BAPPS

Supervision review

The Journal of the British Association for Psychoanalytic & Psychodynamic Supervision

Retirement and Endings

Summer 2011

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Foreword

Anne Power (Lead Editor)

We are always grateful to our authors but in this edition in which we focus on retirement we are particularly indebted to writers who have been prepared to tackle a neglected corner of the psychoanalytic world which was almost virgin, untilled soil.

In a profession where many of us wish to continue working longer than the traditional retirement age, questions of when to stop and how to wind down a practice present a considerable challenge. Two circumstances particularly seem to have militated against the profession developing wisdom about retirement: firstly the universal disinclination to face up to matters which relate to ageing and dying and secondly the practical difficulty that those individuals who have made this transition, and who have acquired understanding and insight into the process of retirement, are lost to the profession and their experience is rarely shared. For this reason it is particularly valuable to be able to include in this edition two voices from those who have already 'crossed over'. Ruth Barnett and Jo Roscoe write as retirees; they both suggest that a gradual process of retirement may be optimal and they both demonstrate that retired therapists experience a strong impetus to continue doing therapeutic work in a new context.

We know that Freud worked long hours almost until the end of his life and other early luminaries of the profession continued into their ninth or even tenth decade. Just as in a religion, devotees will mine the scripture and find what they need to support their interpretation of the faith, perhaps so in psychoanalytic circles. Followers can use Freud's example either to support their intention to work on and give their patients the benefits of accumulated wisdom and experience, or as a salutary lesson, indicating that we need to take a responsible stance and withdraw before our competency is diminished. To help us identify where we stand on this and how we may want to prepare for an eventual retirement, our three clinical papers explore the impact of an imposed ending.

Amélie Noack's paper reflects on the theme of ageing and retirement in different settings and in different eras; she beautifully integrates her exploration of the symbolic with the exposition of the practical. Penny Culliford, writing this piece in the early weeks of her bereavement, and with her late husband's permission, has given us a unique account of the emergency closure of a practice. Her moving paper gives us the opportunity to benefit from the multiple challenges which she and her husband faced and she invites us to learn lessons through which she was forced to live.

In writing about supervising pregnancy, Ruth Simmons has given us a paper tightly focused on the supervisory space. She highlights the unconscious currents which may be stirred in the supervisory triangle by the approaching ending – and beginning – which the birth will bring. Finally Eleanor Creed-Miles review of Murdin's important and much referenced book reminds us of the complexity of all endings and the continuum between 'regular' termination and the imposed endings of retirement. The 'enough' of Murdin's title invites us to apply Winnicott's notion to

the inevitably messy business of retirement, allowing us to think in terms of a good enough ending.

In my research into therapists' retirement I have been struck by the enormity of the task which the retiring therapist and supervisor face. For therapists in private practice both the decision to retire and the process of winding up the work with clients present a significant challenge. For most of us our investment in the work is very great and we are aware that the intense engagement with patients feeds us deeply, as at the same time, we hope, benefiting them.

Whilst supervisors do not set out to encourage a strong transference in their supervisees, and aim to conduct the relationship in a way which is less likely to evoke this, yet we know that the supervisee's attachment to their supervisor can be intense. Once a therapist has completed their own therapy, their supervisor often becomes a significant attachment figure; it seems that there may be a pattern by which newly qualified therapists 'shop around' changing supervisors now and again until finding one where they settle and feel particularly comfortable; once they have found this there is a tendency to 'stay put'. This pattern is not without controversy; some supervisors specifically encourage review and moving on after a certain length of time.

Equally there can be very deep attachment to a peer supervision group – so much so that when a therapists retires there is a reluctance (on the part of the group and of the retiring member) to separate. There may be an attempt at a compromise which allows the retired therapist to continue contributing in some way, though they no longer have their own clients.

The papers in this edition raise interesting questions about retirement; by necessity many others remain unaddressed and the question of the supervisor's own retirement is one of these. Whilst we have not challenged readers with a paper on this topic, a line from Murdin's book may serve to set the issue squarely before us: 'Therapists will stay with elderly supervisors to keep them alive, just as clients will stay to heal and repair and keep their therapists going.' (2000: 170).

Reference

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Since the spring edition of Supervision Review we have very sadly said good bye to Catherine Cooper who has been a key figure in the production of the Review and was involved in our evolution from the BAPPS Newsletter. Catherine has been responsible for all layout as well as overseeing printing and distribution. On the publications committee we owe Catherine a huge debt of thanks for her creative formatting skills, for her patience, and above all for being an embodiment of the can-do attitude. We wish her and her daughter Emily the very best.

Chris Driver, Lynda Norton, Annie Power, Bruce Kinsey, Eleanor Creed-Miles

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When retirement turns into forced retreat

Amélie Noack

Abstract

This paper looks at the vital importance of rest and retirement and its implications of separation, loss and mourning, especially for a profession as rewarding as psychotherapy. The inevitability and need for supervision in regard to facing ageing, illness and death is highlighted and examples are given for this. When these issues are avoided in the psychotherapeutic profession, because they feel so awful that they become unbearable, things go wrong. The consequences are serious for patients and the profession as a whole.

Key words: retirement, rest, mortality, illness, death, separation, loss, mourning.

Having reached a certain age, retirement is more frequently on my mind than ever before. Some older colleagues have recently retired and somebody I trained with is planning to retire this summer. This makes me thoughtful and I wonder why I don't feel ready to retire yet myself. I am hoping to reach a ripe old age and gain further wisdom without acquiring too many aches and pains in the process, which would limit my capacity too soon to work analytically. But even so, the issue is coming ever closer.

One of my patients is nearing fifty and, having recently started a Humanistic therapy training, is constantly reminding her husband ten years her senior and everybody else over sixty that they should face the ageing process and prepare for death. 'It is hard to face mortality', she says. But she has not yet reached the stage of having to face these issues herself and tells me that her husband finds her frankness annoying.

A failure of supervision

Retirement is close to my heart also for another reason, which is that one of my analysts died when I was still seeing him. The last six months of his life and of my analysis with him were remarkable, because they were full of meaningful coincidences. I got very ill in the early summer and ended up in hospital during a holiday, only to resume my analysis to be told that my analyst too had been very ill and in hospital during the break. He had had a heart attack and nearly died. The following months were very difficult. I was aware that he looked still unwell, but was also recovering while obviously in pain. When I tried to address this, he said that nothing could be done about it. When I suggested he might want to retire and take care of himself, he said that this sounded as if I wanted to pre-empty (I am aware that it should read pre-empt) his death. I experienced this retort as sharp and accusative, and it made me feel as if I had been accused of wanting to kill him. It made me feel guilty and unable to raise the issue again with him.

However, I made the attempt to talk to others about it. I opened up the theme of my analyst's age and illness with both my training supervisors and said I was concerned. 'You know how stubborn he is', one supervisor said, 'This is none of your business', the other. It transpired that nobody in the organisation felt able to

take responsibility for the issue, let alone raise it with him. I was left feeling utterly helpless. My sessions became more a concern for his wellbeing than spaces where I could talk about or discuss my stuff.

In the week before Christmas, I developed severe pains in my belly and ended up in A & E on Tuesday evening, because I could not cope with the anxiety this caused me. I was afraid I might be dying. Sometime after midnight I was told that I had a small ovarian cyst, which did not require an operation. I was discharged. The same week, at 7.30am on Friday morning, I got a telephone call, saying I did not need to attend my session, because my analyst had sadly died at 5am.

I still think that the events leading to his death could have been handled differently. I wish they could have been dealt with in a less damaging way for all concerned, me, other patients, my trainers and the training organisation as a whole. But this was not possible at the time. Instead, I was left feeling rebuffed, rejected and utterly helpless.

My analyst himself, I believe, had no supervision, since he belonged to a generation, which considered supervision unnecessary after a certain point in time. His death is over twenty years ago, and in the meantime the profession as a whole has matured. Ethical considerations and standards now assure that today every practitioner must take care of their need for supervision at least in relation to continued professional development.

The unconscious communicative link between analyst and patient, as described in my experience of this time, I still think, is striking. It has major implications for the transference-countertransference dynamics in the analytical situation. My example shows that the difficulties caused for the patient by the analyst's illness are not always taken into account. I would therefore call my experience a failure of supervision, not because either of my supervisors was failing to supervise my work, but because they and the training organisation both were failing me (and others, I imagine) by not monitoring the professional activity or conduct of one of their senior and obviously ill and ageing members, despite knowing of his difficulties. I felt left alone dealing with it, but in my eyes, they were also leaving him on his own and failing him too.

As a consequence, supervision acquires another dimension in relation to our own ageing process as professionals. This is the necessity to be supervised and monitored in regard to our capacity to work in a competent and able way by our colleagues and I could say that it is the organisation's responsibility to create a culture where this can happen. During the long years of working as a therapist this kind of issue is usually highlighted only during serious physical illness or emotional incapacity due to bereavement or other losses. But the need to address ageing and the limitations due to the ageing process is an important issue that eventually all of us must face.

The usefulness of peer supervision

It is over ten years ago that one colleague in a peer supervision group of three became ill with cancer. Sarah had two major operations and each time recovered well. She was keen and able to get back to work and found ways to fit in her various radio- and chemo-therapies, in such a way that her patients would not be necessarily aware of the treatments. The three of us had been colleagues for a

long time and had also become friends over the years. Each of us was aware of her precarious situation in regard to her health, and when her cancer reappeared after five years, my colleague and I made a special effort to help Sarah face up to the fact that she was dying. It took our small peer supervision group several months to deal with all the repercussions of this realisation. For a few months the time in the supervision group was spent mainly preparing for the necessary negotiations with her patients. There was careful consideration and discussion prior to any decision and certainly before talking to the patients themselves. Some therapeutic contracts were ending anyway. One patient was referred to each of us – we felt this was manageable - and the rest were referred to other colleagues.

Sarah finally managed to retire seven months prior to her death, and we celebrated together the completion of her professional life. I firmly believe she would not have been able to do this without talking it all through in our small supervision group. She was then able to travel a little, and visited friends and family abroad to say good-bye. During the last few months of her life, we regularly met at her house, accompanying her also on this last leg of her journey, a process immensely valuable to each of us.

Forced retreat

Helping Sarah to face that she was dying was not easy. However, it seems surprising that so many people in the field of psychotherapy find dealing with illness and the ending of their professional lives such a difficulty. Increasingly, I hear of colleagues who were forced to stop working due to illness. Several colleagues were seemingly unprepared when they realised they were no longer able to continue as usual. Given that the work of psychotherapists is done mostly by sitting in a chair and does not entail any physical exertion, it is difficult to imagine how ill these colleagues must have been for some time, how terrible they must have felt and in what pain, to suddenly have to drop out of work.

I wonder about the effect on their patients. Suddenly and unexpectedly having to retreat, meant in each case that they did not prepare their patients for this separation. Because the therapist was no longer able to sit in a chair, to listen and talk, but instead had to be in hospital, the patients had to be dropped. It does not seem fair to the patients, nor to the colleague, who has to pick up the pieces afterwards.

How difficult is it to give up something that has sustained us over many years of our adult life? Can we even consider relinquishing work that is as fascinating and enriching in so many ways as analytical work? To face the end of one's working life and to give up analytical work, means a real loss, necessitating grieving and mourning. How much more difficult is it to face ending our work life, if it is **only** our work which sustains us? When something feels so awful that it becomes unbearable, then things go wrong.

Retirement - luxury or necessity?

A part of me thinks of retirement as a luxury available only to the rich, who have managed to save the necessary cash and invest it wisely. I see them spending their time partially at the Opera, partially in their country houses, then again at the villa in Spain or on the Bermuda's, as well as cruising the Mediterranean and visiting all those far-away places they never had time to explore before. Another part of me

believes that even ordinary mortals, who live in one property only and dream of growing potatoes on the allotment, may want to retire. The latter option should be open to us all, if we have maintained good health, but this is not always under our conscious control.

I found myself wondering what makes a life a fulfilled one? When does it become easy to retire, to let go and rest, even before being laid to rest for the last time? Can we allow ourselves to rest while still alive and enjoy life in its own right? Or do we have to continue working and earning our living, because we still do not feel we deserve what we have got? What if we cannot allow ourselves to retire and have rest, because we are then possibly faced not only with the loss of work and its meaning, but also with previous disappointments and losses in our life? Is there a connection between deserving rest and learning to deal with separations and endings? Perhaps we can only rest in a satisfying way, if we have managed to face our own mortality. A spiritual attitude might help, and Sarah for instance decided to read the 'Tibetan Book of Living and Dying' in her last few months of life.

Ultimately, I understand the psychoanalytic endeavour, independent from any particular school of thought, as the attempt to come to terms with separation and endings in the process of individuation. Psychic development, I believe, depends on the capacity to be alone (Winnicott 1987) and the further ability to embark on a journey of continuous differentiation. It means (do we dare to practice what we preach?) again and again letting go of the emotional and developmental state that has been there before. This repeated experience of separation entails loss and requires mourning. Freud's famous paper on 'Mourning and Melancholia' (Freud 1985) emphasizes this need for grieving. It focuses, as I believe, on one of the essential, if not the most essential concepts of development. Separation is painful; it hurts and makes us cry. When we can fully give into the feeling, we often sob uncontrollably - or that is at least my experience. The letting go of tears, which is one way of experiencing the alchemical 'solutio' (Jung 1974), is the letting go, which opens the path to the next step on the journey.

Es wird vielleicht auch noch die Todesstunde
Uns neuen Räumen jung entgegen senden,
Des Lebens Ruf an uns wird niemals enden...
Wohlan denn, Herz, nimm Abschied und gesunde!

It might be, even, that the last of hours
will make us once again a youthful lover:
The call of life to us forever flowers...
Anon, my heart: Say farewell and recover!
(From Steps by Hermann Hesse) Translation by Walter A. Aue

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Amélie Noack *is a Jungian Analyst and Training Group Analyst, member of the British Association of Psychotherapists (Jungian section) and the Institute of Group Analysis. She is working in private practice in London and Bristol and teaches and supervises in the UK and abroad, combining Jungian Analysis, Group Analysis and Winnicott's contribution. She also holds Social Dreaming events.*

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Contributions to future Journals

Autumn 2011 Sexuality in Supervision
Lead editors Chris Driver and Eleanor Creed-Miles
Copy deadline 17th October

Supervision and the therapeutic relationship, as in any relationship, can evoke powerful affects and especially those around sexuality, the erotic, heterosexual and LGBT dynamics. How we consider and understand these issues is often a delicate and sensitive dynamic and yet vital in ensuring that these factors are held within a safe framework, understood and given meaning. If you have experience in supervising in this area and would be willing to write an article please contact chris@driver4.prestel.co.uk or eleanorcreed-miles@tiscali.co.uk

Spring 2012 Working with Adolescents and Young People
Lead Editor Bruce Kinsey
Copy deadline 26th February

As therapists working with young people there are often remarkable dynamics of energy, change and challenge; these can so often be lost in the encounter in supervision. If you work supervising those who work with young people, students and adolescents what have you noticed that is different, distinct or special about this work? How do you handle the 'if this was my child I would want her to be told' which is hard enough as a therapist, but you feel the supervisor is being too indulgent or too tough? How do we pass the Goldilocks test of it neither being too hot or too cold but just right? If you have experience in supervising in this area and would be willing to write an article please contact Bruce Kinsey brlk1@cam.ac.uk.

How prepared are we for sudden illness and unplanned retirement?

A personal experience

Penny Culliford

Sorrow enters my heart. I am afraid of death.
Gilgamesh

Abstract
This paper details the impact of sudden illness on a joint private practice when one of the practitioners suddenly became critically ill. It reflects on the lessons learned over the following weeks of uncertainty and the management of an unplanned retirement. It also highlights the knock-on effects on the second practice's therapeutic frame of the 'empty room' and subsequent building adaptations.

Key words: sudden illness, unplanned retirement, containment, collegiate support.

In the opening paragraph of his book: Staring at the Sun : Overcoming the Dread of Death, Irvin Yalom says:

> *Self-awareness is a supreme gift, a treasure as precious as life. This is what makes us human. But it comes with a costly price: the wound of mortality. Our existence is forever shadowed by the knowledge that we will grow, blossom, and, inevitably, diminish and die.* (2008: 1)

Becoming a therapist is traditionally a career for the second half of life often following an earlier career, which, for whatever reason, is no longer providing the satisfaction or interest of our youth. This transition is accompanied by major psychological shifts and hopefully brings with it a growing maturity and insight. Many of us work well into old age and for some, retirement is something we may consider but tend to avoid committing to until circumstance or fate force change. What follows is a personal journey; I hope by sharing this to add to the debate and understanding of how sudden illness can impact on both patients and therapist. It also begs the question, how prepared are we for sudden illness and retirement, and do we collude in a collective denial and worse, project our fear of death onto our patients or repress it by avoiding the final transition into retirement and the prospect of our own inevitable death?

Three years ago my husband became very seriously ill and was admitted to hospital. Little did we know then that he would be in hospital for the next five months. He gave his consent for me to use our experience for this article. That said I do not intend to write about him or his illness, but rather share a little of how that experience impacted on our practices and how we managed it. We couldn't have anticipated this happening but how prepared were we for the unexpected? Had we been in some sort of denial?

The Setting

My husband was running a busy practice having made space to join a new training. Although in his seventieth year he was full of excitement and the sort of rich energy

that comes with experience of the passing years and a zest for life. He had Parkinson's disease but was managing this well enough alongside the aches and pains of the inevitable ageing process. We ran a joint practice from home in two rooms upstairs. We often talked together about how long we would work, and about cutting down hours. He had decided not to take on more training patients in case he couldn't see them through the years of training they might need. He had stopped teaching. He not only had regular individual supervision but also had monthly meetings with a supervision of supervision peer group who had agreed they would be honest if one of them 'lost the plot'. They had known each other for many years so were well placed to review one another's capacity to be working and there was the trust between them to say it. He discussed things with his individual supervisor whenever he had concerns. We both had professional wills and are reasonably efficient about keeping these updated. We both had access to each other's patient lists, and contact details in the event of an emergency, as did both our supervisors. These details were held in sealed envelopes with instructions to open only in an emergency. As his next of kin I knew to destroy his patient computer disc in the event of his death. This contained process notes, the sort we use in supervision and for personal reflection and which are intensely private as opposed to other records such as attendance, history, letters etc. He was in analysis as part of the new training and had arranged training supervision. All was 'hunky dory'. There were no real concerns regarding his fitness to practise. Full retirement was not in the air.

The Event

On Sunday he became ill and decided he must cancel work on Monday. He was in too much pain to call patients himself. Fortunately he kept a weekly calendar printout of his patient diary. This was on his desk and I was able to identify his Monday and Tuesday patients. His sealed patient list was opened and I phoned each patient making simple statements saying he had hurt his back and that he hoped to see them the following week. Late that Sunday evening I had to call an ambulance and he was admitted to hospital. We did not at that time have any idea how desperately ill he was to become. Fortunately I had the forethought to grab contact details of my Monday patients 'just in case'. Intuition, it seems, had kicked in. I sat with him as his condition deteriorated until late Monday afternoon at which time I was due to see one of my patients who was in her own crisis and who I had changed to the later time earlier that day. I had not thought for one minute I would still be at the hospital. What did we ever do without mobile phones?

Lessons

i. Keep diary and contact details updated and accessible if away from office. At the time I didn't have my patients' numbers on my mobile phone but fortunately had remembered to take my patient list with me to the hospital.

ii. Clarify if it is alright to leave messages on land lines?

iii. This information available with the contact details? I used mobile numbers where I had them in the hope that messages would be picked up by the patient and not by another family member. I did, however, have to leave several messages 'blind'.

iv. Does the contact list say when patients are seen?

This may enable you to call just a few at a time. It avoids patients turning up to an empty consulting room.

At this point we still thought this was a brief event and so it felt appropriate for me to support him in this way. We worked together and patients knew me by name as we ran a joint practice so it was reasonable to be speaking to them albeit briefly. I was known as his colleague.

Gathering Storm

He was more ill than initially thought. We agreed I should let people know he would not be working for the next two weeks. I contacted all his patients, supervisees, therapist, and those involved in the training. Still thinking this was a brief hiccough. I told them what we believed was happening, that he had hurt his back.

Meanwhile I continued working between visits to hospital, managing the family home, his office phone and any messages needing a response. Post-it notes gathered. My own processing time shrank. 'It will not be for too long' I thought, 'my patients will be OK for now'.

Lessons

It is really helpful to list when and how often you see people. Some supervisees are seen monthly, others fortnightly etc. Do you need to call everyone on the list? It takes a long time if you do. I didn't know so had to call everyone.

Who should be on the list? Patients and supervisees, but maybe also therapist and supervisor?

What other professional commitments are there which need to be cancelled? Does your professional will have a list of local colleagues who would be willing to cover in an emergency? If you live or practise alone, is this information to hand? Who should have it? How much can your next of kin or close friends initiate and does your professional executor responsible for activating your professional will have all the necessary information? Is there a second person for back up if they aren't available. Might it be easier if this task were shared? Do we know when these colleagues are away? Can they liaise with one another?

Up until now we had been able to rely on each other to take care of things but in an emergency is this possible or even advisable? When does it become an emergency? How prepared is it possible to be? My family know little about analytic practice and therefore should only be made responsible for contacting my executor/ executors and not for doing any more than this. They need to know who the executors are and how to contact them. Executors might need to gain access to your practice / home. Can they?

Long term management

By the end of the second week it was clear my husband would not be going back to work before his Easter break. There was now potentially a six week unplanned break for his patients and supervisees. I accepted it was now not appropriate or possible for me to manage this alone. I had to protect us both and not communicate my distress to his patients; I also had to contain it within my own practice. I did not want to speak to his patients in case I 'leaked' and broke boundaries. The unplanned word, the tone of voice, my own needs, concerns. I contacted his supervisor and we agreed the wording for a letter. I told my husband what we were

doing and that we were looking after everything for him but I am not sure how much he was able to take in. He was particularly distressed about several patients who he thought were very vulnerable. His supervisor and I took over all management at this stage and made arrangements for her to offer these latter patients support if necessary. Another letter was sent.

Initially his supervisor couldn't find his patient list and another had to be sent. I found that addresses on mine hadn't been updated. One patient turned up when I was seeing a patient of my own. The cracks started to appear and impinge on my practice. I can't thank his or my supervisor enough for the help and support they gave during this time. I contacted local colleagues to ask them if they would be willing to see his patients if necessary. Their support was overwhelming.

Meanwhile my more intuitive patients noticed his office light wasn't on and sensed the absence of doorbells and activity up and down the stairs. What was I unconsciously communicating? This all had to be contained and where necessary and possible worked with. It is very likely I missed opportunities to name their unconscious concerns.

Was it right for me to continue working? I discussed this in supervision and chose to carry on rather than take extra time off just before the break. My holiday was due and I personally find it is easier to continue seeing patients than face the consequent disruption of taking unplanned breaks.

Lessons

How much should patients be told? Is it better to say nothing? In supervision we agreed it would be better to say a little to contain the anxiety and to mobilise the adult part of his patients' psyches, rather than leave them with too much unmediated fantasy which could precipitate further possible and unhelpful regression. We wrote informing them he had a severe infection and had been advised to take time to recover fully before returning to work. They were advised to contact his supervisor if they wanted support and she could refer on to colleagues he knew and respected. We highlighted the most vulnerable ones should they contact her. At this time I still believed he would be returning to work but now wonder how much I was in denial.

Loss of both our incomes would make life very difficult. How possible is it to make financial provision for times such as these? Loss of half our income was manageable but I didn't know what the future held. I chose to try to contain and maintain my practice aware that I risked losing a few patients in the storm. How able was I to contain my own patients? Was I unconsciously communicating my distress. My own supervision was crucial at this time, in both my individual sessions and with my peer supervision group. I was greatly helped by their observations, insights and support.

Weathering the Storm

He fights for his life. His practice is now on 'temporary hold' but contained for now. Our future is in the lap of the Gods. I hang on not knowing.

Lessons

I cannot stress enough the importance of the love and support of friends and colleagues. The cards, emails and phone calls were a lifeline. Our families were

wonderful but could not be expected to cope with the impact and professional implications for us and our patients of illness, death and grief. Being free to express the turmoil and reality to colleagues and friends was so very holding. Professional support in supervision was crucial. We received the best of both professional understanding and true friendship from so many. Their care and support continued throughout. It was a lesson on how important our colleagues and friends are and how crucial it is that we do not become isolated as therapists. Reading groups, peer groups, CPD groups, all are vital for our psychological and emotional health alongside supervision and if necessary personal therapy.

After the Storm

I now knew he would not be returning to work. He knew too and grieved. Patients had to be informed. I spent time with his supervisor. We composed another letter and spoke to colleagues about possible referral on if patients wanted this.

Again how much do patients need to be told? We agreed they should be given a clear reason for his sudden retirement but without too much detail. They needed to withdraw some projections and have some reality to work with. They also needed to grieve. We all felt very sad. Several patients expressed a wish to meet once more to say goodbye. It was too early to know if that would be possible. He hoped he might write when he was stronger. In the meantime a few patients moved into new therapies others just had a few sessions to talk things though, but mostly I don't know. We have no idea what the fall out is for these patients. Several wrote to him. Some of those letters remained unread for a long time. Some were written to me and I responded as his colleague. These moving letters expressed much grief but also showed evidence of patients having internalised a good object that can survive and live on. They protected us from their anger but not their sense of loss. I don't know what happened in their therapy only that several reconnected with new therapists and are ‘working well’. Longer term I don’t know. Sadly my husband never fully recovered and died earlier this year. Several of his patients came to his funeral and wrote to me after of their appreciation for being able to attend. I believe this was a healing experience for them and one that offered an opportunity for final closure.

Conclusion

‘Shit happens’ as they say. He developed septicaemia then life threatening complications as a result. It could have happened to anyone, although age and pre-existing medical problems probably made him more vulnerable.

Should we have a retirement age set? Is it ethical to work into old age?

Therapy is all about relationships. Illness, loss and death are part of life and part of any relationship. I am not sure you can reasonably legislate against this. We mature into this work. Traditionally therapy is a career for the second half of life and largely made up of older practitioners. The crucial thing is surely how these crises are managed. I believe they can be contained with the right support and insight into process and individual needs. Teamwork is crucial as is compassion and care for both patient and therapist. A few years ago I attended a week of lectures with a senior and much respected analyst. She was 80, and forgot the occasional word, lost her train of thought at times, was a bit deaf and wobbly on her feet, but by golly she could still teach and her years of experience and her passion for life and soul

work was still there. She still had so much to pass on. I felt privileged to have the experience of working with her. There are few enough old crones and wise old men. Let's celebrate their presence and take the risk. No there shouldn't be rules only a promise to stop if colleagues who know you well say 'time is up'. No one person should make that decision either. It should be at least two and more if there is a dispute. Could my husband have known sooner? He knew he was in poor health but he also knew he was working well and wanted to continue as long as he was able. He still had such a lot to give and a hunger to keep learning. Fate decreed he had to learn another way but not as he had hoped but rather though his body and the worst storm of his life.

His illness means my practice now has disabled access. Both my internal and external worlds have changed and so has the earlier containment I had established with my patients; these changes take time to work through. There is loss and sadness but what has been gained?

- Deepened friendships
- Deepened experience
- A deeper relationship with my husband
- Greater self-awareness

My image is of the terrible Storm of '87 when great old trees were uprooted leaving devastation in its wake. We all have memories of that time. Mine was of returning from Germany to London Heathrow the following morning, our flight having been delayed because of 'bad weather'. We had no idea what had been happening and crossing London the morning after the storm we were confronted with the aftermath. Our beautiful country was changed by one devastating act of nature. What emerged however was that out of old woodland came new growth. It was sad to lose the old but much of it was dead wood and needed to be cleared for the new to blossom.

Two practices have been hit by a storm. My husband's was felled and an unplanned brief retirement followed. My practice suffered too but it has largely survived. I also know I am not ready for retirement yet and that there is still much to learn. Finally, I am reminded and also comforted by the following:

> 'It is only in the face of death that man's Self is born.' (St Augustine in Yalom 2008: 32)

Reference

Yalom, I.D. 2008 Staring at the Sun: Overcoming the Dread of Death: Overcoming the Terror of Death London: Piatkus Books

Penny Culliford *first trained at the Westminster Pastoral Foundation where she subsequently became a member of the conjoint marital team. Drawn to Jungian ideas she later trained with the Association of Jungian Analysts and is a member of IAAP. She has been a member of BAPPS since its inception and has a private practice in South London.*

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Supervising pregnancy

Ruth Simmons

Abstract

This article considers the challenges supervisors face in thinking with pregnant supervisees about their work, and in exploring the uncertainties of working towards endings whether temporary or final.

Key words: pregnancy, endings, ambivalence, supervision.

Endings and their vicissitudes are of considerable interest in the world of psychotherapy. They may create many possible meanings, and evoke many different reactions. These might include on the one hand, shock, surprise, indignation and fear of the unknown, and on the other excited, even pleasurable, anticipation of the unknown, relief, indignation and satisfaction at work well done. There will often be a combination of these feelings and almost always there will be ambivalence; in short endings carry the potential for the widest possible emotional range, depending amongst other things on stages and circumstances of life.

News of a pregnancy often stirs up a similarly rich and usually unpredictable mix of responses, and it is the place where endings and pregnancies coincide, and sometimes collide, in the supervisory relationship which is the object of my interest in this article.

I wish to recognise that the expectation of a baby (this apt phrase) does not only involve the presence of a pregnant woman. There are the partners, both female and male, of that woman; the adopting parents and the expectant grandparents. All of these are holding a child in mind, and all of them will be experiencing the impact both conscious and unconscious of its imminent presence. The expected baby represents a coming together of past, present and future in the imagination, and of course in reality. I'm thinking here of a supervisee, awaiting the birth of his partner's first child, who was aware from the beginning of the shifts in his internal world and of the influence of all that was about to take place for him on the quality of his responses to his patients. In thinking with his patients about the impending temporary break in their relationship, (he was planning to take a few weeks of parental leave), he became aware of the many ways in which not only his patients' fathers were making their presence felt in the transference, in some cases for the first time, but also themes of disjuncture and of things coming to an end.

Even before the birth of the therapist's baby, its impact on her patients, her supervisor and her colleagues will be considerable because the unsettling news will involve such complicated endings. The ending may be an interruption - a temporary suspension of work for maternity leave - or it may represent a final ending of particular therapeutic and supervisory relationships, or indeed of her professional identity as a psychotherapist. Whatever the therapist decides to do and whether this is her first or subsequent child, there will be both uncertainty and the potential

for transformation in the air. Neither supervisee nor supervisor knows for certain the outcome of this ending. The pregnant supervisee in such circumstances may well be struggling with doubt and uncertainty, as well as with the volatility and turbulence so often linked with periods of great change, however welcome. This uncertainty must be borne in mind by both of them during the complex considerations of mindfully bringing both the work with patients, and the supervisory relationship to an end; for the mother at least this is also a beginning.

It has been of the greatest possible interest for me to supervise the clinical work of several women seeing patients during the course of their own pregnancy. I have been struck by how often patients initially respond with pleasure and solicitude when their therapist tells them of her pregnancy and her intentions about the future of their relationship. An illustration of this might be a therapist, who was deeply concerned about the impact of her news on a particular patient who had become pregnant unexpectedly and who believed that she could only be a destructive mother who would certainly harm her child. Much of the work in supervision was devoted to considering ways to make thoughtful use of the links and echoes in operation in the idea and the reality of termination, not only of the therapeutic relationship but also of the patient's pregnancy. In this case, it was possible for pregnancy and endings to be creatively brought together in the minds of both patient and therapist: the patient thoughtfully came to the decision that she was not yet ready to become a mother, and the pleasure with which she had first greeted her therapist's news continued to enrich the quality of the work, with mixed feelings recognised and honoured.

Sometimes this warmth continues until the very moment of ending; at other times, although in my experience this is less common, the patient finds themselves able to dare to explore in depth other reactions such as fear of, or resentment at, loss and abandonment, disappointment and confusion, jealousy, envy and even spiteful grievance.

When altruistic pleasure and concern seem to foreclose on other possibilities, it is necessary to consider what might be being defensively split off into the supervisory space (whether to individual supervision or to group supervision with its characteristic conflicts of rivalry.) Such defensive splitting off is not limited to the patient, but might well be experienced in similar ways by the supervisor and by the therapist's colleagues in the group. There might well be destructive feelings here, that can be denied and disavowed at the expense of clear thinking, and potentially to the patients' serious detriment. It seems to me to be absolutely crucial that the supervisor is able to hold all these mixed feelings in mind (not least of which the supervisor's own), and to contain and think about the anxieties they evoke, while placing the well-being of the therapist herself and that of her patients and the unfolding of their work together at the heart of her attention.

It is always important to avoid thoughtless generalisations and assumptions both about women during pregnancy and about those affected by her announcement . I am aware that I am making the assumption that there will be deeply held reactions of one sort or another, and that it is as well that such reactions are reflected upon and considered in some depth in the supervisory relationship. It is also worth remembering that important and resonant as the process of pregnancy can be, it is never the total sum of the woman's experience; in her sense of herself in all its

often surprising complexity, she is not just a pregnant woman. At the same time, neither the therapeutic relationship between her and her patients, nor the relationship between her and her supervisor, should be reduced exclusively to the process of working towards an ending, temporary or final. Instead, it is as ever the responsibility of the supervisor to ensure that sufficient potential space is made available for 'thought-about feelings and felt-about thoughts' (Alvarez 1992) We need space for the creative unfolding of all aspects of therapeutic work including the supervisory encounter itself.

I have concentrated on the impact of the therapist's pregnancy on her patients to the exclusion of other transferential and countertransferential phenomena and this may reflect gaps in my thinking about pregnancy-determined endings. On reflection, it strikes me that this failure to contemplate the nuanced and shifting nature of such phenomena, which I would hope to be able to do in other supervisory contexts, signifies a particular resistance to admitting to the conflicts and difficulties which the disruptions surrounding news of a pregnancy so often arouse.

At the same time, I find myself wondering if my focus on the pregnancy of the therapist as of unique and paramount significance, is itself an enactment of the split off and denied destructive, ambivalent feelings which belong to her patients, but which they do not yet feel able to recognise.

References

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Selected Further Reading

Clementel-Jones, C 1985 The pregnant psychotherapist's experience: colleagues and patients' reactions to the author's first pregnancy *British Journal of Psychotherapy, 2, 79-84*

Etchegoyan, A 1993 The analyst's pregnancy and its consequences on her work *International Journal of Psychoanalysis , 74, 141-50*

Gottlieb, S 1989 The pregnant therapist: a potent transference stimulus *British Journal of Psychotherapy, 5, 287-299*

Note: Although there is a sizeable literature on the experience of the pregnant psychotherapist, her supervision would seem to be an underexplored aspect of our work as supervisors.

Ruth Simmons *is a member of the Guild of Psychotherapists. She practises in North London, and teaches and supervises at WPF.*

contents

Some thoughts on retirement

Ruth Barnett

Key words: retirement, psychotherapy, Holocaust education.

Whatever we do or try to avoid, life tends to be messy, so too retirement is likely to be messy, even if it is planned ahead. Nevertheless, some thought should be given to retirement well in advance, perhaps even during training to become a therapist. Training courses on the whole do not give enough importance to the therapist's responsibility to monitor her 'fitness to work', which includes 'time to retire' as well as cancelling when ill or 'not up to it'.

In past times, when life was much shorter, neither childhood nor retirement existed. Children were expected to work almost as soon as they could walk and continued to work all their lives until they 'dropped dead in harness'. Now, in the twenty first century, a set retirement age of sixty or sixty-five has become 'out of sync' as more people live into their nineties. The pattern emerging is of multiple retirements from serial careers.

In my opinion, this suits psychotherapy as a profession. Some 'life experience' in a previous career is a useful resource prior to training in psychotherapy and retiring to take up something else seems an equally good idea. How long can a therapist soak up clients' pain and struggle with clients' projections before becoming 'jaded and worn'? Of course, this will need a personal answer. But how honest can we be about the need and timing to retire?

I see two important issues for 'good enough' retirement. Most important is to view retirement as TO something new rather than FROM something 'worn out' or old. Secondly, if possible, retirement should be gradual not sudden – a loosening of the attachment to the current career while building up interest in a new activity. Unfortunately, most employers have little understanding of the wisdom of this. Psychotherapists are at an advantage in that most are at least partly self-employed.

Personally, I am in the process of retiring a second time. My start in industry, though financially promising, was a disaster as I did not fit the ethos and sank into depression. Beginning teaching without specific training was a 'wake-up call' from which I did not look back, though I did catch up with the training through an extra-mural course. Although my heart was in education, I realised, after fifteen years in inner city secondary schools, five as deputy head, I would have to retire within another five or 'go under' with the stress. I completed a basic psychotherapy training during those five years, which both prepared me for retiring from teaching and held my sanity together under the stress. Dealing with disturbed and disturbing adolescents and their sometimes equally disturbing parents provided an extra resource for my new career.

After twenty years practising psychotherapy, I became interested in Holocaust education. Going into schools encouraging teachers and talking with groups of students seemed a logical way of using both my careers. After another ten years the demands from schools (fifty-five talks in 2009 and over eighty in 2010) made

me decide to retire from psychotherapy by the time I reached seventy-five. Now that I am seventy-five, however, three supervisees, now on an ad hoc basis, have not yet left and clients, rather like your own children, keep bouncing back temporarily. Also I do some seminars on training courses, particularly on trauma and/or professional ethics. Adequate preparation for retirement is an important element in ethical practice.

I am aware that I am reluctant to leave psychotherapy completely. The contract with my supervisees is currently that we make a few appointments ahead that fit our diaries and if there is any urgency they can ring me. As they are all graduates, I can leave it to them to use me as much as they need for their clients' benefit. But I am planning this year to ask them to look for other supervision and I will continue up until they do so. As I have been seeing two for over five years, I think this right and proper. Too long with one supervisor forecloses on the broadening and enriching of learning with different supervisors. My one trainee, who I supervise for a dissertation, will end in June and, as I have no clients now, I shall be truly retired by the end of 2011. However, I shall continue to do occasional seminars in training courses, maybe a few assessments with second and third generation Holocaust survivors, and attend two annual conferences: the Cambridge Independents and the International Freud Group of Child Therapists.

Ruth Barnett *came to England from Berlin, to escape Nazi persecution, on the Kindertransport in 1939 at age four with her seven year old brother. After nineteen years secondary school teaching and thirty years private psychotherapy practice, including fourteen years Clinical Director of Raphael Jewish Counselling Service, she now dialogues in schools, universities, training courses and conferences on themes related to racism, trauma and genocide, especially the current rise in Islamophobia and antiZionism. rutheclb@gmail.com*

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Retirement?

In response to Gertrud Mander's Reflections on Retirement from Psychotherapy (*Supervision Review Summer 2010*)

Jo Roscoe

Key words: retirement, counselling, ending.

Gertrud Mander and I have never met; though we have been in the same room a couple of times. She was there, so I heard, when years ago I attended an introductory meeting for would-be Wpf appraisal visitors and from then on her name was, for some reason, 'significant' for me. Was I perhaps picking up a deference or reverence held by the person - long forgotten - who spoke her name?

And then, her last piece for BAPPS echoed my thinking and situation; she dropped the bombshell word ‘retirement’! I also had reached the stage where I was contemplating my future as a counsellor and supervisor; but where Gertrud was clearly certain and decisive, I was floundering in the throes of fearfulness: who will I be, what will I be without my 'counsellor/supervisor' label which says I am a somebody, a thinking person, a functioning member of the world, not a 'past it' little old lady. My age, and its relevance to who I am was brought home to me a couple of years ago. My application for a counselling position – for which I seemed ideally qualified and experienced – was not accepted because I was above ‘retirement age’. This response was from a charity set up to support women who had been subject to discrimination and abuse.

It is true that once upon a time, when a taxi driver called me ‘darling’ it was because I was a fanciable little thing and now it’s because I have a kindly face and remind him of his grandmother. I don't mind that. I tend to be kind to taxi drivers. But to be regarded as automatically not suitable on grounds of age?? - this is apparently legal though not regarded as good practice. It sowed a seed.

'Endings' have never been easy for me, so I have been fortunate to have been able to wind my work down naturally over the last two years without the challenge of abrupt or premature goodbyes. When fate intervened and swept me off to Israel for two years, I was able to depart without client angst. I made a conscious decision not to work as a therapist here though I’ve found another way of working one to one - as an English teacher with a lower income group in Jerusalem.

I think I will continue not to 'work' when I return to the UK. Just being me is rather enjoyable. Perhaps I will take to wearing a thorn proof Irish tweed cloak and hug the hedgerows muttering to myself like the strange woman of my childhood. This would not be to hide and shrink from life but to be suitably garbed for the wild, wet and unpredictable climate of the Cumbrian landscape where I hope eventually to lay my head.

Is there a home for non-practising therapists? What a super discussion group that would make. And it wouldn't matter at all if it degenerated into a coffee and croissant group!

Jo Roscoe *was a counsellor/supervisor and appraisal visitor for Wpf and in private practice; she lives currently in Jerusalem where her partner is leading a project on equal employment issues on behalf of the EU, Northern Ireland and the Israeli Equal Employment Commission. Jo can be contacted at: jo.roscoe@hotmail.co.uk.*

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Book review

How Much is Enough? Endings in Psychotherapy and Counselling
by Lesley Murdin
(2000 London: Routledge)

Reviewed by Eleanor Creed-Miles

I often wonder if our work (in both supervision and therapy) is best thought of as a sort of mutual muddling along based on equality of expectation and assumption. Effective endings in this 'impossible profession' are therefore those which reflect this mutual involvement in the process. Most psychoanalytic models suggest that the optimum desired outcome is the patient/client/supervisee deciding what is enough and then effecting the ending with the therapist or supervisor. Lesley Murdin sensitively and mindfully explores this mutual process with warmth and respect for her clients and patients and good humour throughout.

The introduction to the book focuses on problematic endings rather than those which grow out of mutual review and conclusion. I felt this opening piece reflected the need we have for theory when the going has already got tough and something is unresolved, difficult or feels 'bad' about the way our work is going; in such delicate times we are looking for support. Lesley Murdin carefully explores how deeply therapists and supervisors are affected by endings: 'Ending is inherently painful if it is fully experienced, but it can bring strength and contentment when it is actually achieved' (2000: 21). Chapter five – The Therapist Ends - is tremendously detailed and helpful with this, as are the final three chapters.

In teaching I have recommended this book very highly as it boldly goes where no book has gone before and addresses issues that are otherwise distressing and difficult to approach – reflecting how impossible it is to really talk about (or work around) death and dying. Endings are redolent with past losses and this is carefully detailed in the book. Indeed, chapter four is titled 'Staying Alive' and most of the examples are in the context of a future for both the therapist and the client, even if that is a separate one.

Chapter three regarding illusions and narcissism around ending is the real jewel in the crown for me. It details both how our own unresolved primary narcissistic issues may obstruct our ability to end well – either in our professional practice or indeed in our personal lives. Rather than taking a purely psychodynamic approach here, Lesley Murdin carefully (and again with great warmth) explores the existential and ontological diaspora. In delving into the deepest of wounds and narcissistic affect she opens up the possibility of question and challenge to ourselves.

The patient's unilateral ending (chapter four) is detailed and explores acting out with thorough examples and vignettes. This chapter was the most technical and generic for me, though extremely detailed and helpful.

For BAPPS membership and readership Lesley Murdin's final chapter on Endings in Training and Supervision is most relevant and offers technique and speculation around implications and issues in equal measure.

This magnificent book never shirks the painful and difficult questions around endings and around our own responsibilities in attempting them therapeutically and well. It also does not shirk when endings and losses have to be bad, as they can sometimes inexorably be – whether that is reflecting upon and processing our pathology or that of our clients.

This review may seem rather weak or praisefully bland and that reflects how hard it is to write pithily or critically about a piece of work that is so consummately helpful and thoughtful as this truly useful book is. I highly recommend it and not just in times of need.

Eleanor Creed-Miles *is a therapist and supervisor in the NHS and private practice and has a passionate commitment to offering supervision so that it is both enabling and enjoyable.*

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Contributions to future Journals

Autumn 2011 Sexuality in Supervision
Lead editors Chris Driver and Eleanor Creed-Miles
Copy deadline 17th October

Supervision and the therapeutic relationship, as in any relationship, can evoke powerful affects and especially those around sexuality, the erotic, heterosexual and LGBT dynamics. How we consider and understand these issues is often a delicate and sensitive dynamic and yet vital in ensuring that these factors are held within a safe framework, understood and given meaning. If you have experience in supervising in this area and would be willing to write an article please contact chris@driver4.prestel.co.uk or eleanorcreed-miles@tiscali.co.uk

Spring 2012 Working with Adolescents and Young People
Lead Editor Bruce Kinsey
Copy deadline 26th February

As therapists working with young people there are often remarkable dynamics of energy, change and challenge; these can so often be lost in the encounter in supervision. If you work supervising those who work with young people, students and adolescents what have you noticed that is different, distinct or special about this work? How do you handle the 'if this was my child I would want her to be told' which is hard enough as a therapist, but you feel the supervisor is being too indulgent or too tough? How do we pass the Goldilocks test of it neither being too hot or too cold but just right? If you have experience in supervising in this area and would be willing to write an article please contact Bruce Kinsey brlk1@cam.ac.uk.

Articles for 'Supervision Review'
General Guidance

Autumn 2011 : **Sexuality in Supervision** Copy deadline 17th October
Lead editors Chris Driver and Eleanor Creed-Miles

Spring 2012 : **Working with Adolescents and Young People** Copy deadline 26th February
Lead Editor Bruce Kinsey

Summer 2012 Copy deadline April 30th

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.

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