THE SEVEN DEADLY SINS?
Issues in Clinical Practice and Supervision for Humanistic and Integrative Practitioners

ANNE KEARNS
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In memory of my mother, Regina, who told me never to put anything in writing.

And for Penelope who was patient.
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Introduction

In 1985, following eight years of three-times-a-week on the couch psychoanalysis and clutching a Masters of Science in Clinical Social Work from Columbia University, I came to live in London. An MSc in Social Work is one of the prerequisites to train as a psychoanalyst in New York State, and I wove my way through the two-year, full-time course being taught and supervised as much as possible by psychoanalysts and psychoanalytic psychotherapists. It was my intention to join their ranks. I arrived in London and headed almost immediately for the Tavistock to inquire about training there.

Fate intervened when I realized that I would first have to earn a living to pay for any training I intended to undertake. I went to work for an advertising agency and was sent on an ‘Introduction to Transactional Analysis’, or a TA 101, at a place in Ealing called Metanoia. I went on to train in TA and gestalt. For the past twelve years or so I have been teaching and supervising humanistic and integrative psychotherapists from various trainings around the country. I have also been thinking about the effectiveness of those training courses and some of that thinking will be reflected here.

The practice of psychoanalysis was traditionally passed down by key theorists to their prodigies. This was usually
done informally, the aspiring analyst entering into a ‘training analysis’ with his mentor. Jung and Adler began their journeys as independent theorists by lying on Freud’s couch. Guntrip has written critically of his analyses with Fairbairn and Winnicott. Fritz Perls, the founder of Gestalt Therapy, was analysed and supervised by several of Freud’s disciples such as Horney, Deutsch, Reich, and Fenichel.

The persecution of the Jews before and during the Second World War brought many second- and third-generation psychoanalysts to America. Some, like Horney and Deutsch, remained true to their Freudian roots. Others, like Perls and Reich, created their own schools of psychotherapy by, in Perls’s case, integrating strands of Freud, Reich, Gestalt psychology, existentialism and Zen. Eric Berne, a native North American, developed his Transactional Analysis (TA) as a sort of object relations with popular appeal and ready accessibility.

By the 1960s Perls was well established as a charismatic figure in a movement that Rowan (2001) calls the ‘third force’ – those therapies that developed in opposition to psychoanalysis and behaviourism. Berne’s TA and Carl Rogers’s Client Centred Therapy had also taken hold in a climate in post-war America that emphasized personal responsibility and self-expression.

Despite the recent trend that has seen most training courses that lead to UKCP registration through the Humanistic and Integrative Psychotherapy Section (HIPS) become routes to Masters degrees, there remains a sort of ‘hangover’ from the 1960s when catharsis and ‘speaking one’s truth’ were valued above intellectualization and research. Trainees are required to ‘be themselves’ and to spontaneously interact with each other and
the facilitator in a process group; to use each other to practise their therapeutic skills in smaller groups; and then to be available with their thinking intact to absorb whatever academic input the trainer has planned for the day. This format encourages trainees to regress and, at some level, to be unable to engage with the theory.

I believe that humanistic and integrative trainings, with their emphasis on the ‘here and now’, have ignored the ‘shadow’ at their peril and have produced psychotherapists who may be unequipped to recognize and intervene effectively in processes that enter the therapeutic encounter from the client’s and therapist’s historical, developmental, and personal ‘field’.

It was through my work as a supervisor of nearly or newly qualified psychotherapists that the seed for what became a post-qualification training course called ‘The Seven Deadly Sins?’ was sown. My supervisees and I came to see that there had been a number of areas or themes – diagnosis, schizoid phenomena, addiction, envy, shame, eating disorders, and trauma – that kept arising in their practice that had been under-discussed (or not covered at all) in their original training. I began to refer to these as ‘The Seven Deadly Sins?’. I also began to be interested in how so much of what we describe in our clinical discussions of fragile self-process and the transference relationship was twentieth century language for what our forebears would have described as sin and possession.

This book is my attempt to condense some of what I and my colleagues, Penny Daintry, Joy Appleby, Diane Hodgson, and Mike Lawley have taught on ‘The Seven Deadly Sins?’. Having said that, the opinions expressed in the pages to follow are at times controversial and they are mine alone. What follows is my attempt to make more
accessible some concepts from the world of psychoanalysis, self-psychology, and affective neuroscience, as well as to comment on some of the challenges of working ‘in the real world’ when supported by a humanistically orientated training and philosophy. I am addressing humanistic practitioners as well as their supervisors. The first chapter, ‘The sorcerer’s apprentice’ is aimed more at supervisors, but should be of interest to the clinician as a way of reflecting on the experience of training and on the assumptions made as a result. Chapters Four–Eight focus on issues in clinical practice and in supervision, with the chapter on shame focusing on shame in the supervisory relationship. That chapter, and the one on eating disorders, were written in collaboration with my colleague and partner, Penny Daintry, and have appeared in other forms elsewhere. Much of the book relies on examples from my clinical practice. In Chapter Four I have used a rather lengthy example of my work with a client that I have called Ruth to illustrate how I worked with what some might see as an addictive problem. I also refer to Ruth in other chapters to show how it is possible to look at the same clinical presentation through different lenses.

Although the book follows a sort of logical order, it should also be possible for the reader to read one chapter without having read any of the others.

I describe myself as an integrative psychotherapist, by which I mean specifically that I use both an object relations and humanistic–existentialist approach to my work. Humanistic therapists often are put off by the word ‘object’. To me it just refers to a different kind of human relating that belongs more to the past than to the present. An ‘object’ is an aspect of a past relationship that is internalized by the client and experienced as though it were an
aspect of the therapist or of himself. Fairbairn, who I believe did much to ‘humanize’ psychoanalytic thinking, was an object relations theorist. He pointed out that people seek other people as opposed to the pleasure that Freud originally thought we were after. Even Freud came eventually to describe transference as the patient’s way of living his love. I like that, and it has supported me through some pretty difficult times when it feels as if there is anything but love in the room.

As much as I believe in psychotherapy, am interested in the theory and ever-fascinated and challenged by the practice, after twenty-something years of being a client and a therapist I can honestly say that I’m not sure that the therapeutic relationship is any more effective than other kinds of relationships. Oddly enough it is my uncertainty that keeps me going. I am grateful to my clients and supervisees, who have let me learn from them some of what I share with you here.

I want to acknowledge those who taught me as well as those who have given me opportunities to supervise and teach: Oliver McShane, Joseph Simo, Louise Engel, Senta Driver, the late Sue Fish, Petruska Clarkson, Maria Gilbert, Talia Levine Bar-Yoseph, Gaie Houston, Peter Philipsson, Margot Sunderland, Joanna Beazley-Richards, and Lynda Osborne.

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Introduction

It is my hope that dipping into this book will inspire the reader to explore some of the writers who have had an impact on my work. They have been marked with asterisks in the bibliography.
‘It was a good life being an existentialist, although not too good for all the other, non-existentialist people around one.’

A. McCall Smith, *Morality for Beautiful Girls*

‘The psychotherapist is the true successor of the exorcist. His business is not to pronounce the forgiveness of sins but to cast out devils.’

W. R. D. Fairbairn (1986)

‘Teach us to care and not to care. Teach us to sit still.’

T. S. Eliot, *Ash Wednesday*
CHAPTER ONE

THE SORCERER’S APPRENTICE

The main challenge for me, as a supervisor of emerging psychotherapists, is to teach the theoretical and practical aspects of a psychotherapy that is based on the intentional use of relationship to people who may have had very little experience of clinical relationship, either as therapists or as clients. The paradox is that most of the relational issues addressed in the training are the very ones that the majority of trainees are struggling with for the first time, not just as beginning clinicians but, often, as beginning clients.

It is not unusual for entry-level psychotherapy trainees to have had no previous clinical experience or personal therapy. These trainees look to the outside for learning and may also have limitations in ego development that will affect their growth as a therapist. (Stoltenberg & Delworth, 1987). Trainees at this level tend to focus on the client rather than on themselves and, when they do focus on their own experience, it tends to be as a result of ‘performance anxiety’ and does not usually lead to clinically useful self-awareness. I have found it particularly stretching of myself as a trainer to help trainees to see that having ‘negative’ feelings such as irritation and exasperation towards a client does not necessarily indicate a flaw in the therapist’s character but, rather, can be a form of communication from or about the client.

Even those more clinically experienced trainees still have difficulty in ‘. . . separating useful responses to a
client that are based on accurate perceptions of the client’s interpersonal interactions from countertransference issues that are effectively blocked from awareness.’ (ibid., p. 76). Trainees at this level often over-identify with the client and will resist diagnostic and assessment techniques. This over-identification with the client also often gets in the way of trainees appreciating that there are differences between people, not just in their personality structures, but also in their gender and socio-cultural identities.

It has been my experience that trainees who have not yet successfully separated from their families of origin or from their children will also resist developmental theories and their clinical application. A supervisor of beginning psychotherapists must find a way to deliver diagnostic and child development models in a way that is ‘palatable’; that is to say, that is respectful of the very strong possibility that the trainees will personalize this material and will use it to find themselves in some way deficient. They may take an oppositional position and hold the polarity of ‘political correctness’ as a deflection from any real learning. I want my supervisees to learn to be interested in and excited by their awareness of difference rather than to see it as a failure of empathy.

Helping trainees to reach a clinical understanding of empathy or its first cousin, inclusion, also has its challenges, as many ‘beginners’ view the clinician’s role as necessarily warm and empathic and often see constructive confrontation as, as one trainee frequently put it, ‘being horrible to people’. Beginners also tend to have an aversion to interpretation and fervently believe that humanistic therapists don’t interpret. They do. They just call it something else. In gestalt, the therapist offers an ‘interpretation’ by saying, ‘My hunch is that . . .’. A person-
centred therapist might say, ‘I don’t know if this fits for you but I have a strong sense that . . .’. Call it what you will, what gives interpretation by any other name its humanistic credentials is that it is ‘offered’ as a possibility, not handed down as the official version of the truth.

Beginners also tend to be wary of theory as limiting of the therapist and diagnosis as depersonalizing of the client. My task as a supervisor is to help them to see that theory and diagnosis are ways of organizing and making sense of their thinking and emotional responses rather than pejorative reifications or instruments of power; to see that each clinical intervention involves an awareness of self and other and is choiceful rather than creative or prescribed.

I believe that supervisors of emerging therapists must take as a working assumption that psychotherapists often function within a narcissistic system where we can only value ourselves when our achievements meet our rather high expectations of ourselves. Yontef (1993) has said about narcissists that,

> . . . they do not assume that struggle is normal, do not assume they should have to struggle and do not feel a confident and loving feeling toward themselves as they go through the pain that is involved in learning. [p. 435]

He also reminds us that trainees tend to feel shame when they become aware of what they do not yet know. The supervisor of beginning psychotherapists must be mindful of the potential for shame in the supervisory relationship (see Chapter Seven) and, at the same time, must not treat the trainees as if they are too fragile to face themselves and their own limitations and deficits head-on. I must always struggle to find a balance between recognizing a trainee’s
real limitations and challenging him to move to a new place of knowing without pushing him into a ‘narcissistic trap’ of believing that he is brilliant on the one hand or hopeless on the other. A sense of humour helps.

Above all I attempt to approach my task with the knowledge that I was once a client and a trainee. I hope that I can share what I know and who I am, including the mistakes I have made and something about my own therapeutic journey. I have found that if I can come to this work supported by the memories of my own continuing journey to becoming a psychotherapist, including the challenges that I no doubt presented to my trainers and therapists, then I am less likely to pathologize and infantilize the trainees and more likely to model acceptance of self – warts and all – and, in doing so, to create an environment where staying with one’s confusion and ‘not knowing’ is as valued as is moving towards conscious clinical competence.

Challenging dogma

There would appear to be two types of humanistic and integrative therapists practising in the UK today – those who, like me, learned a first language and, when that language was no longer effective in explaining what we were experiencing as human beings or as practitioners, learned another. And another. The second type is the single school practitioner who has learned a first language and is sticking to it. Even integrative psychotherapy – as if there were any agreement about what that is – is now being taught as a first language. Speaking as someone who has taught and supervised integrative psychotherapists
from different trainings, my experience is that by attempt-
ing to teach many languages at once, or to teach a meta-
language, we have failed to lay a secure foundation and
may be producing anxious therapists. If I think about my
experience supervising integrative trainees I have observed
that those who came to integration after having learned a
first ‘psychotherapeutic’ language are less anxious practi-
tioners and are more able to deal with complexity, ambi-
guity, and inconsistency and to tolerate and to learn from
their mistakes – or failures.

So often, when I sit as a supervisor with someone who
does support one way of thinking about and working with
human experience above all others, or who is surprised
that a concept central to their ‘language’ is shared by or
even originated in another, I’m reminded of the joke
about the guy who dies and goes to heaven. He’s met by
the gatekeeper who asks, ‘Religion?’

‘None’, says the guy.
The gatekeeper looks at his list and says, ‘Let me see
... agnostic ... atheist ... that’ll be rooms 4–21. Come
with me.’

So, the guy follows him down a seemingly endless
corridor with numbered doors. Behind one door he hears
muffled speech and clinking glasses.

‘Who’s in there?’, he asks the gatekeeper.

‘That’ll be the C of E. They like to have sherry parties.’

They continue until they come to a door behind which
can be heard ecstatic laughter.

‘Who’s in there?’, the guy asks.

‘Those are the Buddhists’, says the gatekeeper (mildly
irritated) to the guy who keeps asking questions as they
walk down the corridor. ‘Look’, says the gatekeeper, ‘I
really appreciate your curiosity but I’m going to have to
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ask you to be very quiet when we get down to that next set of doors.’

‘Why?’ says the guy.

‘Because’, says the gate keeper (whispering), ‘that’s where the Catholics are and they don’t think anyone else is here.’

One challenge as a supervisor of ‘single school’ trainees is to help them to see that theories are no more than stories that we tell to explain what makes people tick; that no theory is more ‘true’ than another – just more compatible with a therapist’s personal and historical experience and perspective. It is also a challenge to help trainees to see that concepts such as ‘commitment’, ‘confidentiality’, and the ‘core conditions’ are ideals rather than absolutes. I am being deliberately irreverent because I have too often seen therapists suffer from burn-out as a result of the high expectations they put on themselves to be respectful of their clients at all times.

When I was a trainee in New York, I worked in a unit that provided short- and long-term therapy to municipal employees and their families. Two of the cultural norms that I have embraced from those days are versions of what management referred to as ‘the padded cell’ and ‘mental health days’. The padded cell was a spare room in the unit where we were encouraged to go with a colleague when we had heard particularly troubling stories during an intake interview. Frequently gales of laughter could be heard coming out of the padded cell as one therapist ‘debriefed’ another, using humour to diffuse the horrors of many tales from the city. I used to call it the ‘MASH syndrome’. Far from being cruel and intolerant, debriefing like this helped me and my colleagues to be more available to hear stories that were out of our range of experience.
All staff in the unit – therapists, managers and receptionists – were also required to take a day off every six weeks whenever they felt like it. This did not have to be arranged in advance, nor did we have to feign illness in an early morning phone call. We just phoned in and said, ‘I’m taking a mental health day.’ While I don’t recommend such spontaneity in private practice, I do support my supervisees and colleagues to take planned mental health days. When supervisees are over-loaded with life stressors such as family illness or bereavement I require it.

Deconstructing myths

As a supervisor and as a therapist’s therapist, I am interested in the myths that come to be believed by members of the profession.

I remember spending a few days when I was a trainee with Claude Steiner, who was well-known in the TA world for – among other things – his ‘no suicide contract’. A member of the group presented a client for supervision. The client was a successful professional in his fifties, married to the same person for twenty-something years, who had come into therapy because he was finding himself thinking more and more about leaving his job in the City and moving to the country to paint. He was interested in exploring the meaning of this fantasy at this stage in his life before he shared it with his wife and children. The therapist gave this history and presenting ‘problem’ and then said that she was careful to get the client to agree to a ‘no-suicide’ contract. Steiner replied in genuine amazement, ‘What on earth for?!’ The eager-to-please therapist said that she had been taught to close the ‘escape
hatches’ as a matter of course with all of her clients. Steiner, still amazed, said, ‘When I talked about getting clients to agree to not committing suicide I was working in a mental hospital with crazy people. For God’s sake don’t put ideas into the heads of well-functioning clients!’

Of the ‘myths’ that continue to linger in the background of humanistic and integrative therapies is the myth that can be traced back to Rogers (1951) and his ‘Core Conditions’ of empathy, congruence, and unconditional positive regard. Even though Rogers himself said that of the three congruence – or the therapist’s ability to process and share the way she is being impacted by the client and the client’s story – was the most important, there remains an assumption that I meet over and over again when I supervise trainees that therapists must have positive feelings towards, as well as positive regard for, their clients. I can remember the expression on the face of a newly-qualified therapist when I told her that I found the client she was presenting very hard to like. The therapist looked both relieved and anxious and said, ‘I didn’t know we were allowed not to like our clients.’ In hindsight this was a moment of transformation for the therapist, who has gone from strength to strength since allowing herself to feel and think in ways that might shock the earnest beginner. She has come to trust that it is often in her more unsavoury responses to a client that the sources of the client’s injuries are discovered and through which the therapist’s ability to feel empathy for and hold the client emerges.

Another ‘myth’ in the humanistic world is that of mutuality and horizontality. In my experience true mutuality is not possible in any relationship where one party has ultimate responsibility for another. When that is so it is not possible to give the experience of each party ‘equal’
weight. The therapist needs to attend to her experience in
the room, moment by moment, but also needs to ‘bracket’
all sorts of thoughts and feelings and impulses. The client
has no obligation to do this. In fact we actively encourage
our clients to bring us their deepest thoughts and feelings.
We also insist on some level that they control their
impulses when in the room with us. It would not, for
example, be acceptable for a client to hit their therapist.
In most settings these days it is not acceptable to smoke.

Furthermore with the ‘professionalization’ of psycho-
therapy and counselling, and the accompanying codes of
ethics and practice, our clients have power over us that we
do not have over them. They can – and more and more
frequently do – take out complaints that are not based on
gross professional misconduct, like sexual or financial
impropriety, but rather on perceived misattunement and
ordinary, human frailty that can neither be proven by the
client nor defended by the therapist because of a commit-
ment to confidentiality that extends beyond the termina-
tion of even an unsuccessful therapeutic relationship.

Humanistic psychotherapy’s failure to address the
power dynamics in the therapeutic relationship goes hand
in hand with its philosophical refusal to accept ‘dysfunc-
tion’. Rowan (2001) describes the humanistic view of the
client as being like a plant that, given the right conditions,
will thrive. I don’t entirely disagree. But I have had the
experience of tending plants, giving them sunlight and
water and food, only to watch them wither from a ‘dis-
ease’ that has taken hold at the roots. I believe that an
effective psychotherapist needs to be skilled at offering
relational conditions and needs also to have a healthy
respect for what is not in his or the client’s awareness or
even control. This process gets played out in unconscious
or non-verbal communication between therapist and client.

**To be or not to be?**

Current research indicates that relationship factors are curative. This does not mean – as it is sometimes misinterpreted – that just *being* with another person with the intention to be empathic, congruent, and to respect them unconditionally is enough. I believe that the followers of Rogers and other more humanistic or ‘third force’ theorists have caused the pendulum to swing too far away from *doing* towards simply *being*. As a supervisor I find that single school approach trainees tend to become evangelical about *being*. This zeal often leads to what one of my supervisors used to call ‘gratuitous self-disclosure’ of the therapist’s experience, to the point where the client can become lost in the trainee therapist’s enthusiasm about his newly discovered ability to report what’s going on for him.

I don’t want to appear to knock a therapist’s attempt to know himself better in the clinical encounter, as I believe that it is essential to learn to know oneself in relationship through the psychotherapy that accompanies and, ideally, continues after the training. There is also no doubt in my mind that ‘people’ people are better therapists than academics or technicians. But I want to make the point that *both* people skills and technical knowledge and skills must support each other in the therapy. Technique, which needs always to be supported by theory or collective wisdom, must not get in the way of what’s happening in the room and what’s happening in the room must inform technique.
Countertransference issues for supervision

One of the assumptions that informs my work as a therapist and as a supervisor is that being able to ‘read’ and process transference – or the client’s mostly non-verbal communication of archaic experience – is essential to a successful therapeutic outcome. I feel dismayed when I meet humanistic therapists who tell me that they don’t work with the transference. This is nonsense. All therapists work with transference. It is in the field of any relationship, particularly ones in which there is a power differential. Humanistic therapists work with the transference differently from more psycho-dynamically trained therapists in that they name and observe it rather than primarily interpret it.

In all areas of life people very quickly get into transference relationships with one another. Check your reactions the next time you see flashing lights in your rear-view mirror, or are questioned by a customs or immigration official, or when a colleague junior to you makes a mistake or gets a promotion, and you’ll see what I mean.

I believe that the key ingredient in psychotherapy is the therapist’s ability to recognize, manage, and work with her countertransference responses or, in plain language, with all the emotional and somatic responses that a therapist has towards a client. As a supervisor of trainee or newly qualified therapists, I have noticed that it is often a challenge to get them to bring their ‘negative’ responses to their clients into supervision. I give an example in the next chapter of enacting my terror and dread of a particularly challenging client by failing to hear the doorbell ring. I
was in training at the time and did not feel able to bring my feelings to supervision because I feared being seen as not up to it. (The client had been referred to me by my supervisor who had previously been my therapist.) I was frightened in supervision and frightened in the consulting room, and enacted this in a way that increased my client’s expectation of being abandoned as well as her sense of entitlement. We worked through it. I was fortunate.

In order for countertransference to be a reliable source of information about the therapeutic journey the trainee therapist must take his own therapy seriously and be able to enter into it as unfettered as possible by external forces. When I was a trainee there was only a handful of qualified therapists to choose from, as it was a requirement of the training that I work with a more senior member of my training institute. That meant that my therapist was also my supervisor and trainer for at least some of the time. In hindsight I realize that, as much as I thought I took my therapy seriously, there were aspects of myself that I kept hidden. Fortunately, as there are more qualified psychotherapists available to be therapists for trainees, there is less of what I have come to refer to as a ‘transferential web’. Nevertheless, relationships – both current and past – do impact the therapeutic relationship when the client is a trainee, and need to be considered for their influence on the supervisory relationship as well.

The transferential web

Figure 1 uses Lewin’s (1952) concept of ‘field’ to illustrate the forces in the supervisory relationship when the supervisee is a trainee. It can also be applied to the therapeutic
relationship when the client is a trainee, or a member of the psychotherapist's institute or training organization. Both supervisor and supervisee bring their personal as well as professional history to the relationship. I am particularly interested in the 'professional history', which includes for supervisees their training institute, their trainer(s) and training group and, of course, their therapist. The supervisor's 'professional history' includes her past and current supervisors and therapists as well as the colleagues with whom she trained, who may now be friends, lovers, fellow committee/staff members, or rivals.

Figure 1. The supervision field or the transferential web.
It is likely that there will be some overlap between the cast of characters in the supervisor’s professional past and the supervisee’s current professional and collegial relationships. I believe that it is essential for any successful supervisory or therapeutic relationship with a trainee or a colleague to make ‘the transferential web’ overt. I inquire as a matter of course about the other professionals in the trainee client or supervisee’s field. I want to be as careful as I can not to put myself unwittingly in situations external to the supervisory (or therapeutic) relationship where my ‘wearing a different hat’ could adversely affect that relationship. For example, I don’t want to discover well into the relationship that I have been supervising a client’s supervisor. I also need to be careful in a peer supervision group that I do not discuss difficulties that I may be having with a supervisee without realizing that the supervisee may be in therapy with one of my colleagues. As a participant at supervisors’ meetings where trainees and their progress are discussed, I need to withdraw if one of those trainees is my client. I may also need to get support in my own therapy and supervision to manage what may be evoked in me when a supervisee brings difficulties with a fellow trainee (who may be a client) or with the trainer (who may be a former trainer, therapist, supervisor, supervisee, or client of mine). You see how it can get complicated?

The supervisor and supervisee each have a formal contract (represented in Figure 1 by the solid lines) with the training institute concerning supervision, even if it is unwritten. The supervisee agrees to attend fortnightly supervision and the supervisor agrees, for example, to write bi-annual reports. What can, on the surface, seem relatively straightforward, has the potential for complication when the supervisee brings dynamics of competition,
idealization, and regression from his professional history (represented in the figure by the dotted lines) into the supervisory relationship. The supervisor is often, unwittingly, set up to ‘fight’ with the trainer. I remember trying to help a trainee to see how his client was projecting her father on to him and being told that, according to the supervisee’s trainer, there is no such thing as projection. In my experience it is left to the supervisor to deconstruct the dogma that trainees introject from their side of the professional field or, at least, to help them to see that there is more than one way to look at relational phenomena.

The terms ‘personal’ and ‘professional’, as I have used them in Figure 1, describe and inform the many selves that meet in the supervisory relationship. As a supervisor I emphasize mutuality in the supervisory relationship. Having said that, however collegial I may want to feel with my supervisee, I need to remember that there may be times when I need, metaphorically, to grab him by the seat of his pants to keep him from running into traffic. I also try to remember that I was once in the supervisee’s shoes and found it uncomfortable.

The supervisory relationship operates at different levels from moment to moment. I can – and must – identify with my supervisee from my past experience. At the same time, in the effective present I need also to be teacher, mentor, protector (of the supervisee and the client), and assessor, while simultaneously modelling good practice and methods of intervention.

Guidelines for supervisors

I will offer you here a version of the model of supervision that I have developed and written of earlier with my
colleague and partner, Penny Daintry (Kearns & Daintry, 2000).

**Teach beginning supervisees about supervision**

When I was a trainee, the standard approach to supervision was to ask the supervisee what she wanted from each session. I used to hate this and felt put on the spot and exposed. One of our colleagues makes the analogy that asking a beginning supervisee what she wants from supervision is like a waiter asking someone to place his order when he has no idea what is on the menu. The diner might choose the safe option of steak, because it is familiar, and be deprived through lack of information of a more varied and satisfying meal. Trainees often have very little input on their course as to the nature of supervision. Even when they do, part of establishing a successful supervisory relationship needs to include some discussion of what is and what is not on offer.

Supervisors of beginning therapists need to be aware of the impossibility of teaching into an abstraction. It will not be possible for beginners to assimilate information about interpersonal processes of which they have no experience. It’s a bit like reading about the history and customs of a place before you visit it. It will make much more sense on the plane on the way home.

*Convey a belief that mistakes are normal and that ‘feedback’ is a necessary part of the process; model self-assessment*

Acknowledging that becoming a competent, ethical and compassionate psychotherapist is a life-long process gives an inclusive edge to a new working relationship because it
brings the supervisor and supervisee together on a shared road. Helping supervisees to have realistic expectations of themselves is vital, and I tend to talk about my experience as a trainee in order to normalize what they are going through. I try to get across to my supervisee the message that their inner critic and the high expectations they have of themselves may far exceed what I expect from them. I remember a supervisor of mine who used to say, ‘Relax. This isn’t brain surgery. They’ll live.’

I hope, also, to communicate my belief that psychotherapists must find in themselves the ability to live with not knowing, and to acknowledge that this can be a painful process, particularly for those who defend against feelings of inadequacy by relying on things they have learnt.

When a supervisee gets something wrong, try to give feedback by explaining how to do this better next time, and by describing this as their ‘growing edge’ rather than as a mistake. A dialogic way of beginning to give some potentially difficult feedback might be to generalize and to say, ‘Beginning therapists often find it difficult to . . .’.

If a supervisee’s sense of self is very fragile he may need to perceive the supervisor as ‘perfect’ until he is more internally supported to tolerate difference. With supervisees who are reasonably robust, I try to normalize mistakes by sharing my own, and to model self-assessment by regularly assessing my performance through using examples from my work with clients. If you don’t feel comfortable with this level of self-disclosure, try giving more general examples, prefaced by ‘I have a colleague who . . .’

**Name and expect competition**

This is particularly important in supervision groups. One member of a supervision group of four was having great
difficulty with what she perceived as strengths in the others that she did not possess. She disempowered herself in the supervision sessions to such an extent that, on one occasion, without an intervention from anyone, she criticized herself and her work so harshly that she reduced herself to tears. When the supervisor gently helped her to differentiate what she was projecting on to the others from how she was actually working with her client, the group started to unscramble their myths of the ‘perfect’ therapist and each member – including the supervisor – was eventually able to acknowledge her desire to be the ‘best’. Competition then became something that could be lived with and even enjoyed.

**Identify, name, and fight transference**

When supervising beginning therapists the supervisor can feel invited into a quasi-therapeutic relationship. I know that this has happened when I find myself feeling uncharacteristically withholding, controlling, or over-protective, or when my supervisees continue to bring their difficulties with another colleague to me. The boundary between therapy and supervision is a delicate one and will, inevitably, be crossed from time to time. When this happens it can be helpful to name any transference phenomena (‘I’m not your mother, therapist, etc.’), to make overt any reparative goals and to get the supervision back on track as soon as possible.

**Get into the habit of recommending your supervisee to work on their relational ‘growing edges’ in therapy**

As the main aim of supervision is to attend to the client–therapist relationship, when interruptions in the
supervisor–supervisee relationship become figural and
cannot be worked through usefully as parallel process, I
prefer the supervisee to take their ‘transferential’ issues to
therapy. If they cannot be resolved, I consider the option
of referring the supervisee to a colleague for supervision in
order to avoid a protracted focus on healing the past in
the present at the expense of the client work.

It needs to be said that there will always be some
trainees who resent the requirement for personal therapy
as part of their training and who meet the requirement by
‘attending’ rather than engaging in their therapy sessions.
When this is the case the supervisor is faced with a
dilemma, because a supervisee who is not able to engage in
therapy is also going to be unable to manage his counter-
transference usefully. The trainee’s blind spots or no-go
areas can often get played out in supervision. For example,
a supervisee who is afraid of her anger is likely to lodge that
anger somewhere else. The supervisor is just as suscept-
ible to projective identification (see Chapter Two) as any
therapist and may feel powerfully pulled to enact with the
supervisee that which the supervisee is unable to face in
himself. I tell my supervisees at the start of our relationship
that things will emerge in their relationships with their
clients that may become obvious through a parallel process
in our relationship and that I will expect them to work on
this in therapy and to discuss their insights as they relate to
their development as therapists in supervision.

*Keep a sense of humour*

Louise, my first supervisor, was a Freudian. She was also
incredibly encouraging through her use of humour and
her well-timed ability to tell stories on herself. Once I was
having a difficult time with a client and agonised for days whether or not to tell Louise that I was gay. I finally screwed up the courage and spilt the beans. Louise’s response to my revelation was, ‘You think you’ve got trouble. I’m a triplet.’ Another time when I said that I had been pretty useless all week because I was distracted by something that was going on in my life she said, ‘Not to worry. Sometimes they just need someone to watch the movie with them.’ I often find that it is through humour and a sense of the absurd that I can reach a healing place in a supervisee who takes himself too seriously.

**Make time for relationship maintenance**

I allow time for ‘relationship maintenance’ in individual or group supervision in order to attend to what is happening in the room, and what might be impacting us from outside the room and, therefore, to increase the potential for collaboration rather than projection and regression.

**Name and expect shame**

I see shame as just one of many potential events in the supervisory field that are to be expected and can be worked with. Having said that, the dynamics of the supervisory relationship make shame a potentially disabling force in the field that will only intensify if it is avoided (see Chapter Seven).

**Take all ‘reviews’ seriously**

In another life I used to manage dance companies. One of my mentors when I was in my twenties was a choreographer who, when interviewed and asked how she dealt with critics, answered, ‘If I’m going to believe the good
reviews I need to believe the bad ones too.’ It is very tempting to infantilize and pathologize trainees when they tell us things that are difficult to hear or that don’t fit with our view of ourselves. Fight the pull to do this as much as is possible. And remember that trainees will believe that you have the all the answers and may even see you as more ‘evolved’ than they are. They may need to hold on to their view of the supervisor as ‘sorcerer’ but the supervisor must diligently fight the urge to agree with them. Apart from the likelihood of becoming lost in a hall of mirrors, attending to only our positive reviews breeds therapists who can allow neither a client’s less than positive feelings nor their own to inform the therapy.

Note

1. I do not separate these two ways of responding and agree with Racker (1968) and others that counter-transference is all of the responses that the therapist has to the client.
References


