



(CASE STUDY)



## The supervision protocol in integrative psychotherapy

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### Abstract

The beginning of any profession is difficult, as for the novice therapist, who undergoes supervision to get support and advice. Thus, the objective is to offer an example of support instruments for beginner therapists, for colleagues under professional supervision, which can help them keep track of cases, of the case evolution, of the client's change and of the therapist's self-analysis. The tools proposed are used in Romania, being proposed by the authors of the strategic integrative model of the self and of the strategic integrative model of supervision (Vișcu Loredana-Ileana and Popescu Oana-Maria). The instruments proposed were also used in the case of the client A.C. underlined in this paper.

**Keywords:** The Strategic Integrative Model of Supervision; Supervision Protocol; Status; Supervision Sheets

### 1. Introduction

This paper entails a sequel and an addition to the information contained in a previous publication *The Therapeutic Status in the Integrative Strategic Model of Supervision*. [1] I hope that this study will contribute to the enrichment of theoretical knowledge in the field of integrative psychotherapy and meet the practical needs of my interested colleagues, beginners or supervisees, such as the need for clarification or support related to psychotherapeutic practice and the manner in which we, as psychotherapists, structure our work with the client and record, register it, so that it becomes easy to find information about the cases worked on: either in daily work, or as a source of information in supervision or perhaps as fundamental material in research and study work, as needed.

It all started with the observations made in my office, during the sessions with the client, when I started to apply the strategic integrative model in the psychotherapy practiced [2-5]. But also from the need to have permanently available, an informational support recorded on paper or electronically, about all the aspects related to the client and psychotherapist and for the supervision activity so needed. The registration of all information resulted in the concrete practical clarifications needed, so that I, as therapist, can include in the therapeutic status the relevant aspects of the respective cases.

I admit that I have continued to register my cases out of a personal need. During my career as a supervisee, I also went through quite delicate or difficult moments, which seemed to be difficult to solve at one point. Because, as is normal, I went through my own therapeutic work from the beginning, where I often thought I was subjective as far as I was concerned. In the phenomenological process, I felt that I could hardly find myself in my inner and outer tangle. On many different occasions, the intuition and skills acquired during my training and supervision as a psychotherapist helped me clarify certain aspects of my work with the client and with myself. But it wasn't enough! Supervision and intervention were the "pillars" used as base and on which I still rely on in my own development as a person, but especially as a specialist in psychotherapy. In the supervision sheets, I registered everything that biased or prevented me from seeing my issues clearly, the personal aspects that sometimes blocked me or made it quite difficult for me in my work as a therapist, but which later helped me to enrich my professional experience.

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During my supervision period, drawing up the supervision protocol, which includes the therapeutic statuses of each case worked on in the office and the two supervision sheets [6], I gradually realized its importance. On the one hand, this protocol is an archive of all the work with the client and with myself, as I pointed out above, and on the other hand, it reflects the complexity of a psychotherapist's work. It is also a source of evidence, in cases where complaints may appear from clients, to higher professional and / or legal forums.

I will not insist this time on the theoretical concepts, regarding the Strategic Integrative Psychotherapy, but I will only mention that it is based on a working model - *The Strategic Integrative Model of the Self* - conceived by Prof. Loredana Ileana Vișcu PhD and MD Oana Maria Popescu in Strategic Integrative Psychotherapy. It is based on a complex theoretical system, and in practice the key element is the psychotherapeutic relationship. This model approaches the Self on four areas: the Basic Self, the Central Self, the Plastic Self and the External Self, which meet on six psychological axes: the Biological Axis (B), the Cognitive Axis (C), the Emotional Axis (A), the Psychodynamic Axis (P), the Existential Axis (E) and the Family Axis (F) [2-5].

The Strategic Integrative Psychotherapeutic Orientation is developed in Romania, within the Association of Integrative Research, Counselling and Psychotherapy and in the Institute of Psychotherapy, Psychological Counselling and Clinical Supervision in Romania, affiliated to many similar or assimilated professional systems, national and international.

### **1.1. The model of strategic integrative psychotherapy supervision**

Considering the theme of this manuscript and its limited space, I will point out very briefly some essential elements of the Strategic Integrative Supervision Model, proposed by Oana Maria Popescu and Loredana-Ileana Vișcu. It is part of the second generation of supervision models; it is a relational model, which contains in principle the following: learning in supervision and the factors that influence it, the supervision framework and reflection on the case. [7]

Learning is influenced by common factors in supervision, namely: the supervisor's style, the supervisee's style, the context of their work, the needs of the relational and learning supervisor, the learning styles and the supervisee's educational background, assessment and evaluation in supervision [8]. The supervision framework is in fact the learning space, chosen by the supervisor and supervisee and contains: the place (space) of supervision, the supervision contract containing the objectives, goals proposed and mutually accepted by both parties; the alliance of collaborative-participatory supervision, support and encouragement for the supervisee [7-8].

The supervision framework is in fact the learning space, chosen by the supervisor and supervisor and contains: the place (space) of supervision, the supervision contract containing the objectives, goals proposed and mutually accepted by both parties; the alliance of collaborative-participatory supervision, support and encouragement for the supervisee [7].

The supervision protocol reflects the case (client) presented in supervision, in the therapeutic statuses prepared by the psychotherapist each time after the end / or during the sessions with the client. In addition to psychodiagnosis, this protocol also contains the elements of the intervention framework with the client. The supervision protocol also contains two Supervision Sheets, which include a summary of the supervisee's work and the supervisor's direct support [7].

Thus, this manuscript presents a study, using as instrument the Strategic integrative model of the self, proposed by the authors Oana Maria Popescu and Loredana Ileana Vișcu [2-5], including a short theoretical presentation of the psychotherapeutic status and the way in which this can be applied with the client. The practical exemplification of a client case, using the statuses and the two supervision sheets as examples can only lead to the conclusion that the instruments proposed are of huge significance to the supervisee.

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## **2. Material and methods**

### **2.1. Objectives**

The general objective includes a brief theoretical presentation and practical presentation of the supervision protocol containing: statuses 1 and 13 of the case presented, of A.C., as well as case-related supervision sheets. Why?! Because this can represent a practical model, possibly a beneficial and / or helpful one for colleagues and for supervisees in integrative psychotherapy. I also hope that this model will facilitate the way in which status must be filled in and contribute to a better understanding of the importance of its elements for integrative psychotherapists.

*2.1.1. The secondary objectives include:*

clarification of some aspects related to the supervision protocol (according to the integrative model) in order to challenge the beneficiaries of this work to overcome themselves in their professional development, having at their disposal concrete models, as a source of inspiration; it can contribute to the therapist's correct self-validation, to diminish possible fears regarding the acquisition of professional competences of structuring, management and correct analysis of all information, as well as of the methods and techniques used in therapy, included in the psychotherapeutic statuses;

depending on the uniqueness of the therapists' personality, the purpose and objectives proposed for this career domain, on other determining factors, the knowledge presented here can represent a starting point or the development of each one's self-reflection.

**2.2. Hypotheses**

*Hypothesis 1:* The objectives proposed in this paper can be achieved at a good level, because I still believe that we professionals in a certain field, like other people, have unmet needs all the time. Even the need to be challenged, which can take us out of our comfort zone, is real and supports our upward evolution professionally and personally; practical models-examples, help us as specialists to easily understand the phenomena, processes and working methods. But at the same time, the experience shared with colleagues ensures our sense of belonging to the "guild", in addition to support in solving the problems we encounter, over time; supervision ensures, among other things, a quality professional act, professional competence and continuous personal development.

*Hypothesis 2:* This approach also has a personal gain, as far as I am concerned. Through the feedback received, I can add to my knowledge, I can go over any information and / or practical gaps, correcting what should be corrected in the course of my profession, thus continuing one's psychotherapeutic work determined by human and professional imperfection.

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**3. The psychotherapeutic status**

The psychotherapeutic status created by author Vișcu Loredana-Ileana [6], is a written form that is prepared after each psychotherapy session or that can be partially filled in, with the client's consent, even during the therapy session.

It "mirrors" the session with the client, being a synthesis of a set of data that includes several aspects, including: information and observations about the client, diagnostic data, therapeutic goals agreed on with the client, methods and intervention techniques, the therapist's proposals for the improvement of the psychotherapeutic relationship, the psychotherapist's self-analysis and other pertinent observations related to the case [6].

It can be optionally be filled in by any psychotherapist, regardless of the stage of professional evolution, but it is addressed especially to beginners and to those undergoing supervision.

The psychotherapeutic status contains the following elements:

The psychotherapist's identification data, the client's initials, the number and date of the session, the date of the initial interview;

The structured diagnosis, with the symptoms presented by the client in relation to his personality (clinical picture of the disorder, his personality traits or identifiable symptoms, severity of these symptoms from mild to severe, somatisations, the client's personal resources and social and environmental resources identified);

Process diagnosis, according to the strategic integrative model of the self [3] on areas of the self and on the psychological axes affected to the client, establishing the general objectives with the client and the specific objectives of each session and the next ones in psychotherapy with the client;

Indications for psychotherapeutic treatment, possible recommendations for the client regarding additional somatic, psychiatric, clinical and / or hospital examinations and indications for psychotherapy: estimation of treatment duration, frequency, type of psychotherapy indicated, source of therapy;

The psychotherapeutic intervention, with the description of the current session on the axes of the integrative model of the self-worked on, the objectives proposed to be achieved on those axes in that session, strategies, methods and techniques used to achieve the proposed objectives, description of the client's behaviour when coming to the office, identification of the client's insight, if there were such situations, the changes observed in his/her behaviour;

Homework, as appropriate, ways to encourage the client to change behaviour;

Description of the psychotherapeutic relationship for the current session: the therapist's reflection on aspects related to building the alliance and the therapeutic relationship, the existence of possible moments of "rupture" of the relationship and how to repair it, the therapist's perception of the client in therapy and the time spent with the client, the client's needs, the style of attachment manifested in the therapeutic relationship, the therapist's proposals for improving / maintaining / developing the psychotherapeutic relationship [8].

The benefit for filling in the statuses would consist primarily in practicing and developing skills as novice psychotherapists, regarding the synthesis of data, case conceptualization, and understanding of the therapeutic processes. It cultivates and develops a therapist's divergent and complex thinking model on cases and also maintains organized, efficient work and an orderly and correct attitude towards one's professional activity in working with the client.

The psychotherapeutic status, permanently maintained, also implies a form of manifestation of respect for the client, even if it requires attention, scientific rigor, continuous study, rigorous reflection on the case and consumes a lot of time for the specialist. But it also has benefits: it ensures at the same time for the therapist, the awareness of the need for intervention and / or supervision, allows the structuring of a work style, filtered by one's personality, cultivates flexibility, but is also the mirror of the therapist's work in the office, as socialists in the field state [6-8].

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#### 4. The case of A.C.

The client A. C. showed up at the office unaccompanied, after having previously made an appointment on the phone, at the recommendation of a former client, a high school colleague with the client. A. was 18 years and 2 months old; she was a 12<sup>th</sup> form student at a high school with a humanistic profile. Being a unique, clever child, a straight "A" child, not "nerdy", but perfectionist and ambitious, she never wanted to disappoint her parents and grandparents.

For the last two years she lived with her father, in the city. But A.C. was raised in the country side, by her maternal grandparents, from the age of 3 to 16. Following the divorce of her parents, which took place 15 years ago, the girl remained in the custody of her mother, who went abroad soon after, leaving A. in the care of her grandparents. She was raised according to a "Spartan" educational system - archaic, authoritarian, rigid, uncompromising, with strict rules ("to become strong, resilient, to never make mistakes!" Her grandmother always repeated).

She suffered in silence, alone, without friends ("they can be a bad influence" said her grandfather) for a long time, throughout her life. Often subjected to physical abuse, when she did something wrong or did not live up to her grandparents' expectations (sometimes punished with a beating, isolated in her room and / or kept without food), banned on emotional expression (she was not allowed to cry, laugh out loud, to get angry, to retaliate, to be afraid, etc.), lacking warmth and parental love, endured throughout the 13 years (from 3 to 16 years old) the grandparents' hostility, who incepted the idea that she is a bad girl that no one wants, not even her parents. A. endured all the "censorship" and the unfounded demands from her grandparents, thinking that this was what she deserved, believing to be inappropriate for to be loved and feeling guilty for her parents' divorce ("I was told and I think I was bad!").

The relationship with the mother was "good", the client claims. The client's mother is described by the daughter as: diabetic, anxious, claustrophobic and sometimes depressed. Going abroad almost immediately after the divorce, she remarried, but kept supporting her daughter financially all the time through her maternal grandparents and even kept a long-distance relationship "on the internet" and by phone; they rarely met for a few days, 4-5 years apart, usually on vacation. The father was absent from her life until 2 years ago (when A. was 16), because she was not allowed to get in touch with the father, on the grounds that he didn't deserve it and that he was mentally ill (suffering from chronic depression, anxiety and panic attacks, with permanent medication). At the age of 16, the client ran away from her grandparents, looked for her father and moved in with him, developing a good relationship with him, because the father was alone (he never remarried); his health was much improved, and A. felt that he loved her and respected her very much.

A. C. is a thin young woman, of medium stature, with a weak constitution, straight posture (fitness practice). Simple, neatly dressed with fit “sports” clothes and fitted colours; she has long, blond hair, caught in a pony tail at the back. Pleasant, not wearing make-up (“I’m not used to putting on make-up”), permanently kept eye contact, with her tear-stained eyes with rather pronounced dark circles, expressing deep sadness. She had a warm timbre, low tone of voice almost extinguished; she used speech pauses during the exposition of her “story”. She seemed intelligent, sociable, pleasant, sensitive, attentive, calm and curious. From time to time she showed calming gestures, rubbing her hands or stroking her hair, neck, head. Throughout the psychotherapeutic interview, the client was emotionally charged but “allowed” herself to cry throughout the session and sighed almost after each sentence. Her voice was muffled, barely audible, using longer or shorter pauses of speech. She was open, confident that therapy could help her solve her issues and felt well, without panic attacks. She wished to feel alive.

From the first discussions I had with A. during the psychotherapeutic interview, I realized that I had in front of me a disoriented young woman, afraid for her “precarious” state of health and overwhelmed by her past and all aspects of her life. She spoke of frequent panic attacks “for no reason”, insomnia (sleep / intermittent), permanent fatigue, lack of pleasure, sadness, tendency to isolation, poor general condition, saying she lost 5 kg fast. She stated that she felt sick all the time, had dizziness, headache, nausea, abdominal pain, loss of appetite. She was often overwhelmed by unjustified fears, especially when she was alone at home. She was afraid to be ill and that the “disease” was inherited from her parents, and she might die soon.

During the first sessions, the client manifested irrational thoughts and false, maladaptive beliefs of which she is somewhat aware. Her belief is that she is not worthy of being loved, she felt guilty for ruining the lives of her parents and for their divorce, and as a result of this, her father became depressed and her mother had diabetes; She thinks that her grandparents raised her so in such a “harsh” way, because she was sometimes disobedient, that she was mean to them, and they did so to protect her and get her used to living alone when they couldn’t be there anymore. She often thinks that she is not good at anything, that she is not beautiful, that she does not know how to make choices and when she does they are the worst possible, that her life is destroyed, that she no longer sees the meaning of life anymore, but that she lives more for her father, who is happy because she decided to move with him. And she would like to be well, healthy for her boyfriend too, who is by her side and who cares about her.

I also found out that she didn’t have other friends because she didn’t have time to socialize, being in the 12<sup>th</sup> form and because she had to learn for her baccalaureate exam and because she didn’t trust people either. Her grandparents did not allow her to play with her neighbours’ children, near the house or on the street, on the grounds that they were “badly raised” and could “influence her badly”. She had a close colleague with whom she communicated from time to time, “a friend is enough because you can’t trust today’s girls! ... they are mean, bad and envious”. And 7 months ago she started a relationship and she had a boyfriend named L., a year older than her, with whom she has a very good relationship, but more at a distance, because he is also from the same city with the client but lives more in USA, where he studied and does performance sports (wrestling) and where he has a business with his father. A. says that the two of them stay together only on holidays, go on trips and then they spend all their time together. And that he spoils her by buying her the things she wants, respects her, loves her and tries to help her feel good, at least as long as they stay together. A. has developed an insecure concern / ambivalent attachment.

The mother and daughter don’t really know each other, but they both try to keep the relationship, even at such a distance. With the father she already established a “working” relationship, which they started building 2 years ago, since they have been living together. The father gives her good advice, but also makes her responsible for the decisions she has to make for herself and for her own life.

She felt me, the therapist, empathetic, supportive, open, authentic and understanding. Also, the fact that she was listened to carefully and patiently, non-judged and fully accepted, allowed her to open up and gradually develop confidence in the therapist. I created a very good alliance in the first 5 minutes and the therapeutic relationship, was created from the first session, surprisingly fast for me, which made me think about it.

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## 5. Working instruments used in filling in psychotherapeutic statuses

The working tools used in the analysis of the case presented above and in my work with the client, in psychotherapy, during the 13 sessions in the office (which built the basis for achieving the statuses and supervision sheets according to the strategic integrative model in supervision [6]) are the known ones:

The model of psychotherapeutic status first proposed, by the authors Loredana-Ileana Vîşcu and Oana Maria Popescu in the volume “Supervision in strategic integrative psychotherapy”, in 2017 [8], and later in 2018 in the instruments proposed for the beginner therapist [6];

The notes of each working session with the client and of those after each session, registered in the psychotherapeutic status, regarding the therapeutic relationship, the actual work, tools, working methods, changes, modifications occurred during each working session, etc. according to the status columns;

And equally important for the good resolution of the case and for the supervision activity, the notes regarding the phenomenological aspect of the psychotherapeutic relationship and those contained in the therapist’s self-analysis;

Working instrument that helped in the therapy process of A.C. as:

The manual for the diagnosis and statistical classification of mental disorders, 5<sup>th</sup> edition (DSM-5) developed by the American Psychiatric Association, USA, necessary to establish a structured diagnosis [9];

The strategic integrative model of the self, proposed by Oana Maria Popescu and Loredana Ileana Vîşcu, specific to Strategic Integrative Psychotherapy [2-5];

The psychotherapeutic interview structured according to the strategic integrative model of the self;

Psycho-education;

Methods of awareness and development of the degree of self-knowledge and the way in which the client is valued;

Clinical tests;

Projective tests;

Methods and techniques of cognitive restructuring and reframing;

Techniques used by strategic integrative psychotherapy: relaxation, problem solving, ego strengthening, hypno-analytical techniques, techniques for depression and anxiety, therapeutic metaphors;

Cognitive-behavioural techniques;

Psychotherapeutic strategies: supportive, informative, cathartic, catalytic, etc.

The realization of the psychotherapeutic status and of the two supervision sheets refers to the effective filling in of the forms fields. The forms presented are used, as mentioned before during the supervision period by supervisees and supervisors in order to obtain a clear view of the case evolution, of the client evolution and the beginner therapist’s development [6], [8].

### **5.1. Initial psychotherapeutic status for A.C.**

Psychotherapist: G. A.

Client (code): 4 A.C.

Date: 24.01.2017.

Initial interview: 24.01.2017. Session: 1

Diagnosis

I.1. *Symptomatology in relation to personality aspects*

*Clinical image of the disorder (DSM-5): Anxiety disorders-Panic disorder*

*Client personality traits:* extroverted, active, pleasant, sensitive, intelligent, organized, rational, authentic;

*or identifiable symptoms:* very punctual, adolescent with a normal physical development, medium height, underweight, neatly dressed with sports clothes; pale face, deep circles around the eyes, high respiratory rate, frequent sighing, sweating of the palms; shy, emotional, attentive, curious, slightly anxious.

*Severity of symptoms:* - medium (!?)

*Somatisation:* severe heartbeat / heart rate acceleration, pericardial pain / stinging, nausea, abdominal discomfort, shortness of breath (suffocation or dyspnoea), joint pain, increased cold / heat, and parenthesis (numbness or tingling) at the extremities of the limbs, feeling of “chest pain” sometimes painful physically, severe fatigue, persistent headache, slight tremor, dizziness, feeling unstable, insomnia asleep and intermittent, restless sleep sometimes interrupted by nightmares, irascibility, self-control precarious, diminished attention and concentration.

*Personal resources:* intelligence, ambition; *social resources:* communication; *environmental resources:* her family and her boyfriend.

## 1.2 Process diagnosis

a. For the first therapeutic session:

- *Diagnosis on the axes A, B, C, E, F, P:*

**Axis A:** insecure attachment of ambivalent preoccupied type, significant difficulties in expressing emotions (anger, joy, fear), condition of the affected value (it is consistent in obtaining external valorisation: parents, grandparents, colleagues, teachers, etc.), nervousness.

**Axis B:** activation of the epigenome (anxious mother, father chronic depression), emotional deficit in the first 2 years of life and during the adolescence in the absence of parents; phenotype (depression, anxiety) - depressive facies, slightly bent body posture, tight “gathered” body, genetic vulnerability to stress and reduced ability to regulate stress; average deficiency of body image perception, she doesn’t see herself as beautiful (she doesn’t ware made up at all) although she is beautiful, she sees herself as “fat” in the conditions in which she is underweight; repressed emotions, psychosomatic disorders as a means of emotional expression.

**Axis C:** negative thoughts that sustain her anxious, depressive episodes, irrational beliefs, perfectionist behaviour and low self-esteem.

**Axis E:** anxiety of death expressed though anxiety about illness / death, responsibility anxiety expressed by the feeling that she is overwhelmed by responsibilities (school), slightly distorted expectations about the future.

**Axis F:** transgenerational patterns (resemblance to mother and maternal grandmother), self-sabotaging behaviour in relationships with classmates (by maintaining perfectionism and exigency), maladaptive family pattern, disengaged-chaotic family model, various family conflicts, divorced parents, conflicting grandparents permanently with everyone, and A. is sometimes in conflict with her parents and grandparents).

**Axis P:** she manifests the behaviour of the life scenario: unconscious desire not to exist (somatisations), depressive states, anxiety, perfectionism, self-sabotage behaviours supported by injunctions: do not feel, do not get close, do not belong, do not be yourself; repressed anger, dramatic triangle with successive behaviours of victim, persecutor, saviour; manifested executive subpersonalities.

*The establishment of therapeutic objectives with the client:*

1. Initiation and recovery of well-being, acquisition of secure, adaptive attachment.
2. Experiencing emotional expression, ventilating repressed emotions and diminishing perfectionism, finding the area of emotional balance.
3. Correcting one’s body image, increasing self-esteem and strengthening the self.

4. Working with anxiety, depression, and somatisations and initiating better management.
5. Discovering the purpose in life, identifying goals for its future, and regaining the joy of age and zest for life.

b. For the next therapy sessions. *Therapeutic objectives for the Axes to work on and the approach of the self (Basic Self – BS, Central Self – CS, Plastic Self – PS and External Self –EF) on each axis of the model [4]:*

**Axis A:** re-establishing a secure attachment (BS); the identification and expression of repressed emotions, emotional regulation, working with neurotic guilt (not to hurt grandparents and parents), increasing the security of some emotions (BS / SC / ES);

**Axis B:**

working with body image, acceptance and adaptive management of elements related to genetic vulnerability, understanding the mechanisms of development and maintenance of psychosomatic disorders, learning new behaviours to “extinguish” them (BS / CS / ES);

working with repressed emotions under the influence of attachment (CS / ES);

identifying the stress level and how can the client manage it (CS / PS / ES).

**Axis C:** reframing situations at the cognitive level, restructuring cognitive schemas (CS), restructuring “here and now” (ES) thinking, identifying “if ... then” (PS) mechanisms and working with them; and restructuring the cognitions regarding perfectionism (SP) - correlated with Axis P, working with deficient self-esteem (eliminating information filtering) (CS / PS / ES);

**Axis E:**

Cognitive restructuring and projection on one’s future, identification of one’s purpose in life and the meaning of life (CS / ES);

Identifying the elements that maintain her death anxiety (in its various forms), understanding them and replacing them with new adaptive, positive elements (CS / PS / ES), which eliminate the fear of life;

Finding New Solutions To Eliminate The Accumulation Of Responsibilities And To Prevent The Postponement Of Actions - Procrastination (PS).

**Axis F:**

Awareness of Transgenerational Patterns (CS) And The Maintenance Mechanisms Of These Patterns (PS), “Breaking” The Dysfunctional and eliminating relational self-sabotage behaviours (ES);

Identification of maladaptive family models and roles (CS / PS / ES);

Understanding and solving family conflicts, the dysfunctional relations between them (ES);

Projecting, in the future, a new family model, functional and satisfactory for her and for her future nuclear family.

**Axis P:**

identification and analysis of her life scenario (CS / PS / ES), restoring the desire to exist, to feel comfortable in her body, to succeed in the desired career, to diminish anxiety, perfectionism, self-sabotage (ES) - in correlation with Axis C;

Strengthening of the self (BS / CS);

Work with the functional states of the self, experiencing the state of “the Adult” (CS / ES);

Identifying psychological games, the dramatic triangle and their analysis (PS);



Identification of transference mechanisms (PS) and the repressed emotions associated with them and their expression;

Identification and work with dysfunctional executive subpersonalities and their replacement with other adaptive ones, appropriate to the present situations (BS / CS / ES).

## II. Indications of the psychotherapeutic treatment

II.1. *Recommendations and supplementary examinations*: somatic: I recommend a general medical consultation with the family doctor; psychiatric: not the case; clinical: not the case; hospitalization: not the case.

II.2. *Indications for psychotherapy*: emergency: not applicable; estimated duration of psychotherapeutic treatment: minimum 10-15 sessions; frequency per week of psychotherapy: 1 session / week; type of psychotherapy: individual; financing psychotherapy: by the client with money from parents.

## III. Psychotherapeutic intervention

### III.1. Session description

a. Axis or axes worked on: Establishing a diagnosis according to the six axes.

b. Objectives proposed for each axis for the session: Initial interview, the establishing of objectives on each axis of the model.

c. Methods and techniques used to achieve the proposed objectives:

- Initial interview with the client. Active observation. Axis diagnosis. Establishing therapeutic goals together with the client.

### III.2. Description of the client's behaviour:

Client's behaviour when coming to the office: overwhelmed by "sickness", discouraged, sad, tired, anxious, anxious, communicative, curious.

Identifying the moments of maximum emotional load for the client: The whole entire session was emotionally charged (crying, sighing, muffled voice, pauses) while the client told her story: she was raised in the country side, by maternal grandparents, who were authoritarian, rigid, uncompromising with mistakes, demanding, lacking the warmth and love of her parents, divorced and gone elsewhere, raised with strict rules, without sympathy and understanding from her grandmother, sometimes punished with beatings, isolation in her room and / or kept hungry, with a ban on emotional expression (she was not allowed to cry, laugh loudly, get angry, fight back, be afraid, etc.) to become "strong", resilient, never vulnerable; the anxiety of separation, of abandonment (of the mother) at the age of 3, left a permanent pain in the client's soul, who then believed that her parents broke up because of her and "punished" her by leaving her, because she was not a good child! She endured all the "censorship" and the hostility of her grandparents, being convinced was what she deserved, believing herself inadequate to be loved. The father was absent from her life until 2 years ago, because he was not allowed to contact the client, on the grounds that he was suffering from chronic depression, anxiety and panic attacks. At the age of 16, the client ran away from her grandparents, looked for her father and moved in with him, developing a good relationship with him, because her father was better and she felt that he loved her very much. The diabetic, anxious, claustrophobic mother, who went abroad, remarried, supported her financially all the time and they had a good relationship, at a distance "on the internet" and by phone; they rarely met, on holidays, a few days every 4-5 years or less. A. is an only child, with a very good school situation at all times, a straight A student, without being "nerdy", but perfectionist and ambitious, because she never wanted to disappoint her parents and grandparents.

Description of the client's insight (if there were such situations): The client was amazed by the fact that she "allowed" herself to be vulnerable in the office, that she was able to express her inner pain (catharsis) by crying and that this had a positive effect on her.

Changes in the client's behaviour: Her behaviour modified by replacing anxiety, tension, with a progressive state of calm, release from what overwhelmed her (right back, relaxed shoulders), activating confidence in therapy and hope (expressed on the face-smile at the end of the session).

Homework (if applicable) and encouraging behavioural change in the client:

To make a personal diary in which to write down the type and frequency of “illnesses”, their intensity and duration, the methods used to overcome the illness or to control it;

To make a list of all her uncovered, conscious needs and another list of everything that makes her happy and brings her well-being, contentment, joy, to bring them with her to the next meeting;

To write down her dreams, recurring thoughts, what she thinks should be noted and discussed in the next meetings or whatever she feels she needs to write.

III.3. Description of the therapeutic relation during the session:

The therapist's reflection on how to build the therapeutic alliance (for the first session): The therapeutic alliance was built throughout the session, from the first moment of contact, through unconditional acceptance, congruence and support in the client's moments of emotional tension. I gave her positive strokes, listened to her, encouraged her, and gave her the attention and understanding she needed. I provided her with a safe, warm and quiet environment. I encouraged her to communicate, to be herself, to get involved. We built the therapeutic alliance in the first 5 minutes of this first session, as a basis for initiating and developing a good therapeutic relationship, which begun.

Possible moments of “rupture” of the relationship, how did it happen? and how was the relationship repaired? (possibly from the first meeting or in the following sessions or not at all): not applicable.

How was the therapist perceived by the client in therapy, what feelings of comfort, somatic discomfort, drowsiness, difficulty concentrating, irritation, desire to end the session faster, perception of time in therapy, etc.: pleasant client, submissive, open, communicative, intelligent, it created a comfortable state for me, and time passed very quickly.

The client's needs, the client's style of attachment manifested in the therapeutic relationship: the client's need for acceptance, support, security, understanding, help and the need to trust.

The therapist's proposals for improving the therapeutic relationship: adding other proposals as appropriate.

## **5.2. Final psychotherapeutic status**

Psychotherapist: G. A.

Client (code): 4 A.C.

Date: 18.04.2017.

Initial interview: 24.01.2017. Session: 13

Diagnosis

I.1. Symptomatology in relation to personality aspects

Clinical image of the disorder (DSM-5): Anxiety disorders-Panic disorder

Client personality traits: extroverted, sociable, agreeable, sensitive, intelligent, rational, demanding, empathetic, tolerant;

Identifiable symptoms: dynamic

Severity of symptoms: - weak

Somatisations: rare insomnia

Personal resources: enthusiasm, optimism; social resources: communicative; environmental resources: family, boyfriend.

## I.2 Process diagnosis

### a. For the first therapeutic session:

Diagnosis on the axes A, B, C, E, F, P: the same as for the first session.

The establishment of therapeutic objectives with the client: the same as for the sessions 1 and 2.

b. For the next therapy sessions. Therapeutic objectives for the Axes to work on and the approach of the self (Basic Self – BS, Central Self – CS, Plastic Self – PS and External Self –EF) on each axis of the model [4]: the same as for the sessions 1 and 2.

## II. Indications of the psychotherapeutic treatment

II.1. *Recommendations and supplementary examinations*: psychiatric: not the case; clinical: not the case; hospitalization: not the case.

II.2. *Indications for psychotherapy*: not necessary; estimated duration of psychotherapeutic treatment: minimum 13 sessions; frequency per week of psychotherapy: 1 session / week; type of psychotherapy: individual; financing psychotherapy: by the client.

## III. Psychotherapeutic intervention

### III.1. *Session description*

a. *Axis or axes worked on*: All axes, but more work was done on the Psychodynamic Axis and the Emotional Axis.

b. *Objectives proposed for each axis for the session*:

**Axis P**: calming the “injured child”, working with the functional states of the self, experiencing the state of “the Adult” (CS / ES); identification of psychological games, of the dramatic triangle and their analysis, recognition of the roles of “Victim” and “Saviour” and their expression: - identification of injunctions and leading messages, discovery of transference mechanisms.

**Axis E**: identification of repressed emotions associated with transference mechanisms.

Brief recapitulation of the interventions, punctuation of the most important acquisitions during psychotherapy, on all psychological axes.

c. *Methods and techniques used to achieve the proposed objectives*:

The technique of the metaphor “*Calming the inner child*” was applied to the client in order to work with the “injured child” and it was timely and had immediate beneficial results for the client. She found herself at the age of 3, alone, abandoned, scared, troubled, disoriented, and sad, disappointed. She succeeded in reassuring her younger self and restoring her peace, confidence, joy, and assurance that from now on she would never be alone, abandoned, or sad. Thus, she processed some of the childhood traumas, then she managed to restructure at a cognitive level, the beliefs about parents and grandparents. Intriguing only critical grandparents and the absence of parents, she needed to reconstruct a permissive parental image that would allow her to give up old patterns of thinking, emotions, and behaviours that were part of the old scenario. The client was able to realize that her grandparents were simple people, scared to deal with such a small and fragile girl, anxious and depressed, and that the leading messages and injunctions received from them were not correct and could not be followed. She accepted her mother as an outcast at the time and paid no attention to her irrational beliefs that her mother had left her because she was not a good and good child. She accepted her father for better or worse and did not judge him anymore, she forgave him for his incompetence, weakness, selfishness and cowardice. She looked at her parents and grandparents from an “adult” perspective.

In the dialogue with the client, the benefits obtained within the therapy were highlighted, the novelties learned, we recapitulated all the changes that occurred during the time period spent in therapy. A.C. pointed out the insights she had and their effects on her. We identified together her resources and ways of coping. We clarified how the client will manage the situation in the future and her current state. We agreed and without resentment that the therapy ended

with this session. The client said that she was ready for the end and did not feel it as an element related to abandonment or as a relational “rupture” but as a final stage of therapy.

### III.2. Description of the client’s behaviour:

The client’s behaviour when coming to the office: impatient, calm.

Identifying the moments of maximum emotional load for the client: - the meeting was emotionally charged, but in the end she calmed down and enjoyed the time spent together.

Description of the client’s insight (if there were such situations): amazement and delight in discoveries about herself in relation to herself and her loved ones.

Changes in client behaviour: liberated, calm, satisfied, confident, open, warm.

Homework (if applicable) and encouraging behavioural change in the client: -

### III.3. Description of the therapeutic relation during the session:

The therapist’s reflection on how to build the therapeutic alliance (for the first session): same.

Possible moments of “rupture” of the relationship, how did it happen? And how was the relationship repaired? (Possibly from the first meeting or in the following sessions or not at all): not applicable.

How was the therapist perceived by the client in therapy, what feelings of comfort, somatic discomfort, drowsiness, difficulty concentrating, irritation, desire to end the session faster, perception of time in therapy, etc.: feeling of satisfaction for the therapist and the client.

The client’s needs, the client’s style of attachment manifested in the therapeutic relationship: the need to organize, plan and achieve the objectives proposed for the future. The client’s attachment style has changed to secure attachment. The need to recover and complete the relationship with the mother and to improve the relationship with the father and a warm and loving closeness with her parents was satisfied.

The therapist’s proposals for improving the therapeutic relationship: adding other proposals as appropriate: The therapeutic relationship has finished!

### 5.3. Supervision sheet no. 1 - Case 4 A.C.

1. Supervision needs: Personal need - to receive feedback about the fact that I get stuck from time to time; I exceed without realizing it the 50 minutes of therapy with at most 7-8 min. And in the presence of my client I feel unexpectedly good, much better than I should be; and when we touch on her problems related to school performance, I “jump” a little from “parenthesis” and identify emotionally with her, which raises questions on how good of a psychotherapist I am in relation to my work.

2. Questions asked by the supervisee: why do I feel that this client connects to me with her perfectionism, while other perfectionist clients don’t have this “effect” on me?!

3. Importance of the case presented for the supervisee: I feel that there is a parallel process with the client: transfer and counter transference and that it must be solved in supervision, but I don't know how!

### 5.4. Supervision sheet no. 2 - Case 4 A.C.

1. The supervisor’s questions:

How old is your client now?! Is her first name similar to yours?! What other similarities are there between your client and "teen A." 18 years old (current customer age)?! What were you doing at her age?!

What did it mean for you to have good grades at school?! Did you have a personal justification for your A grades?! Why did they matter to you?! What was happening to you, how did you value yourself when you didn’t get a high grade?! What do values mean to you now?

Do you think that your blockage is related to the girl / teenager A. in you, who is standing face to face with your 18-year-old client?!

What could you do to separate A- the teenager from your client?!

2. The supervisee's answers, reflection on the case from the perspective of the strategic integrative model of the self (Axes A, B, C, E, F, P):

My 18-year-old client, who has the first name identical to the diminutive of my first name (used by my family and friends to call me) is very similar to me, physically, she is just as weak, thin, has features similar to those mine (nose, mouth, eye colour, long hair the same colour as mine at 18). I had the same preoccupations as her, gymnastics, fitness, the same desire to escape to another stage of life when one can be appreciated and free (of exaggerated parental restrictions), the desire to be loved and the ambition to be the first at school, at home and in the spotlight. The common desire to be "the best".

Through phenomenological self-analysis and with the help of my supervisor, I realized that my high grades made me happy with myself, as well as my client, because they valued me positively, they maintained my self-esteem at a good level. When I was graded different, "I was no longer good for anything!", My existence "no longer had a clear justification". The adult A. left (unconsciously) the client to continue to tell herself that there are other personal values (also to be the "first" on, not to be caught on the "wrong foot"), because and the psychotherapist also has to work on her performance anxiety.

The client provoked "small" A. and blocked the "big" one who was the therapist.

My resilience with the client, "being the best friend with the client", blocked or kept the therapy in place. The key to solving it was to let my client discover the joys obtained from small things, which she enjoys. And to discover that through the evidence brought by her from the experience of her life so far, that she is unique and does not need to be "first".

That's how I discovered in myself that I'm actually "unique" as a therapist and I don't have to be an A student with my clients, and that "getting out of brackets" more or less allows the client to bias me, in parallel transfer-counter transference process (Axis P).

3. Insights on the therapeutic relation: The therapeutic relationship was suspiciously good and fast, and my client's performance anxiety biased me.

4. Methods and techniques used or proposed: self-analysis and supervision

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## 6. Conclusion

After the practical example of the 13 (thirteen) psychotherapeutic statuses filled in with the specific elements of each meeting with my client, in the case study of A.C. presented in this manuscript, the goal established in the beginning of bringing clarifications and support instruments, probably expected by those interested in this field of integrative psychotherapy and to give an incentive to the beneficiaries of this paper to add and / or contradict me in the feedback offered, in order to maintain the continuous development of professionalism was established.

During the work with my client and the action of filling in the psychotherapeutic statuses, but also of the writing of this manuscript, I managed to offer a work "painting", filtered by my own personality, thinking and working style as a therapist. Still it was a difficult and delicate, as always, to assume once again the responsibility of everything I do, work and reflect as a psychotherapist, but also as a person. In order to be able to present to readers my work and my worries, I had to accept my vulnerability to be open and even "discovered" in front of the readers of this paper. I still face my own remnants of performance anxiety, to become aware of it, to accept it and to manage it correctly and productively the thousand time, so that I can overcome them and still be me.

I believe and hope that it will be much easier now for my colleagues, novices in the profession, to apply this model of work and to be aware of the usefulness of therapeutic status in their work with clients. But I also considered it a safe, correct and a personal source for possible research studies, papers, publications, etc. in facilitating my office work and in presenting the case under supervision. Extrapolating, I am convinced that my supervisory colleagues will also

consider it helpful and that understanding the supervision protocol will help them to put it into practice, thus achieving the objectives proposed for this topic. I suspect that my “lesson” can be just as useful to others through the practical proof of simplicity of the process result in filling in a psychotherapeutic status, diminishing / eliminating the possible “anxieties” of novices, regarding the acquisition of correct situation management skills.

It will probably boost the activation of internal resources of each of those interested. The idea is to contradict and / or complete my personal way of trying to expose things. How?! ... through new ways of approaching the issues presented in a status, in accordance with the level of each development and with its own system of values. The presentation (according to a concrete therapeutic case) of the component elements of the psychotherapeutic status, for the first therapy session, can clarify its simple structure and the approach for completing any status. It can also be a “stimulus” material for self-assessment and / or self-reflection of each psychotherapist interested in the information presented.

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## Compliance with ethical standards

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### *Statement of informed consent*

Informed consent was obtained from all individual participants included in the study.

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