes of restructuring (insight, so-called "aha experiences"), the change of the centring, an experimentation with systems of reference [17], etc. are made possible. However, this also requires a joint effort to do justice to the complexity of what is happening, to respond to each other in a way as sensitive and differentiated as possible, to jointly endure states of tension that cannot (yet) be resolved.

This kind of black-and-white thinking will appear above all where people find it difficult to understand the motives in the actions of others, but possibly also misjudge their own motives for action, i.e. where they find it difficult to change their perspective, to empathize with others (and also with themselves). This creates barriers in the psychological field that are difficult to overcome.

Bumping into barriers leads to a heightened state of tension and corresponding emotional reactions. In this respect, the regulation of impulsive reactions in the therapeutic encounter is always at stake in the sense of "tipping resistance". "The initial internal arrangement of the therapist can in fact favour beside the vicissitudes of the transference-countertransference an egalitarian atmosphere in which a series of dialogues will bring the patients, through the exchange of perspectives, toward slowly approaching recognizing themselves in their various components. It will then be possible to replace impulsive action with an awareness that enables greater freedom in decision-making [18]. From a psychoanalytic perspective, Trombini here emphasizes the effect that can emanate from an „egalitarian atmosphere" and thus also refers to the effect of field conditions in the overall therapeutic situation - in contrast to an exclusively person-centred view that focuses on the competent or incompetent therapist or the motivated or "difficult" patient for the success or tipping of the relationship. "To adequately characterize the psychological field, one has to consider specific things, such as particular goals, stimuli, needs, social relationships, as well as more general properties of the field such as the atmosphere (for example, the friendly, tense, hostile atmosphere) or the degree of freedom.

These properties of the field as a whole are as important in psychology as, for example, the gravitational field is in classical physics. Psychological atmospheres are empirical realities and scientifically describable facts." [19, p. 377].

6. THERAPY RELATIONSHIP CRISES IN CLINICAL SUPERVISION

We formulated two questions at the beginning: What obstacles must be expected in bringing up and working on problems of this kind in supervision? And: How can the relationship experience in supervision between supervisee and supervisor be linked to the processing of such relationship problems arising in the therapies of the supervisee? To this a third question could be added: What can be learned from the aspects discussed here regarding the therapist-client relationship when it occurs in the supervision relationship itself – a topic discussed in the literature as „rupture and rupture repair in clinical supervision“ [20]?

We understand clinical supervision also as a learning field [21]. This includes that we assume that the supervisee in his reflection of the relational events with his clients will in a certain way also make comparisons with his relational experience with his/her supervisor. Part of this experience is also dealing with the power imbalance or power differential that exists in some respects between therapist and client and is found in supervision between supervisor and supervisee.

Especially in relationship-centred therapies, the therapist may be particularly uncomfortable talking with her supervisor about relationship problems with her client. Even if she can do so, there is a certain risk that she will try to “save face” and to “prove" that the client is responsible for any relationship problems. This will then show itself, for example, in the fact that a certain “pathology“ of the client is put in the foreground and one’s own problems in dealing with the client are not talked about. In such a situation, much will depend on the supervisor’s ability and willingness to talk in a very personal way about what difficulties he himself would have in dealing with a client who – for example – first “lifts him to the skies” and then completely rejects him. Such behaviour on the part of the supervisor is also quite consistent with what Watkins describes in his discussion of rupture repair in supervision as adopting a certain attitude: „humility – openness, accurate self-assessment and according action (e.g., recognizing limitations, acknowledging mistakes), and other-orientation – is the foundation for any and all rupture repair” [20, p. 329).

In a very general way, we think the three questions raised can be answered this way: From the very beginning, the supervisor has the task of counteracting (also by his own example) any notions of the supervisee (and her- or himself) that clinical work as well as supervision work is about the realization of any perfectionist or other absolute claims. The phenomenon of tilting presupposes an initial situation in which there are two and *only* two possibilities of perception. In human life, such cases are extremely rare, if given at all. This insight must be struggled for again and again on both sides of the supervision process.

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