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REFACS

Clinical supervision of young therapists in the context of chronic kidney disease

Supervisão clínica a jovens terapeutas em contexto de doença renal crônica

Supervisión clínica de jóvenes terapeutas en el contexto de la enfermedad renal crónica

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This is an experience report, from 2010 to 2019 in the city of Ribeirão Preto, in the state of São Paulo, which aims to raise reflections on the care of patients with chronic kidney disease and the emotional resonances in young therapists (Psychology students) facing this demand, added to the characteristics of the family life cycle to which they find themselves. Supervisions carried out with 300 students were considered, through analysis of empirical data, arising from supervision notes. The themes raised by supervisors were: *Reflections about the patient with chronic kidney disease*, and *Impacts and emotional repercussions on therapists*. There were consequences of depressive and manic phenomena in the patient-therapist-supervisor relationship through the projective identification process, caused most notably by the feeling of impotence of patients, in the face of the disease and treatment. The young therapist's difficulties are accentuated by characteristics of their own family life cycle.
Descriptors: Chronic disease; Psychotherapy; Psychoanalysis.

Este é um relato de experiência, realizado no período de 2010 a 2019 na cidade de Ribeirão Preto, São Paulo, e tem como objetivo suscitar reflexões sobre o atendimento a pacientes portadores de doença renal crônica e as ressonâncias emocionais nos jovens terapeutas (estudantes de Psicologia) frente a esta demanda, somadas às características do ciclo vital familiar ao qual se encontram. Considerou-se as supervisões realizadas com 300 alunos, pela análise de dados empíricos, advindos das anotações de supervisão. As temáticas suscitadas das supervisões foram: *Reflexões acerca do paciente portador de doença renal crônica,* e *Impactos e repercussões emocionais nos terapeutas.* Verificou-se desdobramentos de fenômenos depressivos e maníacos nas relações paciente-terapeuta-supervisor por meio do processo de identificação projetiva, ocasionados especialmente pelo sentimento de impotência presente nos pacientes perante à doença e ao tratamento. As dificuldades do jovem terapeuta se acentuam diante das características do seu próprio ciclo vital familiar.
Descritores: Doença crônica; Psicoterapia; Psicanálise.

Este es un informe de experiencia, realizado de 2010 a 2019 en la ciudad de Ribeirão Preto, São Paulo, y tiene el objetivo de suscitar reflexiones sobre la atención de los pacientes con enfermedades renales crónicas y las resonancias emocionales en los jóvenes terapeutas (estudiantes de Psicología) ante esta demanda, sumadas a las características del ciclo de vida familiar en el que se encuentran. Se consideraron las supervisiones realizadas con 300 estudiantes, mediante el análisis de los datos empíricos de las notas de supervisión. Los temas planteados desde la supervisión fueron: *Reflexiones acerca del paciente con enfermedad renal crónica, e Impactos y repercusiones emocionales en los terapeutas.* Se produjeron fenómenos depresivos y maníacos en las relaciones paciente-terapeuta-supervisor mediante el proceso de identificación proyectiva, causados especialmente por la sensación de impotencia presente en los pacientes, ante la enfermedad y el tratamiento. Las dificultades del joven terapeuta se acentúan por las características de su propio ciclo de vida familiar
Descriptores: Enfermedad crónica; Psicoterapia; Psicoanálisis.

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INTRODUCTION

Supervision in an institutional context is a great challenge, since the place where attendance occurs permeates the walls of the university. The student is faced with a new environment, full of particularities and without the "physical presence" of the supervisor at the time of service. The supervisor, in turn, takes part in this journey of exchanges, experiences and learning with his supervised, embarking on their experiences from the narratives brought by them, full of meanings, in a genuine exchange of knowledge.

This process is intensified when the scenario encompasses vital themes, such as illness, impotence and death, in line with the stage of development of the family cycle. From the holistic understanding of the human being, the illness process gained a new scenario; the disease came to be understood as a dynamic and multivariate phenomenon. Health conditions can be defined as circumstances in the health of people who present themselves in a more or less persistent manner and who demand social responses[1]. From a systemic perspective, a phenomenon that permeates the individuality of the patient reverberating to all their family members and the people with whom they lives, including the therapist[2].

Chronic disease, in turn, is defined as a permanent pathological state that can leave residual disability and/or produce non-reversible pathological changes, requiring rehabilitation or requiring long periods of observation, control and care. They are produced by morbid processes of varied etiology, which, due to their frequency and severity, are of singular medical, social and economic importance. Individuals with chronic diseases often feel forced to give up any possibility of adaptation and development, and feel the need for constant care. Chronicity can have shaping consequences for psychological life, in which psychodynamic factors such as regression, dependence and passivity become permanent[3]. In this context, depression, anxiety, organic and neurological disorders, changes in body image and self-esteem can arise[4].

Considering the complexity of the illness, it is not possible to add the parts, nor to make a cut for the possible understanding of so many singularities, of such subjectivity[2]. The phenomenon of falling ill must be understood in a circular way, in which, from an event (in this case, the chronic disease), all family members undergo readjustments in the face of stress, resignification and overcoming, resulting from mechanisms of their own self-regulation system. The young therapist comes into contact not only with the patient, but with everyone around them, and for a better understanding of their patient, it is necessary to look at the context, the family and the multidisciplinary team responsible for the care.

This complex plot (illness and all the resulting changes), added to the developmental crises that the therapist, patient and their family are in, constitute a great challenge to care and to the supervisor, who needs to be attentive to movements of the cycle specific to that phase, and to movements arising from chronic disease. In this context, the diagnosis of chronic disease can be understood as a horizontal stressor unpredictable in the course of "normal" development, since the initial stages of the family cycle (1. Young single, 2. Family without children, 3. Family with children, 4. Family with teenagers) are endowed with movements of life impulses and moments of acquisition, and not of loss and death[5].

Anguish and resistance can be generated in the student/therapist in the face of the patient's illness process, since the identifications arising from the life cycle phase contrast with consequences of the disease and the finding of finitude, present concretely in the care environments of patients.

Clinical supervision then becomes an important tool for the psychological reinterpretation of the patient-therapist encounter, technical guidance and also suggestions for reading relevant topics to the young therapist's learning process, in the systematic search for learning. In this process, the scarcity of scientific production that involves, at the same time, the theme of clinical supervision, chronic kidney disease and family life cycle was identified. Thus, this study aims to raise reflections on the care of patients with chronic kidney disease and the

emotional resonances in young therapists (students of Psychology) in the face of this demand, added to the characteristics of the family life cycle to which they find themselves.

METHOD

This study is an experience report, considering the period from 2010 to 2019 in the city of Ribeirão Preto, in the state of São Paulo, taking into account the context of supervision. Thus, it brings an analysis of empirical data, arising from the supervision notes, on: a) Observation and listening to reports of sessions produced by Psychology students; b) The demands presented by them in relation to their clinical performance and the development of work with the patient; c) The supervisors' perceptions and guidelines for the evolution of the case and the therapist's learning in the context of chronic kidney disease in a specialized clinic. For this analysis, psychoanalytic theories and current scientific productions on chronic kidney disease were used as a reference.

Supervisions were carried out as a mandatory activity related to an internship taken in the last year of Psychology Graduation, carried out in health contexts, by Universidade Paulista - UNIP. This is an internship chosen by the students, through the offer of a mandatory internship schedule, which they undertake to carry out in two semesters, with a frequency of three hours a week of attendance at health institutions (Clínica de Treatment Dialysis, in this particular case) and three hours of weekly supervision.

RESULTS

For the analysis of the results, notes of supervisors regarding the context of care for patients with chronic kidney disease were selected and systematic readings of this material were performed. In the period (2010 to 2019), the construction of the themes took place considering the participation of 300 students in training in Psychology.

After systematic reading of the notes, the main topics covered were divided into two axes, namely: a) *Reflections on the patient with chronic kidney disease* and b) *Emotional impacts and repercussions on therapists*.

DISCUSSION

Reflections on the patient with chronic kidney disease

The narratives brought in the supervision of clinical care performed by students with patients with chronic kidney diseases were marked by the history and evolution of the disease. The moment of diagnosis is often described as an abrupt discovery of something totally unknown to the patient, with immediate initiation of invasive treatments, such as hemodialysis. It is also noteworthy in this patient, the lack of understanding about physical/biological aspects of the disease and different treatment possibilities.

Psychic suffering begins immediately with the impact of the diagnosis, as the subject becomes aware that the disease will accompany them until the last days of their life, the treatment is very painful, invasive and causes a series of changes in the usual style of living[6].

As hemodialysis is an intermittent procedure, in which patients go to a specialized clinic three times a week, where they stay for approximately four hours connected to a machine called an artificial kidney[6], psychological assistance can be performed during this period. Thus, patients and therapists need to adapt to the environment and create favorable conditions for maintaining the "therapeutic setting".

During the procedure, some patients complain of physical pain such as discomfort at the fistula site, malaise, indisposition, muscle cramps and other impacts due to excess toxins in the body. These appear linked to speeches of psychological suffering, anger and dissatisfaction with treatment, which often reflect on conflicts with the health team and the family[4,6].

It was noted, from the content of psychological assistance, that the main difficulty of patients' adherence to treatment is linked to diet, especially to restricted fluid consumption. In some cases, especially among younger men, adherence difficulties may be associated with denial, as physical limitations are not considered. The maintenance of distress and depressive symptoms can lead to difficulties in adhering to treatment and impairing self-care in general[3,6].

During supervisions, fantasies of death are perceived in the patients' narratives, especially present in the description of the moment of entry into the hemodialysis machine, which is seen to contain a destructive potential. It is common for patients to nickname and/or name in a pejorative way some machines, blaming them for the death of people.

The anguish of death is often perceived during consultations reported, especially when patients receive the news of worsening or death of another patient. The fact of having the same disease and being periodically subjected to a treatment that does not lead to a cure, promotes a disbelief in its results and the idea that death is sneaking up, regardless of the daily efforts of patients in the search for life.

The machine and health institution are seen as places of imprisonment and condemnation. The desired release is linked to a healing fantasy, associated with a possible kidney transplant surgery. Often, there is an idealized conception about transplantation, such as the end of care and restrictions imposed by chronic kidney disease. In this sense, prior psychological assessment is important, prioritizing factors such as maturity, concepts and feelings about the disease and realistic or unrealistic expectations about the future health condition[4].

Religious beliefs are also perceived in the reports of some patients, who attribute to divine desires the appearance of a compatible kidney for transplant; and others who describe a miracle cure wait.

These beliefs are favorable to treatment by instilling faith in their results; however, in some cases, the belief in miraculous healing makes it difficult for the patient to reflect on their daily health behaviors and responsibilities. It is noted, in these cases, that the diagnosis of the disease was initially understood as a divine punishment or trial of faith; in their reports, patients associate the diagnosis with guilt for episodes/life situations in which they realized they had made mistakes, injustices or antisocial conduct.

With regard to social aspects, patients often complain about losses in their interpersonal life and leisure activities. Social contact is often restricted to the family nucleus in a domestic environment, which can lead to isolation. In the narratives, this is associated with the loss of work and the resulting feeling of worthlessness. Physical restrictions and time limitations, due to duration and frequency of hemodialysis treatment, often impose abandonment of formal jobs and abrupt loss of financial resources, the main stress factor for patients in some studies[3,4,6].

Patients and their families face a process of mourning for the losses experienced, in different areas, such as financial, professional, relational and physical; mobilizing depressive anxieties that can compose a grieving process, the elaboration of which will provide adaptation to the new life situation of the patient and family, a painful and therapeutic process, but not always possible for all patients.

Emotional impacts and repercussions on therapists

The emotional impacts experienced by students in contact with patients are numerous, which must be accepted during clinical supervision. It is known that one of the main purposes of the supervision process is to ensure that the student acquires the necessary knowledge and skills to perform the task as a therapist as properly as possible. It is essential to learn to listen to the patient, to be able to observe what happens in the session, to formulate interpretations and/or interventions using their own equipment, in emotional and intellectual terms[7].

In supervisions, students often begin their reports describing their sensory perceptions about the appearance, color, smell and noise of institutions in the health area. It is noted that

students experience a process of adaptation to the new context of performance, in which it is important to recognize the physical structure of health institutions, the understanding of the functioning of medical devices and equipment present, the dynamics of services provided and of the professional team. This experience has been recognized as a good opportunity to get to know the reality of the institutions[8].

Students are placed in a rich learning context, but one that generates ambiguous feelings, such as epistemophilic impulses accompanied by high levels of insecurity, anxiety and loneliness. Developing psychological assistance during hemodialysis session is also a factor often treated in supervision, since adjustments to the "therapeutic setting" are achieved through a cognitive and emotional effort by the student. This is perceived in an arduous task of maintaining concentration focused on the patient, in an environment surrounded by several professionals who are in full operation. The experience of direct contact with the patient who underwent invasive treatment during psychological care, has aroused intense negative feelings in students, especially in the face of the expression and/or report of physical pain by patients.

There is a feeling of discomfort from students regarding the necessary initiative to meet patients in their beds. This initial moment of the encounter between therapist and patient is often described in an afflicted manner by the defensive posture and/or rejection of some patients in the face of psychological care. Managing these feelings is one of the most important points in supervision.

Students constantly deal with the feeling of helplessness in the face of patients' reports about their current life situation, in view of the losses and limits imposed by the disease and treatment. The main questions addressed to supervisors reflect the students 'desire to learn types of interventions capable of promoting practical changes in the patients' life routine. This desire reveals the illusory and idealized image about the figure of the supervisor and the scope of therapeutic work. Reflection on the difficulty in supporting and managing the feeling of helplessness has therefore proved to be of great relevance in clinical supervision.

Over time, some students complain about the repetition of content in the patients' narratives and the absence of any internal or external changes perceived by them, a factor generally understood as ineffective psychological assistance and failure of the therapist.

The anguish of young therapists becomes unbearable when they witness medical complications rendered to some user of the institution, a moment in which emotional reports often arise, involving pain, fragility and guilt for not having found ways to continue the appointments planned for the day. In some cases, there is even a tendency for students to give up their work or specific patients, who are more resistant, externalized in the form of refusals due to tiredness, sleep or pain.

Then, the importance of reflecting on such reaction from the students is highlighted. Considering the experience of supervision in an academic context, as a mandatory practice of supervised internships, one can notice different levels of anxiety related to the exposure of the clinical material, its performance in the session with the patient and the supervisor's assessment in terms of his learning process . The existence of such conditions means that clinical practice, in such a context, runs the risk of immersing itself in the logic of academic training, regardless of the way the supervisor acts[9].

Students are subjected to strong persecutory anxiety, which can cause two predominant reactions: manic attitudes and marked inhibition[7]. Some resort to manic attitudes and try to make up for their inexperience or lack of capacity with a false perception that they understood absolutely everything that was provided by the patient, presenting an excess of interventions during the session with the patient. Those who are more inhibited tend to repress what they understand about the material, make few interventions (and often ambiguous), factors that make it impossible for them to comply with the minimum required for their role as therapists.

In this context of chronic illness, the young therapist, in the last year of college, in the midst of an individuation process, of achievements and realizations, is faced with issues incompatible

with their movement of acquisition when coming into contact with impotence, fragility of life, possibility of death resulting from the illness process. In this way, anxieties, resistances and active psychic defenses arise that demand the supervisor's skills to carry out careful orientations, so that they can be identified and reflected, in the search for a broader understanding of the individual and group resonances produced by the feelings of finitude, impotence and, mainly, of the unknown, represented by the idea of death, whether physical or psychological.

One of the most important problems to be considered in the exercise of supervision is the identification of students' difficulties arising from their countertransferences, as well as reflecting on the attitude that the supervisor must assume regarding the student's countertransference[7]. This is a countertransference, a specific aspect called "against projective identification", which refers to the content triggered by the patient in the student, determined by the quality and intensity of his projective identification mechanisms "[7]. Some situations are determined by something that the patient induced in the therapist through the use of the projective identification mechanism, leading them, at times, to act in a certain role, assume attitudes, experience certain emotions or function in a way that, unconsciously, the patient needs/wants. In the analytical situation, the therapist can be an active subject of introjections and projections or else the passive object of the patient's projections. Their emotional reactions may be due to their own reactivated conflicts (material to be treated in the student/therapist's personal therapy), or else, their affective resonance may be a consequence of what the patient projected onto them (material to be identified and reflected in supervision)[7].

In the care of chronic kidney patients, the young therapist is often subjected to death anxieties, persecutory anxieties, depressive anxieties or manic reactions resulting from the denial strongly present in these visits. Physical death presents itself in a concrete way to students, who can experience, throughout the visits, the worsening of the patient's disease and even their death, which can lead them to the experience of mourning. Psychological death is experienced by students due to the chronicity of the disease, the continuous presence of pain, the feeling of inertia and paralysis. Such factors can fall on the supervisory group in the form of silence and apathy that invade the participants' minds.

The intense emotional repercussions on young therapists are externalized in their speeches by contradictory requests to the supervisor, as they sometimes announce their desire to give up care, sometimes they beg for idealized interventions capable of promoting a significant emotional change to the patient, including in their daily routine.

In this context, the understanding of the projective identification mechanism and affective resonance present in the therapist-patient care[7] can help the supervisor in their challenging task of using himself as an instrument to develop the student's essential therapist functions, using the supervisor-patient interaction. supervising as a way of understanding the patient[10].

CONCLUSION

Although clinical supervision is a common practice among academic institutions, especially in Psychology courses, there are few studies carried out in a structured way on the subject. It is understood that supervision, from an academic point of view, favors a rich teaching-learning process for young therapists regarding the theories and techniques used in clinical care.

From a clinical perspective, different work styles are present among supervisors, resulting from areas of mandatory internships that make up the curriculum of undergraduate courses in Psychology, and also from the theoretical approaches used by them. Considering only psychoanalytic and/or psychodynamic supervisions, there is still a great variation of style among supervisors, including with regard to the handling of transference and countertransference, specific to the process.

Over the years, from the practical experience of supervising care provided to patients with chronic diseases, it has been possible to notice the repetition of some transference and countertransference contents, present in the patient-therapist and therapist-supervisor relationships.

The reflections were then initiated from the questioning in supervisions about a tendency for students to give up therapeutic work, opposed to moments of excessive interventions during the session with the patient, added to the illusory requests made to the supervisors for new types of interventions capable of achieving greater therapeutic effects on patients.

Such inquiries promoted a rich path of reflections on the performance of depressive and manic phenomena in patient-therapist-supervisor relationships, especially in view of the feeling of helplessness so present in the experiences of these patients, before the disease and treatment. It is understood that the difficulties of the young therapist can be accentuated by the contrast between the characteristics of the family life cycle to which they are.

The present study does not intend to exhaust reflections on the theme, but to propose a possible way of understanding complex phenomena, assisting young therapists and supervisors in their difficult tasks that are their function. In this sense, its main contribution is the presentation of a reflection model that articulates themes, such as clinical supervision, chronic kidney disease and family life cycle, usually treated separately by scientific studies currently present in the literature.

The study presented is limited by the fact that it expresses the reality of a single educational institution, as well as the scarcity of studies. Thus, the need for systematic studies on the topic, which may involve access to the original clinical material (session report), as well as the gathering of information from objective and direct collection techniques, with a greater number of interns and supervisors.

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CONTRIBUTIONS
Ana Paula Parada contributed with the conception, outlining, analysis and interpretation of data and writing of the article. **Ana Carolina Ferreira Castanho** participated in the conception, outlining, interpretation of data and revision.

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