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Supervising Clinical Assessments

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Foreword

Christine Driver (Lead editor)

Assessment of clinical work is always a step into the unknown. There is so much to discover, so much to find out and so many possibilities. The challenge is to try to get to know the person seeking therapy in as detailed and in-depth a way as possible so as to ascertain their clinical needs and allocate them to appropriate therapy. Much has been written about assessment and Hinshelwood's (1991) seminal paper identifies some of the key issues in terms of the patient's past, their internal world, their current life situation and relationships and transference issues perceived in the assessment meeting. However little (I have not found anything) has been written about the supervision of assessments; a process in which the supervisor needs to enable the supervisee to make sense of the experience with the patient in terms of the above and also write a report that will provide clarity to another professional if the patient is to be referred on or provide a clear basis for their own work.

In this edition of the Supervision Review we have four fantastic articles that give an in-depth perspective of the Supervision of Assessments. Gwen Evans provides an examination of the task of the supervision of clinical assessments; Penny Spearman explores how the changing external and organisational environment is influencing the assessment process and addresses some key supervision tasks most pertinent to assessments; Jackie Gerrard takes us through an assessment in relation to the criteria sought and considers the issues the supervisor needs to address with the supervisee and the suitability of the patient for psychotherapy; and Anna Bravesmith looks specifically at supervising the assessments of trainee counsellors in primary care providing brief dynamic therapy. In addition there is a fascinating book review from Bruce Kinsey.

This is a rich edition. Enjoy and have a Happy and restful Christmas break.

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Hinshelwood, R.D. (1991) Psychodynamic Formulation in Assessment for Psychotherapy. In, *British Journal of Psychotherapy,* **8,** pp 166-174

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Supervising Clinical Assessments – Valuing the Impossible Task

Gwen Evans

Abstract
In this brief article some issues specific to the task of the supervision of clinical assessment are addressed. Attention is given to what the supervisory task is about, the complexity of this undertaking, and how it might be valued.

Attitudes to Clinical Assessment
The value we give to the task of supervising clinical assessments is inextricably linked to the attitude we hold about the purpose and process of assessments. Over some years of considerable involvement with clinical assessments I have become aware of a diversity of attitudes and expectations amongst colleagues and tried to give thought to the issues involved and dynamics at work.

During the earliest days of training I have a clear memory of attending a seminar on psychopathology at which the seminar leader introduced the notion of the 'impossibility' of the subject. This induced both anxiety and wonderment. Supervision too 'is practising an impossible task' (Zinkin 1995, p240) and I have often reflected on clinical assessment in a similar vein. On the one hand the task is seemingly impossible. Yet, when due regard is given to every facet of the process, it is possible to arrive at a recommendation as to what is likely to be in the best interests of the person seeking help, who from now on I will refer to as a patient.

Setting and Stance
The supervision of an assessment undertaken by a therapist anticipating undertaking the ongoing clinical work is of a very different order to one undertaken as a piece of work in itself.

The manner in which the supervisory contract is set up and the 'setting and context in which supervision takes place moulds and influences the supervision that is appropriate' (Crowther 2003 p100). This statement is generic to all supervision. Whilst my aim in this article is to focus on some issues specific to the supervision of clinical assessment it is crucial that the broader tenets of the supervision process undergird the task. Namely, that the most important function of supervision is 'to hold, understand and work with the dynamics in a way that processes the experience in the service of the patient' (Driver 2002 p 9) and this is achieved through what is termed the analytic attitude. 'The thrust of this attitude is in the bringing to conscious awareness transference and countertransference communications and how to contain them' (Thomas S 2005 p 144). In addition to the considerable skills required for this therapeutic

endeavour, attention needs to be given as to how the assessment interview was set up; the mode of referral or the source from which the potential patient heard about the institution or therapist and the preformed transference of the assessor. The patient will also have a preformed transference which may or may not be evident at the outset.

An active stance is necessary on the part of the assessor when the assessment interview is required to be a complete piece of work in itself as invariably is the case in institutional settings. Arguably this is also necessary in a private setting. However there 'is the idea that there is no difference between the analytic process in the first meeting and that in any other meeting' (Ogden 1989 p 170). This more purist approach may have its place if referrals have already been filtered. When this is not the case there is a 'need to establish a certain rapport and keep it going… to find out about this stranger's inner world. This may involve questioning…' (Coltart 1987 p133).

It is perhaps whether or not we consider a more active and questioning stance to compromise the analytic process or to be a potentially creative means of embarking upon it that determines our attitude to assessment work and the supervision of it. At what stage in the process does a patient start therapy? Is an assessment interview a piece of work that holds therapeutic potential for itself?

The Task of Assessment and Supervision

Coltart (1993 p78) writes of 'having a clear view of exactly what one wants to elicit from the patient' during the interview. She cites two reasons for aiming 'for as much of the personal story as possible'. The first is so some assessment can be made of the 'psychological-mindedness' of the patient and the second is that a 'detailed history can be of immense value during the course of the treatment'. Without a history Coltart argues (1993 p79) 'there can be no delicate nuances of transference interpretation – only abstractions, too generalised….'. I add a third reason as being that the personal story and biographical data usually provides information about early object relationships which contributes to a psychodynamic formulation. So alongside the task of managing a piece of work in itself which has a beginning, middle and end there is the necessity to conduct the interview on different levels. This includes what the patient presents as the problem and their expectations of therapy, the personal story, biographical data, and unconscious processes. It is of course neither possible nor necessary to cover all bases but a good enough assessment interview when subsequently written in the form of a report provides a valuable baseline reading.

Because the task is so complex and requires considerable skill it generates anxiety. In my experience this is often expressed as a fear of getting it wrong and specifically of 'missing something'. A written assessment report (especially one held by an institution) is exposing in a way nothing else is. We all miss some things and having the humility to know, and sometimes admit it, makes us ordinarily human. It invariably proves illuminating in supervision to consider the dynamics involved and work towards finding meaning in what is missing.

Much (and perhaps all) of the above is stating the obvious. However, it behoves us all to have some clarity of understanding the supervisory task when it comes to assessment. It seems to me that ‘Only working with the unconscious’ (as I have heard said) does not adequately meet the requirements for an assessment interview and this has considerable impact on supervision.

Another major bearing on supervision is how much or little we know about the work of the supervisee. Usually even when little is known a supervisor has some awareness of the level of experience a supervisee has. Some very experienced and capable therapists are inexperienced in the task of assessment and find the transition needed to take up another stance very difficult. Also whether the supervision takes place in a group or is individual and whether or not the work itself is being assessed (as a requirement of training) are all significant factors. In my experience group participation is especially valuable when looking at assessments, as each member brings a different perspective to the material, building up a composite picture.

In her article ‘Assessment – What for? Who for?’ Klein (1999 p 342) persuasively puts the case ‘that to look confidently into the future we need a reliable prognosis based on diagnosis, based on aetiology, tied to therapeutics’. This approach predetermines outcome. Can we, should we, ever offer a ‘reliable prognosis’? The case Klein makes for doing so is strong though ethically this seems to be very shaky ground. Every assessment interview for both patient and assessor is a step into the unknown. The experience is significant, sometimes momentous, and it is in supervision that the experience can be processed. Whilst primarily this is in the service of the patient this is ‘also in a way that is mutative and enables the supervisee to learn and develop their therapeutic abilities’ (Driver 2002 p9). It is perhaps because it is neither possible nor appropriate to conduct an assessment interview exclusively working with unconscious processes that supervision of assessments offers a necessary thinking space to give attention to this.

When I first started undertaking assessments my supervisor made me aware of the strong pull there can be to ‘act into the countertransference’ during an assessment interview. I have never forgotten, and on many occasions have been grateful for this understanding. Years on, with more experience myself, I have wondered what it is that creates this ‘pull’. In part, I think it has to do with not being as available internally to the unconscious dynamics of the interview because of giving conscious attention to another aspect. There is also a pull to act into the patient’s relationship patterns which are, as yet, little known. The significance of the transference may present very early. All who undertake assessments are vulnerable in this regard and I suggest this is a particular area for attention in supervision. There can also be a pull to taking on people unsuitable for psychodynamic therapy. Each of these ‘pull’ factors can get acted into in supervision too.

For example, a supervisee brought to supervision an interview with a young man so unwell, he communicated ‘having no human membership’. Unsurprisingly he

lived alone and experienced frequent suicidal ideation. There were many factors in his personal story of concern, not least the early experience of abandonment by his mother. At the time both the supervisee and I considered referral to group therapy a suitable option and made this recommendation. The notion that his being a member of a psychoanalytic psychotherapy group would be in his best interests was ill thought through. It was only when thinking about this again with a group of experienced colleagues that I could recognise the 'pull' for what it was.

In supervision when 'something odd' or 'I couldn't put my finger on it' is reported or experienced one wonders about the communication. An example comes to mind of an assessment undertaken by an assessor who gave evidence in supervision of undertaking the task with considerable diligence. However, I was alerted by her becoming rather vague when describing the patient as 'contained' but 'something was a bit odd'. When meeting with the patient for a further assessment I experienced 'something odd' too. The appointment happened to be at a time when the passage from the reception to the room was unusually quiet and during the transition the patient suddenly and briefly laughed. The nature of the laugh gave me cause for concern though was not repeated during the interview. I reflected that at another time of day with the building much noisier I may have missed the laugh or not been clear to whom to attribute it. The setting and process allowed me to be available to the experience and gave some indication as to how I might best proceed. This is what the supervision of assessment should provide and one needs to be available to the totality of the experience and information presented.

It is probably a truism that we all see the pathology we are most interested in or that we know most about. The undertaking and supervision of assessment confronts us with a range of psychopathologies, some of which may be beyond our experience. In supervision we need to hold in mind the question 'why now?'. This usually relates to the presenting problem. We need to be mindful too of the patient's expectations of therapy; are these realistic? Does this patient demonstrate having enough ego strength and ability to tolerate frustration? What evidence is there for a capacity for reflective functioning? Is there a significant psychiatric or medical history? Might there be a necessity for referral to a specialist agency (e.g. an alcohol agency, or a unit specialising in eating disorders). Once a recommendation for therapy has been agreed it is important to have a clear idea of who is available to refer to. We need to know too what recommendation to make for those unlikely to be helped by psychodynamic psychotherapy and thought needs to be given as to how this information is given.

Because of limits imposed by the necessity to meet other requirements of a psychodynamic or psychoanalytic training it is often not possible for trainees to get the experience in undertaking assessments to best equip them for work as a qualified practitioner. When it is a training requirement to undertake a set number of assessment interviews the attitude of the trainee can be that these need to be 'fitted in' around other requirements considered to be of more importance. This is a supervisory challenge which I have not infrequently

encountered. It might be the least time consuming element of the training but it should be of equal importance.

Conclusion

The supervision of clinical assessments is a task which is not often addressed and is rather neglected in the literature of assessment in psychotherapy. Consideration needs to be given as to what this might be about. Perhaps in institutional settings there is some resistance to working with something already finished which another therapist and supervisor will be taking on?

I suggest that undertaking this 'impossible task' is not to compromise the analytic process but to give it an indispensable basis which is to be valued.

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Supervision of Client Assessments in a General Counselling Agency

Penny Spearman

‘In assessment we fly by the seat of our pants, and we are hard put at times to manage the interview satisfactorily…’

Lorna Berger (BJP Winter 1999 p.146)

Summary
This paper explores some aspects of how the changing external and organisational environment is influencing the assessment process in a local counselling centre servicing two large towns in Southern England. It addresses some key supervision tasks most pertinent to assessments - screening, the ‘optimal therapeutic intervention’, why now?, making a psychodynamic formulation, who might be unsuitable?, and then draws some tentative conclusions about different types of supervision and the importance of psychoanalytic concepts as part of mainstream future talking therapies.

In the parallel process of Lorna Berger’s comments above, supervision of assessments can be a most challenging activity, with the whole gamut of feelings ricocheting around the room as each client is presented. The paradox of tentativeness and ‘not-knowing’ has to be held together with speedy, decisive decision-making, based on only one meeting with the client - the briefest contract of all. It is therefore an occupation for humility, which, being at the interface of the external environment can not fail but to be influenced systemically by a whole range of external and organisational factors, not least the individual style and background, interests and prejudices of supervisor, assessors and other agency personnel. An additional paradox complicates the process further. Safety and sufficient trust have to be created for the emergence of unconscious material in the interview yet, at the same time, the assessor is eliciting a large quantity of factual information.

The external environment in which general counselling agencies operate has changed substantially in the past ten years, offering glimpses of current political and professional debates. To survive, many community counselling agencies have had to become a key resource to their local area, proactively marketing their services and gaining contracts. Flexibility is necessary when a new contract has been negotiated like the one in the centre where I supervise, with a local Sure-Start Centre, offering 20 sessions of counselling to parents of children under 5 (often at high risk).
In the future, as part of ‘The Big Society’ there is likely to be an increased demand for more integrated services with the whole family. This would include

groups, couple work and family work. Counselling is held in increasingly high regard; for example, it is now widely available in most West Sussex schools. More money has recently been committed to psychological therapies in the government's Spending Review (October 20th 2010) and it is important that centres stay in the mainstream. This means that they must be more 'demand-led' if they wish to be part of the public services provision of the future.

Long-term, open-ended counselling, whilst still the mainstay of many counselling services, is unlikely to attract commissions and contracts because it is too expensive and creates long waiting-lists. As practitioners, we need to become much clearer about demonstrating when it is essential, why it is lengthy and how it is effective. Counsellors are broadening their repertoire of skills to include CBT, work with addiction and other specialisms. Centres doing well have become a key resource to their local community; they are developing strong networks with commissioners and other funders and have recognised the importance of marketing, public relations and outcome measurement. The public is also becoming much better informed and there is a noticeable increase in the numbers of people who have experienced several types of therapy – 'the dose effect' (Howard et al 1986).

Apart from the effects of negotiated contracts, other internal organisational factors also influence assessment and allocation. The range of services available (e.g. groups, couple work, brief counselling) impacts on supervision decision-making, as well as known local specialist agencies for referral. Pressures to find clients for students and the skills and interests of senior counsellors, and also, who has a vacancy, might also be relevant. Contracts can make additional demands with insistence on new policies and procedures, e.g. on child protection, safeguarding and evaluation measures. It is very important to value the range of potential methods and services.

Our belief systems about what is effective with different types of people need to be conscious and no doubt will vary considerably. We would probably all agree with Mark Aveline (Palmer et al 1997) that the priority task is the 'optimal therapeutic decision' (p.93) for the client, but reaching a consensus is complex in the grey areas. When in doubt, we have found it beneficial to offer clients a brief contract for further assessment and clarification. It is also important to discuss with the clients what their wishes are.

We have much still to learn about 'what works for whom?' as Roth and Fonagy (1996) put it and the assessment is the most crucial task to determine the most appropriate treatment. A good therapeutic experience of one method may well lead to another sooner or later. It is beyond the scope of this paper fully to examine the rationale and issues around choosing one option over another but broadly, the frame below informs our thinking. I conducted a small piece of research in a wholly psychodynamic agency offering only long-term, open-ended counselling. The average number of sessions used by clients was twelve. Clients who 'left early' were perceived as failures. They may have been better suited to an alternative form of help.

Choice of Therapeutic Options

	Brief therapy - Assess't + under 10 sessions	Time-Limited e.g. an assess't +10 or 12	Long-term / X 1 open ended or e.g. 1 or 2 years	Psych-analysis X 2-5 times weekly	Group therapy/ themed groups e.g. CSA	Specialist counselling e.g. - Couple Work - Family Work - Alcohol/ drug - Sexual disorders - Eating disorders
Behavioural /Goal-focussed						
Supportive						
Unconscious /in-depth work						

Assessment supervision is also the gateway into the service for all clients except those on the EAP Scheme (where we have both public sector and commercial contracts). Our aim is to try to provide 'good enough' quality assurance for the agency. There are five trained assessors and we meet monthly in two groups for an hour and a half. The number of assessments in each group varies considerably but can be as many as ten clients. Speed is of the essence. Assessments have been written up within an agreed format beforehand and are then distributed on email to the group (using only initial and reference number). Everyone arrives well prepared.

We have very few straightforward clients. GP counsellors now often see those clients for brief therapy. The number of referrals from NHS mental health services has increased and is usually of a very complex nature. We work as a team and the views of the clinical manager and the potential supervisor are also sought after supervision with the most difficult decisions e.g. we recently agreed with the psychiatrist's written approval and back-up, to offer counselling to someone with a bi-polar diagnosis. The clinical manager has the final say. If we are really flummoxed, the assessor sees the client for a second session.

The initial assessment meeting is usually the first face-to-face contact for the client with the agency creating a safe container for the client to tell his or her story. As Klauber (1972) says 'It is essential that it should be therapeutic and not traumatic'. That same containment needs to be mirrored in supervision with an atmosphere and culture where all mistakes can be safely brought and 'blind spots' dealt with. Milner and O'Byrne (2004) differentiate between 'intake assessments' into agencies, which they say are 'used for screening' and first session assessments 'that may end in written formulations' when work will continue with the same patient. Clients are also screening the agency to decide if they wish to continue and embark on the commitment of therapy.
The screening process is a major task. We lay heavy emphasis on the counter-transference feelings of the assessor and use the group process to identify

different aspects of the client. We have made a decision to exclude a client from the service solely because the experienced assessor felt so frightened in his presence. We wrote to the client and to the GP and sign-posted the client to anger management classes. The assessment of risk and the safeguarding of client, therapist and agency are taken very seriously.

All assessments are conducted during the day when several people, including a receptionist, are on the premises. There are counsellor alarms in every room, which are tested regularly. Assessors know that they can terminate an assessment if they do not feel safe or if the client is unable to use the session because of the effect of alcohol or drugs. All clients fill in a CORE form before the assessment and the assessor examines the risk areas before the session and with the client if the score is high. These are brought to supervision.

These days we are quite direct with clients. We ask them if they have had involvement with the Criminal Justice System. We also ask about self-harming, domestic and other violence, sexual abuse, past psychiatric treatment and drug and alcohol issues. When appropriate, letters from GPs and mental health professionals are sought for confirmation of the appropriateness of therapy and not allocated until reassurance is given. Clients must sign GP and psychiatrist consent forms. Generally, we do not counsel clients who are currently in the process of court proceedings, especially domestic violence. An assessor recently telephoned a GP in the very suicidal client's presence and with her agreement made an immediate emergency appointment with the GP. We much prefer to have the back-up of the GP, and the local mental health services if they know clients.

A substantial number of clients are from different ethnic, racial and religious groups from their assessors. Apart from the work of NAFSYAT the psychoanalytic literature on this complex field is very sparse. Digby Tantam (Mace et al p.9) comments on the absence of research into language, culture and religion in therapy. Gertrud Mander (2000) says that differences of colour and race are noticeable immediately and should be put into words and not denied, as with any other obvious difference. Martin (1993) says that assessors are likely to make incorrect judgments about people from a different culture and says there is an increased risk of treatment failure. One of the most difficult assessments I can remember was a woman from a very unusual religious sect that none of us had encountered before (similar to but not the same as the Amish). The client was specially placed with a counsellor who had some knowledge of the sect.

The main work in the supervision group, following the task of assessment is to draw the story together, to find meaning and to make a tentative formulation. Over the years, two questions have gained greater prominence in importance in our supervision**:**

1 Why now? Why not a month ago or six months ago? What has changed or become intolerable now? We are looking for coherence. I was interested

to see that Jeremy Holmes agrees - ‘This must not be skimped’ he says (Mace et al, 1995:p.29).

2 Hinshelwood’s (Mace et al. 1995 Chap.10 p.155 and 1991 BJP) idea - ‘where is the maximum point of pain?’ We find this more helpful and simpler than Luborsky’s (1988) core conflictual relationship theme.

Assessors have become skilled at making a tentative formulation and we then work further on this in supervision. Rob Lieper’s chapter on psychodynamic formulations in Lucy Johnstone and Rudi Dallos’s (2006 p. 47) recent book confirms our experience. This exercise gives further information on what might work best now. What are the risks? How long will the work take? Is there a clear focus? What balance should there be between supportiveness and challenge? Is one-to-one work the best approach for this person? Or is it a relationship difficulty with a partner (then couple work), members of the family? (then family therapy) or with relating to people generally (then group)?

Lieper describes formulations as – ‘the continuing struggle to make meaningful – to symbolise or ‘mentalise’ – what is inchoate and unformulated in experience’ (Dallos et al 2006 p.49). He also warns against a defensive need to over-simplify.

Mark Aveline describes assessment as ‘the product of a complex and uncertain interaction between the form and severity of the problems, the client’s personality, developmental stage, motivation, the skill, motivation and intrinsic power of the therapy, skill healing capacity of the counsellor, malleability of the life situation, and the operation of chance and good and evil fortune…’. In the short time available, assessors have a very skilled and complex task. In supervision, we try to reach a point of coherence of the client’s current situation. We know that it is only at that point in time. When there is little or no coherence after the client has been presented, we wonder about what that means and use the group process extensively, trusting our differing counter-transferences.

An illustration of the perplexing nature of the supervision task was a 43 year-old unemployed married woman presenting at assessment with quite severe depression and marital difficulties, who was dealing with the departure of her only child, a son, to university. Her mother had died when she was six months old and father’s girlfriend then sexually abused her. She was on anti-depressant medication, had had no previous therapy and was referred by the GP. The maximum point of pain in her life, which was being re-triggered, was brought to the assessment in the first five minutes.

The supervision task was to consider sensitively and carefully all aspects of the client - how she had coped throughout her life, how the assessor had experienced her, the history of physical or mental illness, her current support network, her capacity for insight, her ego strengths and degree of fragility and crucially, her motivation to do the work. She had coped well with her life up to this point and she had also had some serious physical ill health. I noted in myself

anxiety and uncertainty about her potential to break down and I was concerned about her potential very long-term dependency and the ending of the work. What if her counsellor left after two years? We would do more harm than good. Would shoring up her defences not be more therapeutic for her than dismantling them? This example illustrates some of the dilemmas and uncertainties of the assessment process.

We have a clear policy about who is unsuitable for counselling. We refer back to the mental health services if people are too ill or disturbed to use counselling; if clients are dependent on drugs or alcohol we refer them to specialist agencies; if sexual dysfunction problems are primary or unusual we refer clients to a specialist NHS Sexual Health clinic; if an eating disorder is severe we refer back to the GP for specialist referral. A recent male client revealed in assessment a serious hidden bulimia since the age of 12, which we referred back to the GP with his agreement. We are also alert to people suffering from post-traumatic stress, even retrospectively, who can be offered specialist treatment. Caplan (1965) said the active crisis continues for 4-6 weeks and current NICE guidelines advise against any treatment for the first month.

Assessors have visited the Henderson Therapeutic Community and undertaken extra training in the field of personality disorders. They look out for symptoms rather than apply labels e.g. an absence of guilt, no sense of responsibility for actions, dull or no affect, evidence of acting-out behaviour, excessive paranoia or self-centredness. None of us is qualified to make a diagnosis and one assessment session is insufficient time to be sure but we are all alert to the possibility. Our priority is to treat every client with respect, but also to safeguard the counsellors and the agency. An example of when this went wrong was a client who was stalking a counsellor after his counselling sessions. When in doubt we sometimes offer a brief or time-limited contract to assess further whether a client can use counselling.

A framework of clear policies and procedures, including clear assessment criteria, is essential to aid good practice and saves a great deal of time and debate. It is helpful to have clear agency policies on the following:

- Do assessors see a mother/ other carer who arrives with a young baby/ child or turn him or her away?
- Are interpreters brought in to assessments?
- Can a severely disabled client bring in their carer if they ask for this?
- Can a client be offered individual counselling….if they are currently receiving couple counselling?… group therapy?… going to AA?
- Can a client request a Christian/ male/ female/ older/ younger counsellor?
- What is the agency policy on shift workers?

What does supervision of assessments have in common across the modalities? All supervisees need to process their work, to put their work into words, just as the client has done with their difficulties. All supervisees need a reciprocal learning environment, where learning can be integrated and mutual support

given with safe and trusting containment. The group processing aspects are very similar too; the parallel process with clients and agency, the use of the group transferences and counter-transferences and the whole group conscious and unconscious.

Assessment is brief work and there are some aspects in common with supervision of brief therapy – the speed and activity in the group, holding the ending in the beginning, thinking fast yet appearing calm, a clear focus to the supervision task and not fuelling the transference. Endings are endemic and frequent in both supervisions and the aim is to ‘separate without harm’ (Mander 2000).

Conducting assessments gives a broad experience and variety of clients. Arguably all practitioners would benefit from undertaking at least eight supervised assessments before practising privately. It is essential for counsellors doing brief work that they are competent assessors. Once counsellors are accredited, I have noticed that they take about six months to find their feet as assessors. They may need extra support in the early months as they can be easily de-skilled and take flight. After about a year they are able to think in the sessions with the client about possible options, notice gaps and can make tentative hypotheses about what might be most therapeutic or helpful and discuss this in the assessment session.

Are there areas, which are particularly highlighted in supervision of assessments? What is unique? I consider that we have an important gate-keeping role both for the client and the agency. We are screening clients for appropriate referral into our services and saying ‘no’ if we have good reason. There is little room for indecision and ‘not knowing’, yet, as mentioned already, paradoxically these still need to be strongly held. Practical issues need to be addressed as well as interpreted. Letters are brought in from referrers and written to GPs and other professionals after the group. Jeremy Holmes (Mace et al 1995 Chap.2) says he does not feel an assessment has been effective if the client has not shown emotion. Although the supervision arouses intensely powerful counter-transferential feelings sometimes, only very rarely do we have to address personal feelings in the group. I am often aware after supervision of feeling drained, which may be less true of other types of supervision?

Conclusion

Poised at the interface of the agency and the external environment, supervising therapy assessments is a challenging, creative and multi-faceted activity with unexpected depths and conundrums that can draw on knowledge and experience from the past and present of any group member. Inevitably, work in the group is being implicitly affected by both external and internal political and professional agendas. Financial survival during uncertain times is a major priority affecting centres and numerous opportunities abound if agencies can be flexible, open and responsive rather than defensive.

The main tasks of assessment supervision are to provide a safe container to explore the entry point of clients into the counselling agency, to gain a coherent picture of the issues, to make the best optimal therapeutic decisions and to sign-post clients accordingly. Gertrud Mander (2000) warns against the 'Scylla of authoritarianism' and 'the Charybdis of permissiveness'. In supervising assessments it is necessary to be very conscious of the power of the decision-making process and to value all the services in the centre as well as recognising that sometimes colleagues outside have the skills and expertise to better help clients.

Mick Cooper and John McLeod (2010) have just published a new book, which proposes a pluralistic approach to therapeutic methods. They say (Therapy Today Nov 2010 p.13) 'Pluralism, unlike integrative perspectives, allows for therapists to hold a pluralistic viewpoint while working in a non-pluralistic, single orientation way'. It is important for supervisors of assessments in general counselling agencies to be aware of their own perspective, as it will greatly influence the decision-making process.

Those of us working as supervisors from a predominantly psychodynamic and psychoanalytic perspective have a great deal to offer our colleagues from other models but we have much to learn too. I have found it an enriching experience to work alongside colleagues from other orientations. Psychoanalytic ideas, especially about unconscious processes, are fascinating, exciting and apposite not only to us, but to many of our non-psychodynamic colleagues. There is nothing quite like supervising assessments to remind us of the complexities and vicissitudes of human nature, the uniqueness of every single client, the vital importance of psychoanalytic concepts in assessment and also the value of other ideas, methods and modalities to help us to understand what Josephine Klein has called 'the ineffable' (2003).

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EAP – Employee Assistance Programmes Nafsiyat NICE

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Supervision of Initial Assessments

Jackie Gerrard

As supervisors, I am sure we are all familiar with the papers of Nina Coltart (1988) and Bob Hinshelwood (1991) – Coltart's on 'Diagnosis and Assessment of Suitability for Psychoanalytic Psychotherapy' and Hinshelwood's on 'Psychodynamic Formulation in Assessment for Psychotherapy'. Hinshelwood focuses on the three areas of object relations in a prospective patient's life, (to get '*pictures of relationships with objects' -* p.167*)* and also the importance of offering trial interpretations to assess psychological mindedness. Coltart's emphasis is on psychological mindedness and she cites various aspects of the psyche that this comprises, ending with some signs of success or achievement in life.

Now the task before me is how to expand on this so that supervisors reading this paper can understand in more detail what is needed from an initial assessment interview. I have recently received an Assessment report from an otherwise experienced Assessor, where in my view, most of the criteria for a report have not been met. So, rather than illustrate from a comprehensive piece of work, I am illustrating from a piece of work that is lacking in essential information so that the Supervisor cannot possibly assess suitability for ongoing psychodynamic or psychoanalytic work.

THE ASSESSMENT REPORT

"Presenting Problem"

B (age 21) was recommended to counselling by his GP. He feels depressed and has problems eating and sleeping. He made himself sick a couple of times and says he feels guilty when he eats. He also feels stressed and anxious. He thought these feelings were triggered by the loss of a relationship but also had an anxiety attack on holiday 6 months ago. He has been on various drugs since the age of 13 and says he takes less now. His parents separated in his early teens. He lives with his mother and 2 sisters with whom he has good relationships and says he is a happy person. He has also had gay relationships from early teens, feeling he knew he was gay from puberty. He is keen on 'training' to keep fit.

Early memories
Seeing some dirty orange sheets. Having hot feet from the footpath.

Current situation
Living with mother and sister. Fully employed with social services. Has some very good friends.

Family History
B's parents separated in his early teens. He was relieved when father left as the atmosphere at home was 'bad'. He was negative about his father who he hasn't seen for many years. B said his father's background was repressed. In contrast mother is lovely and nice and he gets on well with his sisters and his maternal grandmother. He did not like his grandmother's second husband. He thought he was gay from puberty and 'came out' when young and has not had a backlash about this.

Relationship History.
He has had two 2-year relationships and one that only lasted a few months, but he was most upset about this ending and thinks now, in hindsight, that he was depressed throughout this relationship. He is currently in a new relationship of 4 weeks. He was concerned that this is a rebound relationship and that he may be 'using' him.

How did the client present
B initially seemed nervous and unable to make eye contact. He relaxed back into the chair after 15 minutes. He was humorous and articulate. He presented his life as having been happy and unproblematic and when I reflected this back to him he remained silent. He had difficulty in describing his feelings and I felt that he used his wits and humour as a defence against examining the more painful aspects of his life. I commented on this and again he remained silent. I think that his parents' separation affected him more than he cares to admit. I wondered about his early relationship with his mother and whether he had felt he had to repress any unpleasant feelings which may have damaged her.
I was struck that the relationship in which he had felt most attached had been one during which he had felt depressed.

Risk factors to self and others
B said he had no suicidal ideation and although he has sometimes felt terrible, he would not think of suicide. He has no history of violence but said his training 'focuses his aggression'.

Self assessment form
Not completed. I asked why and he said he 'forgot' and then 'I don't know'."

WHAT HAPPENS NEXT
This, by and large, is the sum total of the assessment report I received from which I have to make the following judgements:

1. Suitability for counselling – short or open ended.
2. What sort of counsellor – male, female, trainee or especially experienced

3. Ability to engage in a relationship
4. Ability to tolerate frustration
5. Sufficiently in touch with reality
6. Reasonable intelligence
7. Good motivation for therapy
8. Ability to sustain a commitment
9. Some indication of insight
10. Capacity to symbolise
11. Curiosity about his inner world.

Many boxes were ticked by the assessor. I queried those on: ability to tolerate frustration, a history of some success in life, ability to sustain a commitment, some indication of insight and capacity to symbolise.

To my mind, this report did not demonstrate evidence of any of the above.

Subsequent dilemmas

Firstly, where to begin to elicit from this sparse report who this young man is, what he wants from approaching a counselling agency, and, most importantly, whether the agency has anything that could usefully be offered to someone who would appear to be singularly lacking in curiosity about his internal world.

Secondly, I had to try to ascertain what was happening for the Assessor. I received this report from an Assessor who is usually sensitively tuned-in, thorough and competent. So I was left wondering about whether she was having a very 'off' day, or indeed what was being powerfully projected in the room that had made this assessing therapist so very ineffectual during this interview.

I will offer the reader my response to this report. The transactions were all conducted via e-mail as currently I do not meet face to face with the Assessor or a representative of the Counselling Agency.

MY RESPONSE

"I am sorry to say this is a very thin report, leaving open more questions than it addresses. The prospective client is a 21 year old, gay, young man, suffering from depression and anxiety, eating problems, former drug abuse and somewhat addictive behaviour. I thought perhaps the report reflected the client – in being somewhat 'anorexic'. From what I have read, it is extremely difficult to assess his suitability for counselling. From the evidence of the report, it would seem that perhaps he does not 'engage in a relationship', 'tolerate frustration', have 'a history of some success in life', 'sustain a commitment' or 'have a capacity to symbolise'". (*All these are indicators in Dr Coltart's paper and in the criteria of the Agency*).

For instance, just some of the many questions the report triggers in me are:

1. Why is the level of the suggested fee so low (£10) if this young man is in full time employment?
2. What is he concealing in remaining silent to the assessor's interpretations and interventions?
3. What does his early memory of 'dirty orange sheets' mean to him? Likewise, his memory of hot feet?
4. What do his nightmares/recurring dreams mean to him?
5. Why could he not make eye contact initially – what was going on for him?
6. What is the 'aggression' about in his mind that he uses rigorous 'training' to suppress?
7. What is his job in Social Services? (He could be anything from social worker, administrative worker or office cleaner).
8. If he is truly in full time work, then it is strange he has offered so many times as his being available for counselling.
9. Why do his relationships break up – what happens in them psychologically and sexually?
10. Who rejects whom on account of what?
11. How did he know he was gay in puberty – what does that mean to him?

I have no idea from this report whether or not he is motivated or indeed equipped for psychodynamic work. There is a strong split between 'bad' father and 'good mother', no doubt reflecting many other splits in his inner world. I am intrigued that somehow he has managed to fob off his Assessor, so that her usual perceptive and incisive reporting has become so vague and thin.

With so many questions in mind, I would suggest re-assessing him. However, I think an alternative plan could be to offer him 4 sessions to see what may emerge, and then, if appropriate, a more open-ended contract could be offered. I think he could see either a male or female counsellor, but it would need not to be a new trainee as someone would have to work with issues of seduction and evasiveness. I imagine that he would be more comfortable with a female counsellor as his relationships with female authority figures seem to have been easier than those with male authority."

CONCLUSION

So, what has this real and recent, slightly condensed report and my response to it demonstrated? Hopefully, I have illustrated the key issues that need to be uppermost in the mind of the Assessment Supervisor when dealing with an assessment report. In the report cited above, followed by my long list of questions, I have tried to show the vital missing ingredients which have indicated that this prospective client could not be fully diagnosed or assessed.

No psychodynamic formulation is possible from the paucity of information on B's object relationships and no measure of psychological mindedness can be obtained from the impoverished account of his relationship either to the Assessor or to his own symptoms, thoughts and emotions.

I think the papers that Coltart and Hinshelwood offered us before the millennium are as relevant to the guidelines we rely on today, as they were at the time of writing.

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Supervising an Assessment in Primary Care

Anna Bravesmith

For a number of years it has been part of my role to supervise a group of trainee counsellors in primary care and this has included supervising their assessments. Within primary care practitioners providing brief dynamic therapy are referred to generically as ‘counsellors’ but some of them are trainee psychotherapists, or counselling psychologists in training, or analysts, like myself. The group I supervise consists of individuals from different trainings and often contains qualified counsellors who are seeking to gain hours of counselling in order to achieve BACP accreditation. Furthermore, in primary care the tradition has evolved of using the terms ‘counselling’ and ‘brief therapy’ interchangeably and therefore I use them in this way in what follows. My use of the word ‘patient’ reflects the medical setting, the term GPs and nurses use when referring. It does not arise out of the ongoing debate in analytic circles about when it is appropriate to use ‘client’ and when it is appropriate to use ‘patient’. The issues in that debate are about whether frequent analytic work is in progress or whether it is counselling. Clearly in brief therapy in primary care there is a different criteria for choosing to speak of ‘patients’ which is based on the medical culture in which treatment takes place.

At first I carry out all assessments and refer on to the honoraries/trainees those patients who seem fairly straightforward. After two or three months however, if they are settled in and working well I ask them to begin doing their own assessments. We do some preparation and I suggest that they read about assessment and recommend The Assessment and Selection of Patients, Chapter 4 in *Brief Therapy: Short Term Psychodynamic Intervention* Bauer and Kobos (1987) and Psychodynamic Formulation in Assessment for Psychoanalytic Psychotherapy Chapter 10 by R.D. Hinshelwood in *The Art and Science of Assessment in Psychotherapy* Ed. Mace (1995) In addition it’s useful to read something on forming a focus since all our work is brief in the GP practice. I suggest *Form and Forming a Focus* by Jonathan Smith in Psychodynamic Practice August 2006;12(3) 261-279. This is the didactic part of the supervision and is particularly useful in ensuring that trainees from diverse trainings come together with common discussion points in our weekly supervision group. Some have studied assessment thoroughly and others have not, according to the trainings.

We discuss the purposes of assessment beforehand, as I think when they grasp the purposes thoroughly the task can then take different forms according to the personality and choices of the supervisee. There are many ways of structuring an initial assessment and supervisees are also invited to consider a second assessment if they are unable to cover all the necessary areas at the first meeting.

The assessment would be for the purpose of:

- Inviting the patient to bring a presenting problem and think about what they want from the brief therapy. Containing the patient's anxiety and 'holding'.
- Preliminary diagnosis or clarification of underlying problems and making a psychodynamic formulation. This may be kept in the mind of the assessor and not shared at this stage, or cautiously partially articulated.
- Gaining and recording information e.g., life narrative, details of significant attachments in childhood and adulthood, psychological and physical symptoms, medication, current difficulties etc. (Taking a psycho-social history.)
- Establishing what is likely to be the most effective treatment modality. In most cases Brief Dynamic therapy is offered but consideration needs to be given to the patient's capacity for working with separation after brief work. Sometimes specialised services may be required or psychiatric intervention.
- Establishing an engagement/rapport with the patient so that a working alliance begins to be formed.
- Considering whether the individual counsellor concerned would be appropriate for providing counselling for the patient being assessed. This is partly understood by monitoring of the transference/countertransference but other factors will also influence the decision.
- Carrying out a risk assessment asking about suicidal ideation/plans/any history and finding out what helps the patient to resist suicidal impulses-what makes life meaningful and worthwhile.
- Carrying out a risk assessment regarding self harm and/or alcohol and drug abuse.
- Risk assessment regarding any others especially children within the patient's environment.
- Providing information to the patient regarding options, confidentiality, length of treatment offered etc.
- If dynamic therapy is indicated, considering what sort of approach to take-e.g., supportive or uncovering, focal or less focal.
- If appropriate agreeing a contract with the patient with clear time frame, frequency and starting date.
- If appropriate agreeing a focus for the therapy collaboratively with the patient e.g., a central dilemma or cyclical maladaptive pattern which connects to, but is not identical with, the presenting problem. This may be postponed until a second interview.

Over years I have evolved an assessment form for recording what emerges from the interview and supervisees are encouraged to complete one of these for every patient assessed. I have attached the form as an appendix to this article. It gives spaces to write in (not tick boxes) and helps the supervisee to record information in a structured way. What I have so far described has been mainly about teaching assessment skills, recording and systematising so that the necessary ground is covered and this tends to be cognitively driven. When it comes to face to face supervision unique dynamic aspects of supervisee and patient and

supervisee and supervisor/supervision group unfold and unconscious processes emerge to be worked with. The emotional qualities of each assessment situation arise organically and in what follows I provide two brief vignettes based on composite representations in order to avoid breaching confidentiality.

Dynamic aspects of supervising an initial assessment:

Example 1
Kate has completed her first assessment and is enthusiastic to recount the experience to the supervision group. She liked the patient very much and understood the issues in his life and saw connections between his childhood and his current difficulties. She tells the patient's narrative very vividly from memory and they seem to have engaged with each other quickly. He was accused of rape by his ex-partner, spent some months in prison awaiting a trial and was later acquitted after much distress. He has suffered much loss and is very angry with the injustice of what has been done to him.

It becomes clear that Kate could work well with him but at this stage she is over-identified with the patient and has not managed the tightrope act of balancing between objectivity and subjectivity necessary for an accurate assessment. She forgot to do the risk assessments and it had been hard to form a picture of his relational patterns, being 'too near the wood to see the trees'. The rest of the group feed back to Kate their impressions after she has given a detailed description of the session. They form a tentative picture of someone who has issues with rage and in his manner of relating to Kate reveals a bullying manner. She reports feeling safe enough with him and in her own counter transference has picked up on his sense of loss and misery as he has 'nothing left in his life'. We seem to have two sides of him reflected in the group and we go on to formulate a possible focus on his relational pattern (bullish) and the hidden affect (grief) behind it. Kate is going to conduct a second assessment session and explore risk issues and attempt to collaborate with him on forming a focus.

Issues of difference were also discussed –the patient is from Serbia but did not talk about any experience of traumas during or after the war there. He was also reticent about details of his childhood and the two may be connected. In a second assessment Kate plans to probe further into his memories and into his feelings about the cultural transition involved in his life in UK.

Example 2
Michael's initial assessment of a young pregnant woman whose parents come from the Caribbean started with her arriving late and overwhelming him with an array of 'characters' in her description of her life history. The complexity of the narrative seemed to trigger detachment in Michael and he decided he must complete the relevant questions necessary at assessment in a highly ordered fashion which had a defensive quality. The description given to the supervision group came over as deadening and little rapport had been established between himself and the patient. He did ask the questions about risk, that is often unconsciously avoided by supervisees, but it was only through supervision and further sessions with the patient that the true nature of the specific risk emerged.

The patient's mother had many children by a number of different fathers and she had been brought up, and still lived in, a complex extended family with a lack of close attachment to anyone. Claustrophobic living conditions existed due to sharing bedrooms with siblings and cousins but there was a poor quality of emotional relating. Michael's detachment reflected this young woman's experience and his state of being overwhelmed reflected her claustrophobia. This was a 'core complex' presentation and he unconsciously responded by pushing through a list of questions as if this would break the tension between longing for closeness and needing space.

The young woman feared her pregnancy which meant, to her, that she could never get away from the baby inside her and she expressed her feeling that once the child was born she could leave him with someone else. The risk emerged as a risk of repeating detached relational patterns and of failing to be the good enough mother she wanted to be. There was a potential risk to the emotional development of her baby and her own development as a mother. These issues were picked up by members of the supervision group only after I observed that Michael seemed to have treated the assessment in a mechanical way and that this surprised me, since he could report cases in which he was engaged and more free flowing. I suggested that, although the assessment appeared thorough, a central dynamic had been missed. Again, as with Kate's patient, cultural issues were present and later, when discussing the focus with the patient Michael was mindful to explore explicitly what the patient felt about raising her child in relation to the cultural styles she perceived and had experienced herself. The question arose: what did she want for her child and how could she usefully think about her dual cultural roots?

Conclusion

There are many aspects to assessment and its supervision and unconscious processes reveal themselves in the supervisee's account of the assessment. Although it is one of the more cognitively driven activities in dynamic therapy/counselling, with structured areas that need to be covered, it needs to be subjected to the same analytic scrutiny and free associative processes used for ongoing sessions. The balance between objective 'data collecting' and emotional engagement and relating requires practice and is particularly complicated if one is assessing patients in order to refer them on to other practitioners. Supervisees in the practice where I work are generally assessing in order to work with the patient themselves however, they may find that a patient has not enough ego strength for therapy, at the time when assessed, and may be better off simply going to the GP periodically for what is now termed 'watchful waiting'. Sometimes a patient needs psychiatric assessment or a specialised referral, for example to alcohol misuse unit or to a unit specialising in trauma. I rarely discover that CBT is indicated and it is my belief that the flexibility of psychodynamic therapy is suitable for most cases if applied in an appropriate way - for some people solely supportive, for others challenging and uncovering. Even patients who use highly concrete thinking can be worked with as long as the therapist/counsellor is sensitive to the idiom of the patient and can avoid becoming frustrated or critical about the absence of symbolic functioning.

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CONFIDENTIAL ASSESSMENT FORM
Complete during or after first meeting or 2 meetings

Patient initials: **Ethnicity:** **Age:** **Gender:**

Religion: **Specific needs eg language/disability:**

Name of assessor: **Name of referring GP:**

Name of counsellor referred to:

Date of assessment: **HAD or other questionnaire score:**

Presenting problems & coping strategies
Patient's description of problems
Precipitating factors
Current coping strategies and how/whether they are working
What does patient want to gain from counselling?
Any fears or anxieties about the process

Employment/ skills/financial history and current job:

Current significant others & support networks
Availability of support, emotional and practical
Reported ability/willingness to use available support
Living situation (eg with parents, family, alone, in hostel etc.)

Patient's previous experience of psychological interventions (counseling/therapy/psychiatry/GP support)
Dates, in-house or elsewhere, did it help, what worked, why and how much?
Assessor's perception of the quality of relationships with professional helpers and capacity to engage.

Life story/narrative 1
Childhood and infancy experiences, traumas, separations, deaths, illnesses, cultural transitions, education, socio-economic background, experience of being parented.
Family size, siblings, age differences, position in family etc.
Assessor's observation about idealizations, memory abilities and capacity to describe others, readiness to share or reticence etc.

Life story/narrative 2
Adolescent and Adult experiences, relationship, sexual development, Jobs, educational etc. Patient's description of how life transitions have been managed.
Note the coherence and manner of telling the narrative.

Mental health status
Assessor's view of current mental health status and symptoms reported and observed.
Mood, contradictions, lability, ego strength, quality of defences- rigid or flexible, Intensity of projections, splitting, idealisations, reported acting out, potential for trust, dreams, fantasy etc.

Risk Assessments

Harm to self:
Ask directly in all cases about suicide, suicidal ideation, is there a plan or just occasional thoughts ? Any history of suicide? Intergenerational history?

Harm to others:
Ask only if concerned because of alerting factors
Are children involved or vulnerable? Any history? Domestic violence?

Risk taking behaviours
Ask about use/abuse of alcohol and 'recreational' drugs, and any other risky behaviour suggested in patient's narrative.

Patient's physical health
As reported/as in medical records or GP referral letter
Sleep, Eating/ Unexplained symptoms/ understanding link psychesoma

Assessor's observations and experience of being with this patient
Appearance, manner, emotional state, capacity to observe him/herself and to reflect.
Relational patterns with assessor and with others as reported.
Transference counter transference.
How to understand links between childhood development and current problems?

Psychodynamic Formulation and Focus for treatment
Is it possible to formulate a psychodynamic picture of underlying internal and interpersonal conflicts at this stage?
Can a focus be collaboratively negotiated with the patient for Brief therapy now?
If not, what possibilities have arisen for later collaboration on forming a focus with him/her?

Contract- number & frequency of sessions & start date:

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BOOK REVIEWS

Counselor Supervision. Fourth Edition
Nicholas Ladany and Loretta J. Bradley
Routledge, 2010 Hardcover £28

Reviewed by Bruce Kinsey

Feeling rather proud of BAPPS and all that it has achieved over the years I was somewhat taken aback to find this book to review on my doorstep. Describing itself as a 'practically meaningful text' it proclaims that it covers and critiques not only the primary supervision theories but also includes 'cutting edge topics'. The first three mentioned are '1) multicultural issues in counsellor supervision [e.g., how to balance and manage multiple identities such as gender, racial, sexual orientation, age, and disability in the context of influencing trainees multicultural competence] 2) the supervisory relationship [an essential but sometimes forgotten component of supervision] and its influence on supervision process and outcome 3) supervision of career counselor trainees [e.g., supervision challenges unique to career counseling trainees such as integrating personal and career development']. My heart sunk because I thought we had got beyond this, it seemed at first view not to be 'cutting edge' at all. In fact it often reasserts or re-presents material we are used to thinking about, or familiar with. It was only then that I began to see the purpose and strength of this particular volume, it is a compendium of much that is good and as a one text book it hits many targets spot on.

It is clear from the spelling of Counselor that this is an American book [the authors are from Pennsylvania and Texas] and I struggled to find one book or article referenced from outside of that country despite the often lengthy bibliographies that follow each of the chapters. It struck me as a shame that we all seem to be re-inventing the wheel whereas we could learn much more by an interchange of ideas. Although there are many differences between our countries there are also similarities; they too bemoan 'the alarming fact... that only a token number of supervisors, regardless of work setting, have received specific preparation for supervision' [page 5].

It is all too easy to be critical of all things American and that certainly is not my intention. In fact there is much that is written [and how it is written] that makes this book deserve a wide readership. Contained in this one book are some real gems collated and explored, some of it was new to me, other pieces were written in a fresh and different way helping me revisit ideas and challenge myself.

This hefty volume of 450 pages has put together a diverse collection of essays from 28 authors and most training organisations would want to consider owning a copy in their library. It is too vast a text to do complete justice to in a brief review, I do recommend dipping into it and enjoying both the style and the content, and the gentle way in which your thinking and practice will be stretched.

The book is helpfully divided into four sections the first concerns essentials for training, the second section is on theoretical approaches, the third is on models [such as group, family, assessment] and the final section is one professional issues. There are some interesting chapters on research on Supervision as well as on Ethics. Despite the large numbers of authors the book reads well, and although almost every point is backed by its sources there is a good strong direction in the text and is clear and purposeful. I found myself increasingly enjoying the rather slow and laboured fashion of writing and pedantic detail as the book developed: no stone is unturned, and I began to appreciate the detail.

Heavy on theory, where there is case material it is useful and enmeshed in the text drawing out ideas and reinforcing the more technical ideas. It would have been great to have had more on it anchored in practice, but then the book would have been even larger and more unwieldy.

There is also a refreshingly frank way of expressing some of the ideas in this book. I am well aware that some issues are different in America, but the way that race, gender and sexual orientation matters are written about is clear assertive and strong. They are also handled at depth.

For some readers because much of this book is a collation of other works, there will be too much familiarity; for me there was still much that was new, and great to have in this compilation of ideas. Some of you will be familiar with the work of Kashudin using Berne's ideas on Games Supervisees Play and Games Supervisors Play. It was unknown to me and I found it particularly creative and I look forward to developing some of these ideas with my colleagues. 'Within the supervisory relationship, games may emerge in order to deal with the anxiety, shame, discomfort, and interpersonal conflict between the supervisor and supervisee'. One game mentioned [and often played in Cambridge] was wittily titled 'If you knew Dostoyevsky like I know Dostoyevsky' and concerns the intellectual power game that can occur. Another is 'Heading them off at the Pass' 'indulging in self flagellation in order to elicit reassurance from the supervisor' or 'Little Old Me' where the supervisee is 'feigning weakness in order to seek 'prescriptions' of what to do from the supervisor'. The book does not come over as playful at all, which is a shame as several sections are written with a light touch [not without depth] but with an inviting manner reflecting the desired culture of shared learning in the supervision space. I think that people training to be therapists would find such a way of exploring the dynamics as helpful and full of insight.

Another idea I enjoyed playing with was the supervision Genogram. Here the supervisor asks a trainee to outline their history of supervisors. 'Using a code similar to a family genogram, the trainee identifies his or her supervisors' demographics, the nature of supervisory alliances, the professional contexts where supervision has occurred, and the models of supervision utilized. Other features that can be added are the theoretical orientations of supervisors, descriptors of supervisory styles, evaluation processes, and the positive and negative critical events.' Using this diagram for reflection of what someone is

looking for or avoiding, or to engage with their history and how it might affect what will be happening could prove creative and engaging.

There are several other sections that I could write about but one in particular I wanted to highlight, and that was that concerning young people and work in school too. In the essay on this it became clear that the situation in the States was not entirely different to that here [‘neglected, unmet, unlikely, and perceived as unnecessary’ p255]. There is a lack of specific thought given to much of the work with children, and the lack of good and appropriate supervision. The collation of various sources and ideas currently in America was useful, but much of it seemed difficult to translate to work in our school system, and more seemed to concern the dynamics of institutions rather than being child centred. [It might be an idea for a future volume of this Review to be given over to the topic of supervising work with children].

The more I read this book the more I enjoyed it, and the more I wanted to recommend it. Not a light or easy read, it certainly worth serious attention.

Bruce Kinsey *is Senior Tutor at the Perse School in Cambridge, as well as a Psychoanalytic Psychotherapist and supervisor. He is researching into Psychoanalytic understandings of Religious violence at Cambridge University and has recently written on a Psychoanalytic approach to religious healing.*

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Contributions to future Journals

Spring 2011 - Supervising God (Bruce Kinsey and Lynda Norton will act as joint editors for this edition. Copy deadline 30th February)

We warmly invite you to consider contributing an article……..

- There has been much written about the place of religion in therapy and the potential for avoidance of the encounter: we have been wondering what happens when the 'God in the consulting room' gets expressed in the supervisory space.

- God can enter the supervisory dynamic in a multitude of ways. It may be via a strong belief system held by the client, the supervisee (or supervisor). How do we as supervisors work with the supervisee to think about these issues?

- At times the belief system may be rigid and used defensively - how can the supervisee be helped to reflect upon and address these? However at times the spiritual dimension/quest can be pathologised rather than seeking to understand what it means. How can difference be respected and worked with? Can there be space for the divine in the consulting room? If so how?

- Many of us work or have worked in Charities and organisations which often seem to have a large super ego and/or huge ideals powerful meta-narratives. Sometimes these create a creative space in which to work, but this is not the only side of the picture. We have been wondering what happens when ideas of God appear in supervision either directly or indirectly.

- Perhaps you work in the religious and/or charitable sector and wonder what the added dynamic brings/reveals/distorts in both individual and institution. How does the optimism or hope that a faith dimension can bring so often land up seeming punitive? And how does that affect the relationship with supervisor and supervisee, 'is my faith bigger than yours?'

- The topic can be tackled in any way the author wishes - providing that the theme is addressed from the perspective of psychoanalytic/analytical psychology and also that the focus is upon supervision - working with these issues with the supervisee in order to help them address issues in the consulting room (vignettes may be from the perspective of the supervisor or the supervisee).

- Articles are usually 2,000 words (approx) although where appropriate and by negotiation we can offer flexibility up to 3,000 words. 'Nuggets' are also welcome i.e. shorter, more informal pieces raising an issue/ query or sharing a perspective.

Please contact Bruce brlk1@cam.ac.uk or Lynda lynda.norton@ntlworld.com if

you would like to explore the possibility of contributing an article.

Summer 2011 – Supervising Retirement and Other Endings
(lead editor Anne Power. Copy deadline 30th April)

Many of us will have had the experience of supervising a colleague who is facing the prospect of retiring and going through the significant practical and emotional challenges which this poses. Inevitably we will face this task of supervising retirement without having any personal experience – our own retirement will sit somewhere in our unconscious as something which must be faced one day. We thought it would be particularly helpful to share experiences in this field which is very under-represented in the literature. We hope that Gertrud's paper in this edition will serve as a taster to encourage readers to share their experience; it would be very good if we could include papers from supervisors at different stages in the process of retirement.

We are also hoping to include one or more papers on other types of endings, be these for re-location, pregnancy or ill health which is perhaps the most frequent and complicated cause of ending and one where the supervisor's role may be particularly stretched. If you could write about supervising retirement or other endings please contact anne.power@gmail.com.

Autumn 2011 – Beginnings and Endings in Supervision.
(lead editor Chris Driver. Copy deadline 17th October)

The beginning of any relationship is a journey of discovery and certainly supervision is no exception as we get to know both supervisee and patient. But this process also entails understanding a range of issues, including our countertransference, in order to begin and develop the supervisory process. Endings in supervision also have their own specific factors and focus. Could you write an article on beginnings and/or endings in supervision? If you could please contact chris@driver4.prestel.co.uk

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Articles for 'Supervision Review'
General Guidance

Spring 2011 **Supervising God** Copy deadline February 30th
Lead Editors Lynda Norton and Bruce Kinsey

Summer 2011 **Retirement and other endings** Copy deadline April 30th
Lead Editor Anne Power

Autumn 2011 **Beginnings and Endings in Supervision**
Copy Deadline Oct 17th
Lead Editor Chris Driver

Theme: Articles need to address the theme from the perspective of psycho-dynamic / psychoanalytic / analytical psychology and focus upon supervision (vignettes may be from the perspective of supervisor or supervisee).

Copy Deadline: This allows time for editing / checking queries prior to the committee meeting and 'Supervision Review' going to print. NB. If you would like feedback on a late draft please let the lead editor know beforehand and agree an earlier deadline to allow sufficient time for this process.

Article length: Articles are usually 2,000 words (approx), although where appropriate and by negotiation we can offer flexibility with this wordage up to 3,000 (approx). 'Nuggets' i.e. more informal / shorter pieces are also welcome.

Format: For articles please include the following:-

- **Title of article and name of author**
- **Abstract** – a one paragraph summary
- **Six key words** - The key words are for use by the internet search engines for the e-journal
- **Main text**
- **Bibliography**
- **Biography** - a few sentences of personal biography.

E-Journal: Please note that any published article will also be included in the e-journal on the BAPPS web site.

Copyright: If you wish to include / use any of your material previously published in a book / journal please ensure that you liaise with your publisher to obtain permission.

Lead Editor: This rotates between Chris Driver, Annie Power, Lynda Norton and Bruce Kinsey. The role of the lead editor is to provide support and constructive feedback during the process of writing & submission. Please do not hesitate to contact us if you have an idea for an article and would like to sound someone out or if you have any other queries.

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