

Creating a space to supervise - opportunity or persecution? ¹

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It is just ten years since I began to supervise psychiatric trainees regularly, and I am grateful for the chance to think and talk about it now. One of the themes in this presentation will be the transition from hospital doctor to therapeutic psychiatrist which has been my own story, and also that of my trainees, but I think what I have to say will resonate also with other professions in which psychotherapy is a central part of the task. I am not proposing to discuss group supervision, nor other techniques of review such as audio and video tape, and the one way screen. All these have their special effects which probably override, or at least obscure, the dynamics of the more common and familiar scene in which two people sit together in a room on a regular basis primarily to discuss the work of one of them, the trainee. This routine is what I mean to talk about, and what I have to say is very much a personal view of what is in any case a personal process.

There are in fact two distinct tasks in supervision. One is tutoring, which is about professional development generally. The trainer is the guardian of the trainee's journey through the institution and tries to foster in him or her the identity of a particular discipline. What, for example, is a psychiatrist and how does he differ from a psychologist? Just because these distinctions are so often blurred in a psychotherapeutic setting it's important to make them clear. The other part of the training task is supervision of clinical work, which includes psychotherapy with individual patients, but also work with couples, families and groups which may not be so intensive. I think both tasks have much in common, and that most learning takes place when attending to a particular piece of work which the trainee has done, or is about to do. The clinical process is the very stuff of supervision. Books, seminars or lectures can not possibly focus on this with the same intense attention. Definitions of this or that profession, or theoretical debates about schools of therapy will not further learning as much as direct attention to clinical experience. By this I mean hearing about the work the trainee has been doing in some detail - asking questions like: what was it like being with that patient? what did he actually say? what did you actually say? what almost unmentionable thoughts did you have about his problem? and so on. There is no expectation in this kind of supervision of a polished piece of work

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from the trainee. Contact with patients is never really like that, however we might wish it to be. So I am talking here about a meeting with the trainee that is inevitably personal, and which reflects in many ways the experience he has had with the patient. Supervision by definition always involves a third party, and the position of the trainee is always in the middle. On one side, the patient and on the other, the supervisor. Both can be persecutors, but they can also be helpful.

Antitherapeutic doctors

Using my own development for illustration I will begin with some comments about how supervision helped me to make the transition from doctor to psychotherapist, then I will mention a little of what I have learned as a supervisor, both about the process of supervision, and finally about the process of therapy itself. My own primary training was in medicine and paediatrics and I am proud of the skills I developed then, but I want to say that one of the basic assumptions of doctoring is entirely wrong for psychotherapeutic work. This is the assumption that doctors are not meant to be disturbed or even affected by patients. They should of course be sympathetic and see the patient as a whole person but they should not experience anything which will put them off the scientific and intellectual track. I have many competent colleagues who appear to be working to this rule. In this way the doctor treats himself as less than a whole person. In some areas of medicine this is probably good enough, and I am not at the moment trying to criticise the medical profession, only to say that it is not, as it stands, a psychotherapeutic one. That is the first point. The second is that supervision, in my experience as a trainee, consisted largely in the undoing of these medical attitudes and learning how to be influenced by patients. This was a slow and uncomfortable journey for me. Finally I want to say something about my own efforts as a supervisor who has tried to ease trainees out of their medical strait jackets so that they can become therapeutic psychiatrists.

I had considered calling this "confessions of an anxious and impatient supervisor" because I have been reminded in preparing it how much of my anxiety as a trainee has stayed with me as a trainer, in a disguised form. I did not much enjoy the experience of supervision as a trainee. I felt very exposed, sometimes quite threatened. I remember particularly the persecuting stare of one of my first supervisors when I was trying to wriggle out of the reality of my immature work. I brought a mass of material for supervision but had little idea of what it meant. I was not able to see the wood for the trees. I so wanted to be a good psychiatrist. I had plenty of letters after my name so in the eyes of the public I certainly should have been well qualified. But I had not been trained to think about what I was doing. Although quite good at listening and being sympathetic I was not conscious of the effect the patient was having on me.

Most junior doctors, in this country at least, do not have any one-to-one supervision, and no opportunity at all to consider what role they should be playing. They just imitate their seniors who are, I am afraid, far too often quite unsatisfactory models - arrogant, impatient and omnipotent, like gods. Because the juniors are so anxious to do the job properly, which means not getting it wrong, even those who are quite sensitive people are infected with this model. Medical students start out with generous ideals, but these are easily put aside under the pressure of their first jobs in hospitals. Young doctors want to do the best for their patients but soon find that they had better think first of their seniors. They have to get good references to get ahead in their careers, and patients don't write references. The hospital model of the doctor that I am describing works essentially like this:- there is something wrong with the patient and the doctor's job is to put it right. Put very simply, in a language without verbs; patient wrong, doctor right. If he can't get it right, he's lost the battle. One distinguished doctor I knew said that when a patient died he felt that God had won and he had lost. That is how big he had to be to work properly. For this kind of doctor, and I suppose he is most often male, the patient is a not only a nuisance but a serious threat. Despite the text books, illnesses and the patients who have them do not fall neatly into categories that can be sorted out by scientific medicine. As he begins to recognise this, the doctor is put on the defensive because he is unable to perform perfectly. As a result he develops a form of depression, or a defence against it. Either way the patient becomes a persecutor, a bearer of failure.

I was not conscious of any of this, except on occasions when I found I was glad not to have to see certain patients. I thought that I could make people better if I tried hard enough, without being aware of what I was meant to do as a psychotherapeutic psychiatrist. Most of the time I was so entranced by the role that I was playing that I lost sight of the task I had to perform, if I had ever actually seen it. My conscious aim was to be friendly, helpful and even playful in clinical work. I must have realized that omnipotent doctors won't get far in child psychiatry; but without any understanding of the process I was still trapped in the old model. I was still responding to the patient's urgent desire for help without reflection, as if it were really possible to provide instant relief from pain. This was particularly obvious when dealing with very anxious parents in child psychiatry clinics. My supervisor made me see that, even if I thought I knew who I was, I didn't know what I was doing. This simple discovery took me several years to make and it is the essential, and painful, breakthrough for trainees in supervision. I am sure you can remember your own efforts to master the apparently simple injunction to stick to the task, and your own unique ways of failing to do so. If you can't remember, then it's a good thing you have come to this conference!

Learning that therapy is not about being in control of the process was for me a hard lesson - something of a let down, but also a blessed relief, from the male doctor role I had learned to play in hospitals. Trainees in other professions may not themselves be so stuck on this model but it is still the most powerful one around when someone is in pain and needs help urgently. If things are bad enough, the patient is likely to try and put you in the doctor role, whatever your profession. Though we are all now familiar with it, remember the first time you felt the extraordinary force of a patient's hope in you. You not only had to listen, you had to deliver. Here was somebody who not only expected you to sympathise with their pain, but also to take it away. It is quite a remarkable phenomenon. There is only so much one can do to prepare trainees for this paralysing experience. Even in role play, quite articulate trainees will become mute when faced with a colleague who has taken on the part of a patient who demands to be rescued from an unbearable emotional situation. At these moments the mind of the clinician becomes empty, which can be quite alarming. It is probably helpful to trainees just to point out that in the heat of the therapeutic moment it is not unusual to forget what you are meant to be doing. A hospital doctor might wish that a supervisor, if he had one at all, would help him to avoid such loss of control, which he fears like a terrible nightmare. Supervision of therapeutic practice has the opposite goal, which is to prepare the clinician for paralysis, not to wish it away. Trainees need to learn that useful therapy is unlikely to occur until the therapist has had some empty moments - some spaces not immediately filled with premature interventions.

The supervision

I now want to discuss the process of supervision itself. From the trainee's point of view, as I have suggested from my own story, this is also a space which can be alarming, and one which he may wish to avoid. I am very conscious of this as a tutor.

The trainees I am responsible for are senior postgraduate doctors who are committed to a career in child and family psychiatry. We meet weekly for an hour and usually discuss a number of cases, individual children and parents and whole families, but also review the progress of the training as a whole, which of course goes beyond clinical work. Most of the clinical work they do is not formal psychodynamic psychotherapy, but almost all of it is meant to be therapeutic. At the start of training, many of them are not in analysis or therapy themselves.

I must say that until I was preparing this presentation I had not thought very much about what I do as a trainer. I have always been very active and involved, and have sometimes criticised myself for intervening too quickly with advice when I think that the trainee has lost his way. Only now, under the obligation to

have something to say about supervision in this symposium, am I curious about the origin of this behaviour. Why do I tend to rescue trainees from their uncertainty in supervision, rather than let them struggle on their own? There are a number of answers to this question, some of which are irrelevant here, though I should mention in passing the rivalry that is provoked by the work of very gifted trainees, whom we are lucky to have quite often in this clinic. Supervisors can of course be very competitive. (I should also say that although I am talking of the trainee as 'he', most of ours are women. We have about equal numbers of men and women applicants for these training posts but more women are successful in getting them. I have also used 'he' for the patient even when that may be a woman, a girl, a family or a group.)

The main point I want to make, however, is that I now realise how much of my practice as a trainer is determined by my own previous experience at the receiving end of supervision. As I have said, this was often uncomfortable, and potentially humiliating. While I am giving supervision, I am constantly reminded of what it was like having it. I identify not only with the trainee's discomfort, but also with former supervisors and remember what they did for me that I found to be most useful in relieving my unease. Although I want trainees to be prepared for the inevitable blockages, the mute empty moments in therapeutic work, I do not see why they should need to have this kind of experience in the room with me. So if the trainee appears to be stuck I tend to be very helpful and offer some idea of what I would be inclined to do in that situation. I am not saying "do this", but instead "This is what I would do". One of the most rewarding aspects of supervision is to be put on the spot by curious trainees who really want to know why you do what you do. I have sometimes found it surprisingly demanding to answer these basic questions, which are almost like those of a small child. They really make you think about your own habits of thought and practice. This is how the supervisor learns from the trainee, and if this isn't happening the trainer has become stale. The master has to be able to learn from the apprentice.

Perhaps active and helpful participation goes against the grain of the non-directive tradition of supervisory practice, which may be regarded by some as the psychodynamic ideal. According to this view the trainee has to find his or her own way, just like the patient. I think this is potentially quite persecutory, because trainees are so often lost and can't find any way at all. Also it leads to an atmosphere in supervision which is similar to the analytic one. The trainee begins to feel like a patient which is persecutory simply because this is not, in fact, the case. Sometimes this kind of atmosphere is unavoidable, and even necessary, but I am convinced that supervisors should always be on the lookout for opportunities to remind the trainee that this is not therapy, and that the supervisor is actually a colleague who has not only been through this process

himself, but is also prepared to talk about it. (One similarity with analysis is, however, worth keeping and that is the sanctity of the hour. Like therapy sessions supervisions should be very hard to cancel.)

I am most grateful to a former supervisor who often emphasised how his observations about my work were relatively easy to make with hindsight in the supervision session, away from the pressure of the therapy room some days before; He would say, when suggesting what I might do with my patients, "if I were you I would say this....." , making it clear that he might well have failed to think of it at the time. Nevertheless he was generous with his thoughts. Although he seemed to be a shy person in other settings, he was friendly in supervision. At the beginning of our weekly meetings he always asked "How are you?" - something I know he did not do with his patients, and encouraged me not to do with mine. He seemed to know how bad it feels to miss the obvious and then have it pointed out to you, so he softened the blow with these reservations. But I felt that he also used the time to share some of his own new thinking about the science of mental life and the art of therapy, so that he would get quite excited, as if he enjoyed the freedom to wonder about this extraordinary craft. He told me about his own experiences as a beginning therapist, which suggested to me that he could identify with my difficulties in making appropriate contact. He would coach me about what words I could use with patients and, often a neglected matter, how to phrase even simple letters to them, particularly when they had not turned up for an appointment. Sometimes he would say "good!" when he thought well of a piece of work I had done, but he was quite capable of bursting bubbles with interjections like "that's crap!". which was not humiliating, because it was done with affection. This kind of partnership, which I see as an apprenticeship for the trainee, has been a model for me. Even so, the supervision hour was almost always an anxious sweaty time. I am sure I was not alone in this. We need to remember just how exposed our trainees are when they bring us their work.

I think it is a myth that helpfulness fosters an unhealthy dependence in trainees. Unhelpful supervisors, who reveal very little of their own struggles towards understanding, and come out only with a glorious *bon mot* once each meeting, create an even more clinging attachment. Whether they intend it or not, they are bound to foster the trainee's conviction that the supervisor is perfect and knows everything, but isn't going to tell. The supervisee then becomes like a gambler on a fruit machine who goes on and on, waiting for the next jackpot. I do not believe that the trainee's development is hindered by giving advice. If I have an idea about what the trainee could do, or what I would do in those circumstances, I do not usually hesitate to say so. Supervision of therapeutic work is a discussion about possibilities between two people, both of whom are learning. This is not necessarily the case, say, in the teaching of arithmetic or

music, when the pupil has to find out the right answer, or the right notes, for himself, with only minimal prompting. This is the difference between learning and being taught. In clinical work there are no right or wrong answers, but there are good and bad ideas to be explored.

It will be clear from what I have said so far that I do not want supervision to be a persecutory experience for the trainee. In particular I do not want my apprentice to assume that I would necessarily do it better, just because of my role. It is almost always easier to think things out when you can talk it over after the event.

The trainee as therapist, with the supervisor on his back

Now I will consider the trainee at work with the patient. The supervisor is not in the therapy room but he is still in the trainee's mind. The poor therapist has two persecutors: the patient in front of him, and the supervisor behind. If there is to be only one primary task, which is it? To answer to the patient, or to the supervisor? Whatever stance the trainer adopts, helpful or enigmatic, the learner will find it hard to forget him. I remember being constantly harassed during the therapy session by the obligation to remember it all and write it up in the proper order for next week. This can get in the way, because it takes the trainee out of the therapy room into the supervisor's office. Other forms of recording, such as audio or video tape can be even more oppressive. But feeding the supervisor with material is not really the point of recording anyway. The function of the write-up is not merely to have something for the supervisor next time, but to learn how to think about what one is doing at the same time as one is doing it. Such self-consciousness is not just a nuisance, it is an obligation, which makes the difference between a social encounter and a therapeutic one. This is the beginning of internal supervision, which is the object of the whole exercise.

During supervision trainees often say quite candid things about the thoughts and wishes they had during the therapy session that they are reporting. For example - "I felt that she wanted me to listen to the whole story and say nothing until it was finished" or " I was afraid that if I didn't do something to help there and then he would rush out of the room and harm someone" or "I wondered what his girlfriend thought about his big moustache". Now this is information which we can recognise as very important and useful, but because of the taboo on reacting, trainees often feel that they should not be having such thoughts at all or, if they do, that they should certainly say nothing to the patient about it. But the curious thing is that what the trainee reports in supervision is often very elegant, sensitive, and thoughtful - just the sort of thing that would be worth saying to the patient, perhaps with minor modifications. It's simple enough for the supervisor to ask at such a moment, "

did you say that to the patient and if not, why not?", which usually leads to a productive discussion. It might turn out that it was wiser not to speak after all, but the trainee gets the opportunity both to look at different possible interventions and also to practice putting things into words. These rehearsals are effectively role plays, with both trainer and trainee taking part, trying out various forms of words to see what it feels like to say them, and what it feels like to hear them. This is the literary or poetic function of therapy. As long as the trainee thinks that only the supervisor can do this with him he will be free in supervision but stuck in therapy.

In spite of his creativity the trainee does not recognise his own judgement until it is encouraged out of him by the supervisor. While sitting with his patient, he keeps wondering what the supervisor would say. One solution to this bind is to give in to it, to encourage trainees to continue their dialogue with the absent supervisor while they are doing therapy. At the moment of blankness, or even sheer panic, many trainees will wish that the supervisor were there to ask them what they were thinking about the patient. But there is no need to wait until the next supervision to do this. He can ask the question now. A potential persecution can then become an opportunity - an external supervisor is becoming an internal one. The trainee is getting curious about the effect patients have on him.

This kind of curiosity is often quite innocent and immediate, like that of a child. Gifted and clever people who have learned to behave like grown-up professionals need permission in supervision to notice their own spontaneous reactions, before they get censored. Like the parents of little children they are quick to silence these observations in themselves. "Mummy, look at that funny person!" says the observer - "Hush, child, it's rude to point." says the censor. I remember seeing a distinguished psychoanalyst doing a consultation for a patient, who had already been interviewed by other psychiatrists in the same meeting. This patient had a very strange face, shockingly obvious to everybody. But none of the preceding interviewers mentioned it. The analyst simply asked him "What do you see when you look in the mirror?" This is not a polite question, but it is respectful, and it is potentially therapeutic. Being polite often means not noticing what you see, or not commenting on it. While I would never encourage trainees to be offensive, they can use the supervision time to explore the difference between good manners and good therapy.

Conclusion

The novel idea which supervision has to get across is that therapy is not so much about trying to influence the patient as seeing in which ways the patient is influencing the therapist. One of the most familiar pressures on a trainee is to keep the patient in therapy. If patients want to leave therapy the trainee

inevitably thinks this is his fault, that he is not good enough. He will use up all his energy desperately trying to influence the patient to stay. He thinks that this is what the supervisor wants. Because they have to learn and get experience, trainees can too easily assume that the object of the exercise is to keep hold of the patient at all costs, to fill him up with therapy, like some sort of medicine, and present the product at the next supervision or, as I have heard it put: "to get some patients into therapy and some therapy into the patients". Training schemes depend on their well-cultivated supply of cases, so this assumption is not unreasonable. In supervision we can help trainees by showing quite clearly that this is not the task. Patients are not obliged to come to therapy, and might stay away for all kinds of reasons, some of them therapeutic. We have to encourage in our trainees a discipline of curiosity about the process of therapy, whichever way it goes.