A selection of papers presented at the Advances in Clinical Supervision Conference, Sydney Australia, 4-6 June 2013
Foreword

This collection of papers represents a sample of papers from the Advances in Clinical Supervision: Innovation and Practice Conference, conducted in Sydney from 4-6 June 2013 and hosted by NSW Institute of Psychiatry (NSWIOP).

The aim when we first came together last year with the idea to host a national conference on supervision was to create an opportunity for like-minded educators, managers, clinicians and supervisors to share their experiences, expertise and professional experiences in a collegial atmosphere. An interdisciplinary conference of this type, dedicated solely to the practice of clinical supervision, had not to our knowledge ever been held in Australia. So it was with great excitement and some trepidation that we embarked on bringing together local, national and international delegates.

In the end, over 200 delegates come together over three days to share their experience and knowledge on clinical supervision research, education, theory and practice. Diverse practice areas including tertiary education, hospital, community health, NGOs, private and public sectors were represented. This collection of papers represents a sample of the conference presentations and demonstrates the excellence of the papers submitted for the e-monograph. This monograph does not do justice to the full conference in capturing the enthusiasm, interest and energy of those who attended the three days and it would seem that this inaugural conference highlights the need for future forums on clinical supervision. We hope that you find the papers informative and that you will be able to join us for future education events at the NSW Institute of Psychiatry.

Christine Senediak
Conference Chair
NSW Institute of Psychiatry
Official Opening Address

John Feneley

Ref: Feneley J. Opening Address: Advances in Clinical Supervision Conference, Sydney Australia, 4-6 June 2013.

For those of you who don't know me or anything about the NSW Commission let me tell you briefly: it was established July last year and I was appointed from 1 August. The Commission is NOT a budget holder and its brief is to improve the mental health and wellbeing of people in NSW - it does this by driving reform in mental health services and policy in NSW.

In pursuing reform we will be guided in particular by people with a lived experience of mental illness and their families and carers. We are required to develop a whole of government Strategic Plan for Mental Health due in draft form to Government in March next year. If you google the Commission you can find information about that process and how to participate as an individual or agency.

But enough about the Commission.

I feel it is important to support the Innovations and Practice, Advances in Clinical Supervision Conference as it shares our goal - to improve clinical practice and outcomes for the person with experience of mental health services.

We all know how easy it is for a person living with a severe mental illness to become isolated. How much worse would it be if the person's primary clinician also becomes isolated from professional supervision and mentoring? This could happen just as easily in a busy metropolitan hospital as it could in a community mental health team or consulting room.

We all can and do make mistakes. We can all experience periods of professional impairment. Structured support and oversight can safeguard against this to reduce the chance that the consumer will suffer unintended consequences. Clinical supervision is an important aspect to providing and gaining perspective and hopefully will guide insight into professional decisions. Central to this is how supervisors can centre the lived experience of workers in the same way as workers need to centre the lived experience of consumers.

In rural, remote and particularly in Indigenous communities clinical supervision is especially important as most of those employed in mental health either live in the community as a member or are known to the patient / client in some way. Clinical supervision can assist the worker in making important decisions about boundaries and expectations that are often blurred.

We need to have a broad church of how supervision is delivered. This would include virtual mechanisms (particularly important for rural and remote professionals), one-to-one AND group supervision for all service providers, on both an intra and inter-disciplinary basis. This would include for example peer workforce members.

We need not only supervision but mentoring, that is training and development, career advancement opportunities and work life balance.

We all understand the issues that surround clinical supervision and the tensions between service delivery and supervision, and the need to better value the role of clinical supervisor; these are not insurmountable if we all concentrate on the shared goal to improve consumer outcomes.

I wish you all a very good conference and hope that you will walk away from these couple of days refreshed and with new ideas on how to better provide services to your clients, carers and colleagues.

John Feneley
NSW Mental Health Commissioner
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Advances in Clinical Supervision Monograph, NSW Institute of Psychiatry, 2013
The relationship in clinical supervision: Models preferred by allied mental health professionals who work with traumatic disclosures

Margaret Pack


Paper presented by Margaret Pack at the Advances in Clinical Supervision Conference, Sydney, 4-6 June 2013.

Dr Margaret Pack is Associate Professor of Social Work and Humanitarian Studies at Charles Darwin University, Northern Territory, Australia. Originally from Wellington, New Zealand, her research on clinical supervision was conducted among postgraduate allied health professionals (social workers and occupational therapists) completing studies at Victoria University of Wellington, New Zealand.

Abstract

Clinical supervision is a process of engaging with a more experienced peer to reflect critically in an ongoing way upon one's work in the helping profession. As social workers, clinical supervision is a requirement of professional association membership/registration as it is seen as a developmental tool for individual social workers and a quality assurance resource for their managers. Based on research previously reported in a study of matched pairs of supervisors and supervisees working in a health context (Pack, 2011), a relational approach was found to be preferred in clinical supervision by social workers who engage empathetically with clients who disclose trauma. A comprehensive model that addresses the following is recommended as constituting a ‘good’ supervisor relationship. In particular as such a relationship enables/ provides: 1. A regular forum for ongoing peer review and critique in an established supervisory relationship; 2. The means for maintaining professional effectiveness by addressing transferences with students/clients and colleagues in the wider organisation; 3. Identifies gaps in training and future developmental needs from a professional development perspective; 4. Clarifies caseload balance and future personal/career directions; 5. Encourages self-care and facilitates referral to other services e.g. Employee Assistance Programmes.

Introduction

‘There’s a very therapeutic side to it because as you explain the particular problem or a particular challenge sometimes you find it’s all becoming clearer as you explain it to this one incredibly experienced person.’

British Prime Minister reflects on the value of his weekly meetings with the Queen.

Dominion Post Newspaper, March 2013.

This quotation from an unexpected source speaks to the importance of relationship in facilitating a critical-reflective process in which options can be explored to problem solve and to find a way forward. In this quotation British Prime Minister David Cameron also seems to be describing the power of the physical presence of the Queen and his ongoing relationship with her as facilitating this process. This critical-reflective process has long been considered a feature of what is important in clinical supervision (Hawkins & Shohet, 1989). In forging an effective supervisory relationship where clinical dilemmas and ethical issues can be safely and openly discussed, the context of an ongoing supervisory relationship is established (Furlonger and Taylor, 2013). Specifically it is important that this relationship is non-shaming and affirming of the supervisee who is encouraged to talk about their practice without fear of censure and personal judgements (Yontef, 1996). Ironically, the power deferential of the supervisor militates against any assurance of ‘safety’ as clinical supervisors have a mixed role with responsibility to ensure the welfare of clients and the employing organisation (Pack, 2009 and 2009a).

In earlier research I have undertaken, I identified that new supervisees experienced ‘shame’ or a descent into avoidance behaviours due to the potential for what is known as narcissistic wounding in the psychotherapeutic literature (Yontef, 1996; Pack, 2009; Pack, 2009a). I wondered if the potential for shaming among recent graduate practitioners who were also new to clinical supervision coloured the dynamics of the relationship in clinical supervision as well as their definitions of what was a ‘good’ supervisory relationship. I was mindful that clinical supervisors have a role in ensuring the client’s safety and so may have a different view of clinical supervision from their clinical supervisors.

I was interested also in the quality of the relationship established in clinical supervision as enabling a critical-reflective process. I researched with matched pairs of supervisors and supervisees the nature of the relationship and the various meanings clinical supervisees and supervisors assigned to ‘effective’ clinical supervision. Specifically I was interested in how the nature of the critical-reflective process that was established in clinical supervision facilitated the disclosure of traumatic or critical events and examples of errors in clinical judgement and casework.
To explore the elements that were important for supervisees in clinical supervision, I found it necessary to undertake a phenomenological investigation of the meaning of clinical supervision that supervisees and their clinical supervisors considered important. From this preliminary study I discovered that supervisees had a narrative of wishing a safe place to explore and deliberate ‘difficult’ and often ambiguous aspects of their practice in the mental health services. This emphasis was in contrast to clinical supervisors’ narratives. Within the clinical supervisor narratives ‘safe practice’ on behalf of the client and employing organisation was emphasised. The clinical supervisors’ emphasis on the client and employer was due to their senior management role and responsibilities within the organisation (Pack, 2011; Pack, 2011a).

**Rationale and Aims of the Research**

This research is part of an exploratory study with matched pairs of clinical supervisees and supervisors engaged in clinical supervision in the New Zealand context (Pack, 2011a and b). An earlier literature review was conducted as the initial step in this research, which is reported elsewhere but will be summarised throughout this paper (Pack, 2009). As co-ordinator and lecturer of a postgraduate allied mental health programme, I asked pairs of clinical supervisors and their supervisees who were completing the programme what their ‘most difficult’ practice scenario taken to supervision had been as part of a research project approved for ethics by Victoria University of Wellington, New Zealand. Secondly, I asked clinical supervisees how they had resolved or dealt with this practice issue in clinical supervision. The aim of the research was to determine if the self-reflective and reflexive process described by Napier and Fook (2001) and Gardner (2009) was experienced by the social workers and occupational therapists completing their postgraduate studies. Secondly the aim was to explore models and elements of clinical supervision that were considered useful by the supervisees as they navigated their first year of employment in the mental health services as social workers and occupational therapists.

**Research Design and Methodology**

Gardner (2009) and Napier and Fook (2001) recommend critical-reflective theorising to enable social work practitioners to draw out their theories of action directly from accounts of their own practice. This process occurs through an extended reflection on practice. Due to the challenges these approaches make to more traditional paradigms of theory development, from an earlier literature review, I was aware that critical-reflective theorising challenges what conventionally is considered as ‘knowledge’ (Pack 2009; Napier and Fook, 2001). Theorists such as Gardner (2009) recommend analysing extended case narratives with reflection from the participant on their experience of practice dilemmas to inform our understanding of the process of clinical reasoning. Reflection on this process often leads to ‘breakthroughs in practice’ (Napier and Fook, 2001) where the social worker who discusses practice reflectively comes to view his or her practice more positively in difficult situations (Napier and Fook, 2001). Based in this reflective theorising about practice, I wanted also to know how supervisees entering a new field of practice made sense of the complex situations they routinely encounter in their practice. In this regard, asking about the experience of clinical supervision highlights the gap between theory and practice that new graduates in social work experience routinely (Harre-Hindmarsh, 1992). Thus I aimed within the interviews to engage reflection on the kinds of situations clinical supervisees as a group define as ‘challenging’ or what they see as ‘obstacles’. By doing this I also was hoping to clarify if what clinical supervisees saw as ‘difficult’ was related to practice and the supervisory relationship itself. Secondly, I also inquired whether or how they resolved these ‘difficult’ situations to determine how the relationship and critical-reflective process assisted or hampered the resolution from the clinical supervisees’ perspectives.

With this focus, I aimed to explore the narratives that clinical supervisees say they develop about what they do in clinical supervision, drawing from examples that represent applications of their use of practice wisdom.

**Characteristics of Participants**

Out of the letters sent to 25 clinical supervisors and 25 clinical supervisees who were currently or had been involved in the allied mental health programme in 2007-8, 10 supervisors and 12 supervisees agreed to participate in the research project. Participants were all currently engaged in clinical supervision as ‘pairs’ of supervisors and supervisees. All clinical supervisees were completing post graduate studies as they worked full time within their first year of practice in the mental health services.

**Data analysis**

Once the interviews were completed and transcribed, the responses under each of the questions were compared. Key words and responses were identified and highlighted from each of the interview transcripts and these were considered together as forming themes. The emerging themes were then clustered to form categories and checked with participants to confirm the validity of these key themes and to glean ideas about the relevance of the categories chosen, as suggested by Braun and Clarke, 2006. Pseudonyms were assigned to each participant that were not their real names but were used to identify their individual contributions (Pack. 2011 and Pack 2011 a). This paper concerns the supervisee responses only so the themes from the supervisee interviews are reported.

**Findings and Discussion**

The clinical supervisees discussed their ‘most difficult’ practice situations involving clients at risk of self-harm, deprivation, death or suicide in their descriptions of their most difficult case scenarios taken to clinical supervision (Pack, 2011 and 2011a). This theme mirrors Napier and...
The importance of ongoing peer review and critique in an established clinical supervisory relationship

The relationship established in clinical supervision enabled clinical supervisees to trust and feel confident enough to explore areas of ambiguity and complexity without fearing shaming or personal humiliation in the eyes of their clinical supervisors for not knowing what to do. This avoidance of shaming through a quality of trust and respect with clear boundaries in the relationship with clinical supervisors are considered important pre-requisites of effective clinical supervision (Baum, 2007; Pack, 2009 and 2009a; Wepa, 2007). The following excerpt with the supervisee relates 'safety' as being essential to the primary purpose of 'learning' in clinical supervision:

Elizabeth: 'I see clinical supervision to mean a safe place for me to explore any difficulties I've been having at work, not only to talk about problems but also to look at positives and see how I have achieved those. Being a new practitioner, it is also a really good place to learn from my clinical supervisor.'

Structure was also important in terms of safety. Structure involved having a clear contract and theme for each session. Starting with an agenda that was collaboratively developed at the start of each session was considered important: 'The clinical supervisee preferred to have a sense of control about decision making related to bringing cases and initiating ideas for each session, so proactively structuring and driving the process of clinical supervision.

The following comment was from a clinical supervisee who wanted to set the theme for each clinical supervision session to enable a self-reflective exploration with his clinical supervisor as to what these 'difficulties' were all about:

Thomas: 'I set the agenda for supervision, so we can discuss what I want to bring to the table, or if I'm sort of - 'I don't have any ideas' - my supervisor here will come up with some ideas we can talk about. For example, the last supervision, I've been finding the change from inpatient mental health to community mental health is such a big change, so we talked about the changes. So we talked about why I was having so many problems about it. It hasn't been the easiest change for me'.

Collaboration to formulate an agenda for each clinical supervision session was also central to another clinical supervisee (Fiona)’s definition of ‘safe’ and ‘effective’ clinical supervision. She preferred to have some flexibility for formulating her thoughts as she went along, in addition. Fiona valued an opportunity in clinical supervision to analyse her wider organisational context in which she practised as a social worker:

Fiona: ‘If there are particular things that I want to discuss; I bring my own agenda with me, otherwise we do just discuss, what comes up and it's quite a free and open... so it's not necessarily as structured as it maybe should be, but we tend to cover a lot of ground and I find that it gives me a really good opportunity to kind of hone my own thoughts about things and think a lot about them. My most recent supervision session was about the wider political environment at my work and how that filters down and impacts on my clients.'

Offering a 'different perspective' was a common theme across the supervisees’ group within this relationship of safety and trust. In the following excerpt from an interview with a supervisee, David discusses the problem-solving he does with his clinical supervisor in clinical supervision. Continuity of the supervisory relationship was an important feature of the relationship allowing him to go deeper into areas in which he was needing to develop his practice:

David: 'We talk about particular clients. A lot of clients that
come through community mental health, my supervisor has worked with before, so he knows, he can offer different perspectives on how I am seeing things. Um, yeah, [pause to take a moment to reflect] that's really good. Also, we do go into specifics, especially if I'm sort of struggling with something. I have been able to identify areas that I don't really know what I should be doing next in. So it is a good place to talk about those things as well.'

Another clinical supervisee took her student assignments to clinical supervision as they involved practice issues that she sought help with. Clinical supervision was used to brainstorm ideas for her post graduate studies as well as for her practice:

Lisa: 'Normally I just take a case that I am wondering about, that I am baffled about or that I have questions in my mind about or am unsure about. They are the sorts of cases I would take to supervision. I would also take my assignment that I would need to talk about and just go over that with my supervisor so she can support me with the assignment.'

When clinical supervisees were of the same ethnicity and from the same country of origin having a clinical supervisor of the same ethnicity/country of origin was one of the factors considered important in maintaining the relationship with the clinical supervisor. This was a theme for international supervisees working and living in New Zealand. This shared ethnicity/ experience of living in the same country had forged a stronger relationship between them in clinical supervision. This finding mirrors previous research studies reporting shared ethnicity between clinical supervisee and supervisor as a factor for success in the clinical supervisory relationship (Wepa, 2007).

Rosemary: 'I think that the fact that she [clinical supervisor] comes from the same continent helps. When I have queries or I have different perspectives she is able to come to my level and ask if she doesn't understand where I am coming from and then support me from there. Whereas I have found in the past that when people were not of my ethnicity or who don't understand me, it's quite difficult to get through to them to understand where I am coming from. What works is having someone who understands your perspective who has an idea of where you are coming from. I think it is about meeting the person where they are and then working from there. That makes it really important for me.'

Maintaining professional effectiveness by addressing transferences with clients, colleagues and others in the wider organisation

'Unsticking the stickness' is how another supervisee discussed his experience of clinical supervision. His clinical supervisor reflected on his narrative of 'stickness' as the supervisee's expectation of needing to have all the answers for a client with high and complex needs. The transference between the social worker and client was explored, illuminating an important learning for the clinical supervisee:

Joy: 'It [clinical supervision] changed my whole view of the situation, really. When I was speaking, I remember using the words: 'I'm stuck'. And it really changed by the end, talking about it, who exactly was 'stuck'. And I went away feeling like it wasn't me that was stuck, which gave me a whole different perspective.'

For another clinical supervisee, she viewed clinical supervision as keeping her focused on the way forward as she found she became lost in details which obscured the wider picture of what was happening:

Rosemary: 'I think they [my clinical supervisor] just give me a way to analyse any particular issues; or a way of, kind of, checking things. I can get a bit lost in detail, or a bit lost… a bit focussed on particular issues, and those sessions in particular give me a really good way of kind of expanding my focus - or bringing it in, depending on what's supposed to happen, and give me a way of re-viewing the situation, or re-analysing the situation. Kind of re-focusing.'

Another supervisee stressed the importance of having a similar practice model to her clinical supervisor who was very experienced and familiar with case management. Knowing that her supervisor shared the same theoretical and practice background provided safety, as together in clinical supervision, they were able to explore underlying assumptions and values in practice with clients. This clinical supervisee anticipated the time when she could self-supervise with an internalised sense of clinical supervisors' sage advice aligning with her own clinical reasoning in complex cases:

Fiona: 'I think it comes back to what we were talking about, about that focus on case management is important at the start when you do need to check a lot of your decisions and you do need to check a lot of your assumptions, when you kind of get a little bit more experienced and get better at that reflective practice for yourself you maybe don't need that secondary check on your practice as such and that can become a bit broader.'

Identifying gaps in training and future personal/professional career directions

The managerial discourse of clinical supervision as being primarily a tool of quality assurance for employing organisations exists alongside the psychodynamic framework which sees clinical supervision as a developmental process in which the supervisee gradually learns from a more experienced supervisor to act more independently and competently over time (MacDonald, 2002). These mixed meanings and purposes of clinical supervision are considered reasons for the persisting lack of uptake of clinical supervision despite measures to facilitate access to it. (McBride, 2007). These two discourses – the managerial, and the psychodynamic, co-exist in the narratives of the clinical supervisees and supervisors who were interviewed. Clinical supervisees saw clinical supervision as a safe learning environment in which
they felt cared for. Clinical supervision was seen for the supervisee group as a way of gaining a more accurate and accepting sense of self as a worker and as a person. Through the vehicle of the supervisory process and the interaction with the clinical supervisor clinical supervisees considered this personal and professional development was facilitated. When this was not the case the climate was not deemed ‘safe’ enough to allow the supervisee to be completely honest and to freely disclose core issues with the clinical supervisor.

One of the supervisees interviewed, Joy, reported an unhelpful experience of clinical supervision prior to her current clinical supervisor. The negative experience was with a clinical supervisor who was also her line manager. Then another social work manager from another area, offered her clinical supervision to support her post graduate studies. Through this subsequent clinical supervisor’s assistance with her studies, she was more fulfilled with her experience of clinical supervision. She remained hopeful of this clinical supervisory relationship continuing beyond completion of her studies:

Joy: ‘she is supportive of me doing this course so she actually asked me if I wanted me to do my supervision with her and said: ‘yes’. She offered to do the supervision because she supports the course. But I don’t think if I wasn’t doing the course she wouldn’t have offered to do the supervision. Just that supervision this year has been really good, it’s been different. It has contributed a lot to my learning and I just wanted to say that every practitioner needs regular supervision to keep on track. I’ve really enjoyed supervision this year and I hope I can still have her next year after the course.’

Though not all clinical supervisees were clinically supervised by a member of their own professional group, the value of being supervised by a person of the same profession was emphasised by clinical supervisees. This shared frame of reference was viewed by clinical supervisees as affirming of professional identity and values, as Carolyn explains:

‘I think that the way that social workers view the world, their work, their profession, is different – particularly in the health setting, from the way that another discipline – particularly the nursing profession – would view things, and the focus I think that a social worker has is different to what a nursing colleague would have. And my team is predominantly nurses so that’s why I’m using them as my core. But getting away from that sort of medical, biological, sort of bio-medical model, and away from a symptom is such a relief in clinical supervision.’

Exploring self-care

A positive relationship between clinical supervisor and supervisee enabled a trusting relationship in which difficulties related to practice could be raised without fear of censure. The following comment from Joy exemplifies what this relationship was related to:

‘I think we have a good relationship, I find it quite easy to talk with her. She’s quite open, she is quite honest, she is quite fair, unbiased as well. So I find her really helpful and useful. And also I find that she can also understand some of my perspectives of where I am coming from and so that makes it easier for her to support me as we can work from this. And yeah, we have a good, open, honest relationship. I can talk with her about anything and everything.’

When a ‘safe’ relationship was established, the clinical supervisee could explore difficulties related to the workplace that were found to be personally distressing. In the following excerpt from an interview, Carolyn experienced an acute grief response by seeing a client name on a white board with the subtitle: ‘deceased’ on a meeting room as she passed by the empty room. She had not been advised that the client whom she had some involvement with in the day programme had died by suicide the night before. As she this was not her client, Carolyn was not included in the ward critical incident stress debriefing the day after. Due to her immediate distress and acute grief response, she sought help from her clinical supervisor and found this helpful:

‘She [the clinical supervisor] had thought with me in depth about my own cultural understanding about death and how we view death. So explored how the hospital handles death and the mistakes that have happened in the past. And the good thing that came out of the whole supervision was that there needs to be some consistency when clients die across the ward and not just in the services because she also told me about other experiences of staff not knowing their clients had actually passed on and hearing that two years down the line. And how we actually traumatised the staff.’

Conclusion

The results of this qualitative, exploratory study indicate that for supervisees, through discussing complex and difficult cases in clinical supervision, they came to view their practice both more positively and more self reflectively and reflexively. The relationship enabled this depth of reflection from the supervisees’ perspectives.

The wider research project with pairs of clinical supervisors and their clinical supervisees highlights the differences in supervisee and supervisor roles and perspectives of clinical supervision (Pack, 2011 and 2011a). The wider study also highlights cross-disciplinary themes as to what constitutes clinical supervision from the 'most difficult' practice scenario taken to clinical supervision (Pack, 2011 and 2011a).

There are a number of recommendations that can be made on the basis of the themes emerging from the supervisee narratives of most difficult practice scenario taken to clinical supervision. Interestingly, but not unexpectedly, these themes are different for clinical supervisors and clinical supervisees respectively. For clinical supervisees, information on the process of clinical supervision needs...
to be demonstrated more dynamically than is possible on paper. In fieldwork education modelling the process of clinical supervision could be exemplified in role play and using other audio-visual means (For example, see Pack, 2010). Greater attention to discussing the power differences in the clinical supervisory relationship explicitly, allowing choice of clinical supervisor, and fostering a high quality of relating in the supervisory relationship are suggested in the supervisee definitions of clinical supervision.

Providing adequate time and resource in terms of the training of clinical supervisors for the role and then the organisation following through with an infrastructure of support, is one of the imperatives from the clinical supervisors’ perspectives (Pack, 2011 and 2011a). Training for new clinical supervisors who have a ‘dual role’ as the clinical supervisee’s line manager and clinical supervisor is also highlighted as a neglected area, fraught with complexity in balancing organisational agendas with the development of the clinical supervisee’s emerging professional sense of self.

New practitioners working with trauma have specific needs for relational models of clinical supervision (Etherington, 2000). A comprehensive critical incident stress management programme is also needed with individual, team debriefing options. Vicarious traumatisation education is needed within clinical supervision as evidenced in other studies (Sommer, 2008; Furlong and Taylor, 2013). Clinical supervisors have an ethical obligation to inform employees about the inherent dangers about engagement with trauma and critical events. Case-load mix of trauma versus general mental health work needs periodic review and adjustment. Fewer years of experience connected with increased levels of vicarious traumatisation and trauma-related signs (Furlong and Taylor, 2013). Clinical supervision needs to raise awareness of vicarious traumatisation and awareness of how it might manifest for the individual clinical supervisee new to the mental health services.

In summary, this research project focused on interviews with clinical supervisees has illuminated the nature of the relationship that occurs between clinical supervisors, and their clinical supervisees who are new to clinical supervision. This process mirrors the experience of social workers and occupational therapists learning to work in diverse and differing cultural contexts with their clients and with their multi-disciplinary teams. Meaning-making for clinical supervision is a process that new graduate allied health professionals engage in alongside their clinical supervisors to develop clinical reasoning skills. For clinical supervision to be ‘successful’ from the clinical supervisee’s perspective, opportunities for learning from clinical supervisors in a ‘safe’ relationship need to be available. This kind of relationship encourages critical reflection on practice that scaffolds clinical supervisees into being confident and ethical professionals as they trial their ‘theories-in-action’ with their clinical supervisors before implementing them in the practice setting.

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Freedom to conjecture within the Balint group: Powerful supervision for mental health professionals

Frank Meumann

Ref: Meumann F. Freedom to conjecture within the Balint group: Powerful supervision for mental health professionals. Conference paper presentation: Advances in Clinical Supervision Conference, Sydney Australia, 4-6 June 2013.

Dr Frank Meumann is President of the Balint Society of Australia and New Zealand. He is an accredited Balint group leader and leader trainer. He has been leading Balint groups since 2005. He currently leads four ongoing Balint groups. Dr Frank Meumann is a general practitioner and medical educator from Hobart. He has been involved in general practice vocational training for 25 years, having initially been a GP supervisor then State Director of the RACGP Training Program. He later took on the role of CEO of General Practice Training Tasmania. Dr Meumann has a special interest in the doctor-patient relationship and in teaching doctor-patient communication.

Background

This paper is entitled: ‘Freedom to Conjecture Within the Balint Group.’ This is about the origins of Balint groups and their use in supervision. Balint groups were started by Michael Balint, a psychoanalyst, in the early 1950s. He and his wife, Enid Balint, met with general practitioners to explore the many dimensions of the doctor-patient relationship. They had weekly meetings for many years. This was the earliest documented and systematic attempt to bring together the physical and psychological dimensions of clinical care for general practitioners. One could think of this as an early form of group supervision for general practitioners.

Michael Balint wrote a landmark book entitled, 'The Doctor, His Patient and the Illness.' He exposed many of the mysteries of the relationships between general practitioners and their patients. He coined the term 'patient-centred medicine.' Balint groups provide a means of supervision for doctors and other health professionals around their complex relationships with patients. They also provide doctors and other health professionals with a deep understanding of their patients’ illness experiences, and important aspects of themselves as health professionals. Balint groups provide a platform for inter-disciplinary supervision, learning, peer support, and enhanced clinical care. They can also be viewed as one of the antidotes to doctor burnout. The Balint group method has been refined over the last sixty years. It is widely used in the United States, Great Britain, Scandinavia, Eastern and Western Europe. It is an obligatory part of doctors' vocational training in parts of the United States, Great Britain and Germany.

A Balint group may meet a number of times over a few days or become an ongoing group over months or years. The author has been running a Balint group for general practitioners for the last seven years. This group meets every month. He also leads an ongoing inter-disciplinary Balint group, comprising psychologists, social workers, psychiatric nurses and doctors. These mental health practitioners come from a variety of organisations in the public and private sectors. This group meets monthly. The author also leads two Balint groups for psychologists and counsellors within Relationships Australia. This is an example of the use of Balint groups for supervision within one organisation.

Description of the Balint group method

The membership of a Balint group remains fixed, as far as possible, for the duration of the group. A new member may be admitted to the group with the participants' permission. The optimum size of a Balint group is 8 to 10 people. A Balint group may be led by one leader, however it is preferable to have two.

Prior to the commencement of the group there is agreement on group rules, which include confidentiality (everything said in the group will remain confidential, whether it is about the patients, group members or colleagues), respectfulness (everybody is listened to and their contributions are respected, no unwelcome or intrusive questioning of group members) and no discussion of the case outside the group. This is to ensure safety of the participants, patients and colleagues.

Members of the Balint group have the opportunity to present a case of particular concern and have the group discuss that case. The presented patient could be difficult, puzzling, or make the doctor feel uncomfortable. At a Balint group meeting the leader calls for a case to be presented. The presenter gives a brief description of the case from memory. There is no preparation for the presentation and there is no note taking. The presentation lasts for about five minutes.

The group leader asks the group for clarifying questions of fact. This phase of clarification lasts for about five minutes. The group leader limits the time spent on clarification of fact as too many facts may inhibit imagination and speculation. Then there is the push back phase (moving the chair back), when the presenter of the case (referred to as ‘the presenter’, ‘the doctor’, or ‘the therapist’) listens
to the deliberations of the group from the ‘outside’. The group ignores the presenter. The group is encouraged to explore what might be going on for the patient, the doctor and within the doctor-patient relationship. There is encouragement of a mood of conjecture. The group looks at the issues from all angles, with no need to justify any particular speculation. Participants are prepared to take different views from the rest of the group.

The use of ‘I’ statements (If I was the doctor I would be feeling…If I was the patient I would be thinking…) and the use of metaphors is encouraged. It is important for the group not to be looking for a solution, and not to be giving advice. The group adopts a non-judgemental attitude. After about 35 minutes of conjecture the presenter is invited to re-join the group. He or she may then participate in the discussion. The Balint group leader closes the discussion at a set time (usually 40 minutes, but it may be longer).

Balint groups usually meet for 1½ hours and two cases are discussed in this time. Some groups have one case discussed over one hour. The Balint group leader ensures the groups starts and finishes on time. This is part of holding the ‘frame’ of the Balint group. The Balint group leader makes interventions during the discussion. These are to support the functions of the Balint group: to provide a safe place for emotional reflection on troublesome cases, to help the presenter of the case to further understand the case, to look at blind spots and assumptions and to help members grow and develop. A Balint group is not a psychotherapy group, encounter group, traditional case discussion group, topic-for-discussion group or advice-giving group.

Organisational aspects of Balint group work

Australia and New Zealand’s peak body for Balint group work is the Balint Society of Australia and New Zealand (BSANZ), of which the author is the President.

The BSANZ has established a pathway for Balint group leadership training leading to accreditation as a Balint group leader. Currently, the BSANZ has 16 people formally enrolled in the training pathway. The BSANZ Leadership Accreditation Pathway involves training, supervision and observation. The training includes experiential learning at two Balint Leadership Intensives and leading or co-leading a minimum of thirty Balint group case discussions. The supervision includes ten (one hour) supervision sessions per year for two years. Each leader in training has a designated supervisor. The observation includes being formally observed leading four Balint group case discussions.

The BSANZ runs an annual four-day Balint Leadership Training Intensive. There is a strong emphasis on Balint group leadership training, supervision and observation at this event. The BSANZ is affiliated with the International Balint Federation, which holds an International Balint Congress every two years. There are many Balint leadership workshops in Australia and overseas.

The Balint group method is suitable for educators and supervisors to explore their complex relationships with learners. Many such Balint groups have been run within the Australian General Practice Training, Australia’s peak body for general practice training.

Summary

Balint groups provide an effective method of supervision for health professionals. The Balint group method provides clinicians with a space to explore the complexities of their relationships with their patients, and receive peer support. Balint groups also provide doctors and other health professionals with a deep understanding of their patients’ illness experiences, and important aspects of themselves as health professionals.

References


For more information go to: http://balintaustralia.org
The art and craft of assessing clinical supervisors

Paul Bailey, Valda Dorries, Analise O’Donovan, Matthew Bambling


Abstract

We are a Queensland Design team of four senior clinical supervisors, educators and researchers, who feel connected to an increasing network of individuals and groups, nationally and internationally, who are designing responses to these questions: How do we, as senior clinical supervisors, welcome new practitioners into the growing discipline of clinical supervision? How do we know who are competent and effective to practise as generic clinical supervisors? Who ought to assess clinical supervisors? What methods of assessment ought to be used? Who ought to accredit clinical supervisors?

The need for answers is pressing for, as Bailey, C (2009) writes ‘at present, there is a market free-for-all in relation to supervision training…As the quality of training is so variable, those who employ supervisors have few means other than word of mouth and reputation to guide them about the value of a specified training…This does seem strange given …the general belief that supervision is an integral element of good practice’ (p.54).

There does appear, at least, to be a growing consensus in the literature on what generic clinical supervision is. As Bernard & Goodyear (2004) write, ‘mental health professions are more alike than different in their practice of supervision. Regardless of professional discipline, supervision can be described in terms of core skills and common processes. Therefore, there exists a corpus of knowledge about clinical supervision that is broader than what is found in the literature of any of these (other) professions’ (p.1). However, before there can be general agreement on what is appropriate education, the emerging profession of clinical supervision still needs to agree on how practitioners are to be assessed and by whom? To contribute to the national and international conversation regarding how to assess clinical supervisors, this Design Team offers the conference the results of our work to date.

The Art and Craft of Assessing Clinical Supervisors

Good morning and thank you for being here. Over the next twenty minutes, I wish to give you a glimpse of the work that the four of us in the Design Team have been creating in Queensland.

We follow in the footsteps of many other international theorists and researchers on Clinical Supervision, including Bernard and Goodyear (2004), who have written that:

‘mental health professions are more alike than different in their practice of supervision. Regardless of professional discipline, supervision can be described in terms of core skills and common processes. Therefore, there exists a corpus of knowledge about clinical supervision that is broader than what is found in the literature of any of these professions (e.g. psychology, counselling, social work, family therapy, psychiatry, psychiatric nursing). Because of this assumption, we have drawn from interdisciplinary literature to address the breadth of issues and content that seems to characterise clinical supervision in mental health practice.’ (1)

The time may be ripe in this country for an in-common approach to Clinical Supervision, as Fitzpatrick, Smith and Wilding (2012) write:

‘Although there may be some supervision issues that are profession- or organisation- specific, there are also clearly many others that are similar across different professions and different organisations…By gaining an understanding of what high quality clinical supervision is and how it is best put into practice, it is anticipated that this will form the first step in developing an understandable and useful supervision policy.‘ (2)

Yet, as members of this developing field in Australia, this art and craft, how do we know that someone is safe and competent, is skilled enough and sufficiently experienced, has the appropriate attitudes and values to engage in what Elizabeth Holloway has referred to as one of the most complex activities clinicians do? (3)

The Design Brief

The four of us are all senior Clinical Supervisors. We began with the challenge of addressing an anomaly we had been witnessing: Queensland Health, like many other similar
bodies throughout the States and Territories, recognises and values the need for generic Clinical Supervision for its frontline Mental Health staff. Yet, to date, the matter of formally assessing who are the safe and competent generic Clinical Supervisors has been delegated to the ‘too-hard basket’.

When we began, what we soon found, or rather what we failed to find, was a set of formally agreed-upon generic competencies by which Clinical Supervisors in the Queensland Health Mental Health Services could be assessed. In order not to continue colluding with this anomaly, we thought that we might be able to create a generic assessment process, pilot this to a small group of Queensland Health staff from the range of Mental Health disciplines and then write this up as a research project. Such research, if successful, could be used to advocate for such an assessment process to be more widely adopted within the organisation and maybe even more widely. We also thought the outcomes of this initiative would be our contribution to the growing national and international dialogue on the subject.

We were well aware that a number of Mental Health disciplines do have their own standards and processes for accrediting Clinical Supervisors. Here, we acknowledge the work of the Psychology Board of Australia and the Psychotherapy and Counselling Federation of Australia among others. However, the problem for us, as a Design Team, is that these assessment and accreditation processes remain discipline-specific. As such, the emerging generic discipline of Clinical Supervision, with its common-factors approach to the field, would require generic Clinical Supervisors to be accredited by a range of Mental Health disciplines before they would be eligible, as Queensland Health encourages, to clinically supervise across disciplines. There does not yet appear to be in this country a wider federation or network or an association that has distilled the common-factors approach to Clinical Supervision, set the assessment standards and is ready to offer a formal accreditation process.

Our work, therefore, is to create a set of generic competencies, seek wider agreement for these generic competencies, then pilot the assessment process that we are designing to a selected group of Mental Health practitioners within Queensland Health, offer this up as a research project for wider implementation.

We were mindful that undertaking this task would not be easy nor straight-forward. As Bernard & Goodyear (2004) write that: “…establishing criteria for evaluation may be the most challenging and conceivably most labour-intensive aspect of the evaluation process….The difficulty of establishing criteria for evaluation and the equally difficult task of measuring them is a professional reality.” (4)

So, too, Bond & Holland (2008) are similarly sobering, when they write that: “Attempts to evaluate clinical supervision systems are notoriously difficult.” (5)

However, between the four of us, we have probably had a hundred years or more of experience as Clinical Supervisors and also, though less so in terms of years, as Educators, Researchers and members of Clinical Supervision Governance, and, so, we began our work on this new challenge.

**Principles Guiding our Design Work**

Agreeing on the transparent principles that would guide our work became our step number one. The following is my view of our consensus on principles:

A common-factors approach. As Bernard and Goodyear (2004) assert, ‘mental health professions are more alike than different in their practice of supervision.’ (6) Clinical Supervision is a craft, a discipline to be learned, that is generic. As well as gaining the generic competencies, Clinical Supervisors may develop their skills further by applying to be specialist Clinical Supervisors in a particular discipline, such as Psychology or Psychotherapy, Social Work or Occupational Therapy or some other discipline. These ‘specialisms’ would be assessed and accredited by already existing Boards or Associations.

Commitment to life-long learning. Because we consider that Clinical Supervision is a career-long commitment, we expect each practitioner, no matter what their level of seniority or experience, continues to engage in his or her own Clinical Supervision. And, so too with Clinical Supervisors, we accept as a given that all Clinical Supervisors engage in regular supervision of the supervision they offer others. Thus, if an applicant is deferred by the assessment panel as not yet being ready to be recommended as a sufficiently safe and competent Clinical Supervisor, this is not the end of the road. He or she is simply encouraged to continue developing in the competencies and to present for re-assessment at a later stage.

Clinical Supervision is also an art. Other animals don’t make art. Art is a human activity. It is safe to say, as Hustvedt (2012), writes that: ‘it is only possible because we have the faculty of reflective self-consciousness; that is, we are able to represent ourselves to ourselves and muse about our own beings by becoming objects in our own eyes’. Unlike simple skills building, ‘art requires editing and thought as well, but finding the rightness one is looking for and knowing when to stop is a mysterious process and emerges from places in the mind that are often hidden’…Art engages us not just intellectually but emotionally, physically, consciously and unconsciously. It is a relationship. When we love a work of art, there is always a form of recognition that occurs. The object reflects us, not in the way a mirror gives our faces and bodies back to us. It reflects the vision of the other, of the artist, that we have made our own because it answers something within us that we understand is true. This truth may be only a feeling, only a humming resonance we cannot put into words, or it may become a vast discursive statement, but it must be there for the enchantment to happen – that excursion into you that is also I’. (8)
The art of Clinical Supervision moves through empathic attunement with the assistance of mirror neurons intentionally towards the faculty of reflective self-consciousness, into the space Freud (1914) called ‘playground’ and the ‘intermediate region’, which Winnicott elaborated as the essential space for creativity. (9) In this space, we, as Clinical supervisors, reflect on case conceptualisation and ethical complexities, on vicarious trauma and an array of other themes. Clinical Supervision requires a developed level of self-awareness. This follows on from the previous principle. The capacity to facilitate colleagues to reflect more deeply on the competency and safety of their work and to explore their own blind-spots is dependent on Clinical Supervisors being willing and able to do so for themselves.

Transparency of process. Who is to assess? Who is to be assessed? By what methods?

Transparency of the generic assessment criteria. Assessment happens within relationship. This is in line with the strong recommendation from Hawkins & Shohet, 2006, that ‘the evaluation process needs to happen within a direct form of relationship and not by the examination of paperwork by a distant and unknown committee’. (10)

Our Journey so far

What we offer today is not our goal reached nor our tasks completed. Rather we offer to you our work in progress.

There does seem to be, in the literature, a consensus on what generic Clinical Supervision is. Carl Rogers shone the light. (11) Following his lead, the literature on clinical supervision appears unanimous in asserting that ‘the establishment of a high quality supervisory relationship is a central aspect of supervisory competence’, (including Hess, 1987; Worthen & McNeill, 1996; Ellis & Ladany, 1997; Holloway, 1997; Watkins, 1997; Henderson, Cayyer & Watkins, 1999; Muse-Burke, Ladany & Deck, 2001; Bernard & Goodyear, 2004; Hawkins & Shohet, 2006; Falender & Shafranske, 2007). (12) It seems obvious, therefore, that any assessment of Clinical Supervisors needs to focus primarily, though not of course exclusively, on rating an applicant in terms of his/her capacity to relate as a Clinical Supervisor. Yet, how to do this in a way that the many professions and organisations across the various States and Territories and countries might accept is the challenge.

Yet, despite these urgings for such a common-factors approach from a growing number of Clinical Supervision Leaders, ‘at present, there is a market free-for-all in relation to supervision training…As the quality of training is so variable, those who employ supervisors have few means other than word of mouth and reputation to guide them about the value of a specified training…This does seem strange given…the general belief that supervision is an integral element of good practice’. (13)

We seem to have put the cart before the horse regarding the education of Clinical Supervisors. Before there can be agreement on what is appropriate education, the emerging profession still needs to agree on a generic map of what effective supervision is, how it is to be assessed and by whom, how it is to be accredited and by whom? Why is this so? Is it because the art and craft of assessing and evaluating colleagues ‘typically a weak suit for most supervisors’? (14) This may be so, as Bernard and Goodyear point out, because assessing one another ‘hits so close to home’. Professionally, we each ‘draw heavily on interpersonal and intuitive abilities’ with the consequence that we can confuse our performance as professionals with our worth as a person. (15)

Yet, the answer to the question whether assessing and evaluating are critical to effective Clinical Supervision is unequivocal (16) and, therefore, it follows that Clinical Supervisors ought themselves to be rigorously assessed.

Who will be assessed?

We, then, addressed the question, given the principle of life-long learning, at what stage of their professional development will practitioners be eligible to be assessed? If Gladwell’s (17) hypothesis has some validity, at what point in the process of achieving mastery, of moving through the 10,000 hours of practice, is an Applicant ready for formal assessment?

We recommend that practitioners may apply for formal assessment as generic Clinical Supervisors only after they have satisfied the following criteria: completed a course of education on the theory and practice of Clinical Supervision consolidated their education through at least two years of post-training experience as a Clinical Supervisor, which has included regular supervision of their supervision practice a recommendation from their supervising Clinical Supervisor, who is aware of the generic assessment criteria being used, that he or she is ready for such formal assessment.

Why would Individuals choose to be Assessed?

Given the current nature of the territory of Clinical Supervision, with its rivalries, educational diversity and apparent conflicting standards, we reflected together on why practitioners might wish to apply to be formally assessed regarding their generic competencies, particularly if their discipline-specific Boards or Associations or Educational Institutes have already accredited them for their specialised discipline-specific Clinical Supervision competencies. Among the many possible reasons we considered are:

for their own professional development;
because the employing bodies may require such an assessment;
they may be aware of practising without having undergone any formal assessment of competency or safety as a generic Clinical Supervisor and may simply wish to redress this anomaly;
to be included on a formal Register of assessed and accredited generic Clinical Supervisors;
to be part of promoting the growth and development of the...
Who will assess and how and by what criteria?

The next matter that we considered is who would be safe and competent to assess the safety and competence of generic Clinical Supervisors? This is an easier matter to answer once the process is under way. However, the matter of who would be on the very first assessment panel, in my view, still needs interdisciplinary consensus.

However, once this initial question is resolved transparently and satisfactorily, we recommend that, in keeping with the emphasis on the quality of the supervisory alliance, that the assessment process itself models and mirrors the characteristics of any effective alliance, including, as Hawkins & Shohet (2006) advocate that ‘the evaluation process needs to happen within a direct form of relationship and not by the examination of paperwork by a distant and unknown committee’. (18)

In addition, each assessor, in our view, would be expected to have successfully undertaken appropriate education for this challenging role, as well as having been assessed themselves previously as being a safe and competent generic Clinical Supervisor.

We recommend that a panel of two senior and accredited generic Clinical Supervisors assess an applicant using a range of methods and a transparent set of criteria. The particular methods and criteria we propose seem to be gaining increasing consensus among the different professions and organisations with vested interest in the development of the profession of Clinical Supervision.

Methods of Assessment

We advocate that these will include:

- a face-to-face interview
- the applicant’s prior written responses to a series of questions (the Design Team is aware that there may well be matters that are too time-consuming to be addressed within an interview and may be more effectively and efficiently answered in written form. However, if the written answer is not clear or satisfactory, then the issue can be discussed in person with the panel in the formal assessment interview).
- an excerpt from an audio or videotape of one of the applicant’s recent Clinical Supervision sessions. How the applicant is as Clinical Supervisor on the tape will be discussed more fully in the face-to-face interview
- a written report from his/her current Clinical Supervisor.

What is the Profile of an effective Clinical Supervisor?

The Design Team understands that the assessors’ understanding of what constitutes effective generic Clinical Supervision will be central in this template for they will be charged with the active responsibility for deciding whether a particular applicant is sufficiently safe and competent. And, as Bernard and Goodyear point out, ‘evaluation is a delicate blend of subjective judgement and objective criteria. Yet sometimes our personal subjectivity contaminates our professional subjectivity evaluation becomes less intuitive and more biased.’ (19) Thus, in order to reduce personal subjective bias, we advocate two safeguards: firstly, each assessor be required to be educated into this role and, secondly, each assessor and each applicant will be given a clear list of objective assessment criteria related to essential generic knowledge, attitudes and values. The Design Team has distilled from international literature the criteria for such generic assessment. There does appear to be some consensus on the constituent areas comprising good supervision.

Ellis and Ladany (1997) undertook a methodological review and concluded ‘that there is empirical support for differentiation of extreme qualities of supervision (best and worst)’. (20) Thus, we propose a 5-point scale, with a clear ‘snapshot’ profile of what each measure may look like. The Design Team is still refining this aspect of our work.

To preview where we are going with this and acknowledging our indebtedness to the pioneering work of Falender & Shafranske (2007) and others to guide us, we have outlined a profile of what both 1 and 5 look like on a 5-point scale. These profiles have been ‘inferred from the literature on “best” supervision and include ‘the following: capacity to enhance (supervisee) self-confidence through support, appropriate autonomy and encouragement. In the “best” supervisory relationship, there is comfort in self-disclosure of perceived errors, by either member of the supervisory dyad capacity to model strong working alliances and to develop strong working alliances with the supervisee. This would include mutual trust, respect and a willingness to commit enthusiasm and energy to supervision ability to dispense feedback, give constructive criticism and provide evaluation knowledge of multiple formats of supervision and skill in each of these formats (e.g. videotape, live supervision) adaptability and flexibility excellent communication of case conceptualisation, with strong theoretical underpinnings ability to maintain equilibrium and, as appropriate, a sense of humour even in the face of a crisis ability to identify and bring up potential conflict situations or areas of discomfort with the supervisee openness to self-evaluation and to evaluation by supervisees and peers. (21)

In addition, it is crucial, as Holloway and Carroll (1996) remind us, that Clinical Supervisors do not lose perspective and remember the impact of clinical supervision on client outcome. To fail to hold this perspective is ‘a bit like viewing parenthood solely for the enrichment of the parents’. (22)

Studies, though, of “worst” Clinical Supervisors ‘did not necessarily identify opposite characteristics as those attributed to “best” supervisors. Instead, each end of the spectrum appears to possess its own characteristics. Falender and Shafranske (2007), in accord with Magnuson
et al. (2000) describe the ‘overarching principles of “lousy” supervision, which we have used as profile 1 on the 5-point scale. These include:

- unbalanced supervision, which does not represent all elements of the supervision experience or focuses on detail to the exclusion of larger themes
- developmentally inappropriate supervision, which is not sensitive to the individual developmental needs of the (supervisee), intolerant of differences or not allowing the (supervisee) to have separate views or styles from the supervisor
- poor modelling of professional and personal attributes, which occurs when supervisors are untrained or poorly prepared to supervise and are professionally apathetic, lazy or uncommitted to the profession, when they are disinterested or inept in the organisational-administrative sphere, neither expectations nor standards of accountability are clear, and supervisee needs are not assessed in the technical-cognitive sphere, the supervisor is viewed as unskilled as a clinician and as a clinical supervisor and, therefore, unreliable as a professional resource in the relational-affective sphere, the supervisor does not provide a safe environment, gives too little or too much affirming and corrective feedback, is insensitive to the (supervisee’s) developmental needs, and imposes an agenda, avoiding issues that arise between supervisor and supervisee
- being unavailable or lacking time for supervision
- disagreeing theoretically or conceptually with supervisees
- being too nondirective or vague
- engaging in personality conflicts with supervisees
- spending too much time on administrative issues
- discussing their own work too much
- being distracted or preoccupied with their own personal problems
- being authoritarian, inflexible or intolerant
- demeaning the supervisee
- being indirect or avoidant and not fostering supervisee autonomy
- lacking the capacity to form and maintain a healthy relationship. Instead, engendering mistrust, defensiveness and criticism’. (23)

What are the Generic Clinical Supervisor Competencies?

The Design Team has almost refined what we consider these are and have almost completed our template of assessment criteria based on these generic competencies. Once these are complete and have been ratified by the Reference Group that we will offer our work to, the next step will be to pilot the assessment process within one of the seventeen Queensland Health Service Districts and, then, to write up the results of the research.

The Challenge of Implementing the Research Proposal into Practice

In Queensland Health there is an exciting opportunity to embed the accreditation process and principles within the mental health service context. Since 2007 a Supervision Training Program has been evolving, managed by the Queensland Centre for Mental Health Learning, with a mandate given by the Clinical Supervision Guidelines for Mental Health Services (2009) to implement a developmental alliance based framework, ‘becoming an effective and fully competent clinical supervisor’ is a developmental process, and ‘effective clinical supervision relies on the development of a strong alliance between the clinician and the supervisor’. QH is committed to ‘competency based clinical supervision’, ‘clinical supervision is a distinct intervention and specialisation that involves a specific set of generic competencies irrespective of professional discipline, practice setting, consumer focus and delivery model’ (24).

The transparent principles that guide our design work are fundamental to implementing the research proposal into practice:

- A common-factors approach.
- Commitment to life-long learning.
- Clinical Supervision is an art.
- Clinical Supervision requires a developed level of self-awareness.
- Transparency of process.
- Transparency of the generic assessment criteria.
- Assessment happens within relationship.

The Wider Professional and Organisational Context.

The Design Team is cognisant that operationalising the developmental assessment process may be challenging in the wider professional and organisational context. There is an obvious tension between the principles we outline, in which the development of the supervisor to be a safe and competent Clinical Supervisor is at the centre of an alliance minded approach, and that embodied in a pass/fail culture. To reiterate my earlier statement – this means that the assessment process itself models and mirrors the characteristics of any effective alliance, including, as Hawkins & Shohet (2006) advocate that ‘the evaluation process needs to happen within a direct form of relationship and not by the examination of paperwork by a distant and unknown committee.’ (18)

Thus we anticipate implementing the assessment process and the research proposal with supervisors who are participants of the QCMHL Supervision Training Program and are experiencing alliance based supervision with their own supervisors. Importantly evaluation becomes an integral part of the program – and not an added extra or an end it itself.

Engaging individual supervisors in the learning and assessment process

If we look at Schön’s ideas and substitute ‘supervisee’ for ‘client’ it becomes clearer:

Just as reflective practice takes the form of a reflective conversation with the situation, so the reflective
A practitioner's relation with his client takes the form of a literally reflective conversation & He recognises that his actions may have different meanings for his clients than he intends them to have, and he gives himself the task of discovering what these are. He recognises his own obligation to make his own understanding accessible to his client, which means that he needs often to reflect anew on what he knows and the reflective practitioner tries to discover the limits of his expertise through reflective conversation with his client.
— (Schön 1982: 295)

He has to see on his own behalf and in his own way the relations between means and method employed and results achieved. Nobody else can see for him, and he can't see just by being 'told' although the right kind of telling may guide his seeing and thus help him see what he needs to see.
— (quoted in Schön 1987)

Making the Decision that a Supervisor is Not Safe and Competent

It remains ironic though that the duty of care and ethical responsibility to assess a supervisor as not safe and competent, has been in the 'too hard basket' of service managers and professional leaders. Ironic in the sense that the anxiety aroused for the governance group through deferring a practitioner as not yet safe and competent enough, with whatever repercussions may follow, results in a paralysis to act. This has meant a likely collusion with unsafe practice. The Design group trusts that the despite how fraught the challenge, the organisation will find the moral courage to embed an appropriate accreditation process.

Summary

This has been a brief glimpse into how the four of us have been designing a way to welcome practitioners into the role of being generic Clinical Supervisors.

References

4. Bernard & Goodyear, ibid. p.23
20. Cited in Falender & Shafranske, ibid. p.44.
22. Cited in Falender & Shafranske, ibid. p.44.
Introduction

Due to the increasing demands on health services and concerns about the growing costs of health care delivery there has been a pressing need for reform in the way that health services are delivered (Council of Australian Governments, 2008). As a consequence, there has been a sharp focus on ensuring the workforce is adaptable and able to deliver efficient, evidence-based interventions that are safe and effective (National Health and Hospitals Reform Commission, 2009). Redesign of the workforce has resulted in changed models of care and greater utilisation of allied health assistants for the provision of health services (Kumar, 2011). More than ever before there is increased urgency for the workforce to be equipped with the necessary contemporary knowledge and skills to effectively function in this rapidly evolving environment.

Within this context, clinical supervision is seen as having a key role in the provision of professional support and clinical governance for health workers. This view is reflected both nationally and internationally (Dawson, Phillips, & Leggat, 2013; White & Winstanley, 2010). For example, Health Workforce Australia has invested in the creation of a National Clinical Supervision Competency Framework (Health Workforce Australia, 2011). In addition, various professional bodies seek evidence of ongoing clinical supervision practice for clinicians to meet professional registration and accreditation standards (Australian Association of Social Workers, 2000; Australian Psychological Society, 2007; Occupational Therapy Board of Australia, 2012).

Despite there being much written about how to provide clinical supervision, there is limited empirical evidence (Crow, 2008), and mixed findings (Butterworth, Bell, Jackson, & Pajnkihar, 2008), about whether clinical supervision is effective in enhancing professional support or improving clinical governance. Also, studies have provided minimal evidence about what elements actually contribute to making clinical supervision effective. In the main, empirical studies have focused on nursing populations and there has been limited research on clinical supervision outcomes for allied health professionals (Dawson et al., 2013). This study sought to identify whether clinical supervision was perceived to be effective by a range of allied health supervisees and to identify components that contributed to effectiveness.
Method

A cross-sectional quantitative study was conducted with the population of allied health professionals who were working across multiple sites in a Queensland metropolitan community health service.

Procedures

Data was collected from respondents via an anonymous on-line questionnaire, administered through the health service’s internal email system. The data was collected at 8.5 months post implementation of the intervention – the delivery of structured individual clinical supervision. Two day training programs were available to both allied health supervisors and supervisees prior to the introduction of this clinical supervision. Previously the clinicians within this service had received clinical supervision but it had been delivered on an ad hoc basis.

Ethical approval for the study was obtained from the Behavioural and Social Sciences Ethical Review Committee at The University of Queensland and from the Human Research Ethics Committee of the health service.

Measures

Effectiveness was measured using the MCSS-26\(^\text{©}\) (Manchester Clinical Supervision Scale) (Winstanley & White, 2011) which has a score range of between 0 and 104 (higher scores reflecting greater effectiveness). The MCSS-26\(^\text{©}\) has 26 items rated on a 5-point response scale ranging from 0 = “Strongly disagree” to 4 = “Strongly agree”. This recently revised scale is quick to complete while maintaining good internal consistency ($\alpha=0.658$ to 0.868, Winstanley & White, 2011). The scale measures three domains of clinical supervision as outlined in the Proctor model (Proctor, 2011): normative, restorative and formative; using six subscales: importance/value of clinical supervision (“CS sessions are not necessary/don’t solve anything”), finding time (“It is difficult to find the time for CS sessions”), trust/rapport (“My supervisor gives me support and encouragement”), supervisor advice/support (“I learn from my supervisor’s experiences”), improved care/skills (“Clinical supervision makes me a better practitioner”), reflection (“CS gives me time to reflect”) (Winstanley & White, 2011). Although the MCSS was originally developed for use with nursing populations, it has been satisfactorily employed with allied health populations and norms for allied health staff have been developed from amalgamated datasets (Winstanley & White, 2011).

Participants

Eighty-two community allied health professionals participated in this phase of the study. This represented a 68% response rate from the population of allied health clinicians (n=120). The sample comprised Dietitians, Occupational Therapists, Physiotherapists, Podiatrists, Psychologists, Social Workers and Speech Pathologists. As expected, the three largest professions of Occupational Therapy, Physiotherapy and Social Work, together comprised 73% of the total number of responses. Females accounted for 89.9% (N=71) of all respondents and is consistent with the gender bias generally found in the Australian health workforce (AIHW, 2009; Health Workforce Australia, 2013). Participant’s ages ranged from 24 years to 66 years with a mean of 41.97 years (SD = 11.80 years). The majority of participants were born in Australia (n=65, 79.3%), seven participants (8.5%) were born in the United Kingdom and the remaining ten participants (12.2%) originated from ten different countries.

Participants varied in the number of years experience in their profession, with a reported range from <1 year to >40 years; (M=9.52, SD=3.84). More than half of the participants had greater than 11 years experience in their profession (n = 46, 56.1%), indicating a mostly experienced workforce. A breakdown of participants by profession is provided in Figure 1.

Data Analysis

The demographic data was described using frequencies and measures of variability (means and standard deviation). Perceived effectiveness of clinical supervision was operationalised using the MCSS-26\(^\text{©}\) (Winstanley & White, 2011). The data from the MCSS-26\(^\text{©}\) was benchmarked against the scale’s normative dataset for allied health staff (Winstanley & White, 2011). “Effective” clinical supervision was defined as attaining an overall score of 73 or above on the MCSS-26\(^\text{©}\) scale as this is the suggested efficacy threshold for this measure (Winstanley & White, 2011).

Specific variables were identified to determine those elements that made a difference to the perceived efficacy of clinical supervision. These focused on procedural aspects that formed the “infrastructure” around the clinical supervision delivery. This focus was taken as only a small number of studies have included the effects of procedural aspects in their investigations of clinical supervision outcomes for allied health professionals (e.g. Collins-Camargo, Sullivan, Washeck, Adams, & Sundet, 2009; Kavanagh et al., 2008; Kavanagh et al., 2001; Mitchell, 2008). In the main, studies have confined their interest to specific procedural elements such as clinical supervision training (Collins-Camargo et al., 2009; Kavanagh et al., 2008), frequency and mode of sessions (Mitchell, 2008), or commented on the lack of clinical supervision procedures (Dawson, Phillips, & Leggat, 2012; Dawson et al., 2013). A definition of “Best practice” clinical supervision was developed based on procedural principles identified in the clinical supervision literature (Bradley & Hojer, 2009; Clinical Education and Training Institute, 2011; Ellis, 2013).
Best practice was defined as meeting all of the following five criteria: receiving clinical supervision, attendance at clinical supervision training, having some choice in the allocation of clinical supervisor, having a completed clinical supervision agreement and having a clear understanding about the boundaries of confidentiality in the clinical supervision relationship. Based on the above criteria, a “Best practice” group could then be compared to a “Less than best practice group”. Analysis using independent-samples t-test was undertaken to determine any differences between these two groups. Data analysis was undertaken using SPSS Version 20.

Results

Participant’s MCSS-26© scores ranged between 32 and 100 (M=73.23, SD=14.70). The published benchmark for allied health staff is M=74.7. The two groups of “best practice” (n=21) and “less than best practice” (n=44) did not differ in terms of demographics. Those in the “best practice” group (M=78.81, SD=12.34) rated the effectiveness of their clinical supervision significantly more highly than did those in the “less than best practice” group (M=70.57, SD=15.12), t (63) =2.17, p=.033. Significant differences, favouring the “best practice” group, were also found for the MCSS-26© Restorative domain, and the subscales of Trust/Rapport, Supervisor Advice/Support, and Reflection, pss=0.032. In addition, those in the “best practice” group rated the effectiveness of the Restorative domain more highly than the published benchmark although this difference represented only a trend towards significance (p=.052). Figure 2 shows the group data compared with the normative data for the Normative, Restorative and Formative domains.

Discussion

This research has demonstrated that clinical supervision, incorporating best practice principles, can have positive effects on outcomes. The best practice clinical supervision was effective in providing professional support and facilitating reflective practice for allied health workers. The difference in outcomes between the best practice group and the less than best practice group is particularly notable given the short length of time that the clinical supervision program had been established (8.5 months). This suggests that the variables identified for defining best practice can contribute to positive outcomes even within a relatively short time frame. The finding that the best practice group had a higher mean for the Restorative domain than the published benchmark, although not statistically significant, is especially noteworthy as this benchmark relates to allied health staff where clinical supervision has been well-established (Winstanley & White, 2010).

The study highlights the value of having appropriate infrastructure to support the delivery of clinical supervision by demonstrating that specific components can positively impact the effectiveness of the clinical supervision that is delivered. The findings underscore the importance of establishing a structured clinical supervision program that includes training for supervisors and supervisees, provides some choice in clinical supervisor and has clear clinical supervision policies and documentation processes that clarify the boundaries of confidentiality in the clinical supervision relationship. Given the competition for resources within the health sector, this study has important implications for managers of allied health services who wish to support the delivery of effective clinical supervision. Targeting resources to areas that have been shown to contribute to effective clinical supervision delivery makes for wise investment given the key role of clinical supervision in the provision of professional support and clinical governance.

No other study has been identified that has specifically explored the relationship between outcomes and clinical supervision organisational procedures for allied health clinicians. Specifically, these procedural components could be referred to as the “infrastructure” that underpins effective clinical supervision practice. The study’s findings make an important contribution to the developing evidence base for best practice clinical supervision for allied health professionals.

Acknowledgements

We thank the management and allied health professionals of the community health service for their interest and participation in this study.

References


Figure 1: Participants by profession

![Participants Pie Chart]

- Dietitian 6.1%
- Podiatrist 4.9%
- Occupational Therapist 28%
- Physiotherapist 12.2%
- Psychologist 3.7%
- Social Worker 32.9%
- Speech Pathologist 6.1%
- Other 6.1%

Figure 2: Best Practice group by Less than Best Practice group by normative\(^2\) data

![Bar Chart]

\(^2\) Winstanley & White, 2011

Council of Australian Governments. (2008). National Partnership Agreement on Hospital and Health Workforce Reform


Conceptualising the generic competencies required to provide clinical supervision to Australian psychologists: A thematic analysis

Kirsty Olds and Russell Hawkins

Abstract

Clinical supervision is the most prominent and frequently used method for teaching therapeutic skills to psychologists in training (Milne & James, 2002). Engaging in clinical supervision is also considered an appropriate method of maintaining standards of practice and meeting professional development requirements for fully registered psychologists (O'Donovan, Halford & Walters, 2011). Yet despite the strong reliance on clinical supervisors to train and assess the competency of provisionally registered psychologists, the profession is still at a stage where the specific knowledge, skills and attitudes that comprise the competencies of clinical supervisors are yet to be operationalised (Falender & Shafranske, 2012).

Within Australia, efforts have been made to specify the competencies required of Psychology Board of Australia (PBA) approved clinical supervisors. In May 2013, the PBA released the “Guidelines for supervisors and supervisor training providers”, which outlines a list of supervisory competencies and the minimum level of training required to become a board approved clinical supervisor. These guidelines are a major step forward in regulating the supervision of probationary psychologists, and progressing a competency based approach to the training of Australian supervisors.

Various other efforts to conceptualise and seek consensus on the broad domains of clinical supervisor competence have also been made internationally (Falender et al., 2004; Fouad et al., 2009; Green & Dye, 2002; Rings, Genuchi, Hall, Angelo, & Cornish, 2009; Roth & Pilling, 2009). However, while these efforts provide a demarcation of broad competencies, the profession is still lacking comprehensive frameworks that provide the “specificity and procedural detail to serve as useful templates for competent supervisory practice” (Reiser & Milne, 2012, p. 166).

In order to extend the existing evidence base, and develop a comprehensive framework that outlines broad domains of competency and the associated knowledge, skills and attitudes required to supervise Australian psychologists, it was considered important to systematically consolidate, synthesise, analyse and organise the existing competency frameworks that have been developed internationally.

This paper summarises findings produced from a thematic analysis of international competency frameworks targeting clinical supervision. This study is the first stage of a broader research project that seeks to conceptualise the specific knowledge, skills and attitudes necessary to supervise Australian psychologists.

Introduction

Clinical supervision is the most prominent and frequently used method for teaching therapeutic skills to psychologists in training (Milne & James, 2002). Engaging in clinical supervision is also considered an appropriate method of maintaining standards of practice and meeting professional development requirements for fully registered psychologists (O'Donovan, Halford & Walters, 2011). Yet despite the strong reliance on clinical supervisors to train and assess the competency of provisionally registered psychologists, the profession is still at a stage where the specific knowledge, skills and attitudes that comprise the competencies of clinical supervisors are yet to be operationalised (Falender & Shafranske, 2012).

Within Australia, efforts have been made to specify the competencies required of clinical supervisors have been made by the Psychology Board of Australia (PBA). In May 2013, the PBA released the “Guidelines for supervisors and supervisor training providers”. In this document, supervisory competencies and the minimum level of training required to become a board approved clinical supervisor are specified. These guidelines are a major step forward in regulating the practice of clinical supervisors supervising probationary psychologists, and progressing a competency based approach to the training of clinical supervisors.

Various other efforts have also been made internationally, to conceptualise and seek consensus on the broad domains of clinical supervisor competence (Falender et al., 2004; Fouad et al., 2009; Green & Dye, 2002; Rings, Genuchi, Hall, Angelo, & Cornish, 2009; Roth & Pilling, 2009). However, while these efforts provide a demarcation of
broad competencies, the profession still lacks frameworks that provide the “specificity and procedural detail to serve as useful templates for competent supervisory practice” (Reiser & Milne, 2012, p. 166).

Currently, one of the challenges in understanding the existing evidence base is the lack of consistency between each of the frameworks in terms of how they have been structured. The differences in structure across each of the competency frameworks make it hard to interpret the evidence base as a whole, because it is difficult to recognise the unitary concepts that bind similar competencies when each of the frameworks are structured differently. Without easy identification of such patterns, interpreting the evidence base becomes difficult.

Another challenge in interpreting and understanding the current evidence base is that in reviewing each of the competency frameworks, it is immediately obvious that there is great variation in terms of the focus and level of attention that each framework gives to specific components of competency. If one is to use the existing evidence base as a guide for supervisory practice, it then becomes unclear about how to reconcile these differences across competency frameworks.

In order to conceptualise the competencies and associated knowledge, skills and attitudes required to supervise Australian psychologists, it was considered necessary to consolidate, synthesise, analyse and organise the existing competency frameworks developed internationally. This way data can be systematically extracted from the evidence base as a whole, informing the development of a competency framework and building on the weaknesses of the existing documents.

A thematic analysis is a systematic process that identifies themes or patterns within qualitative data (Boyatzis, 1998). It also provides a way of organizing and describing the data (Braun & Clarke, 2006) and enables qualitative data to be translated into quantitative data if necessary (Boyatzis, 1998). Conducting a thematic analysis is a way of establishing the strength of evidence that already exists for each competency, and also brings attention to the competencies with the least level of consensus, therefore highlighting future directions for further research.

**Method**

Competency frameworks for clinical supervisors within the field of psychology were sought for the analysis. The inclusion criterion for documents to be included in the analysis was that the competencies were built upon expert consensus. An initial review of the literature was conducted by searching the databases PsychINFO and PsycARTICLES. This revealed only a small number of competency frameworks that meet this criterion. A broader search for standards of practice and/ or competency frameworks endorsed by international professional bodies and registration boards was conducted by reviewing the websites of professional bodies and registration boards across the following countries: Australia, New Zealand (NZ), United Kingdom (UK), and the United States of America (USA). The data set for the thematic analysis includes documents from each of these countries. The competency documents chosen for analysis represent the opinions of a diverse range of psychologists, locally and internationally. By analysing the documents collectively, international expert opinion is aggregated, therefore strengthening an understanding of the evidence base as a whole.

**Procedure**

Each of the five documents identified as meeting the inclusion criterion were subjected to an inductive thematic analysis, based on the guidelines of Braun and Clarke (2006). The first phase of the process involved becoming familiar with the data by reading and re-reading each of the competency frameworks and taking notes to record patterns and ideas for codes.

The second phase involved generating initial codes to produce a coding manual. This was a data driven process, so codes were developed from data extracts across all of the documents in the analysis. The codes were developed based on the explicit meaning of each extract of data within the data set. This was conducted by systematically going through the entire data set. Once the coding manual was produced, codes were applied to each of the documents in the analysis. The principle researcher initially coded the data manually. This was followed by manual coding of a sample of data (three of the five documents) by an independent coder, in order to examine the accuracy of initial coding. Any discrepancies were then discussed and the coding refined until agreement was achieved.

Once the coding of extracts had been completed, the last phase involved segmenting the coded extracts into themes. This involved using a excel spreadsheet to sort coded extracts by collating them into potential themes. Primarily, the dominant factor influencing the determination of themes was the presence of similar codes across the data set. However, some of the subthemes were determined based on a latent thematic analysis, where a more interpretive approach was required. Once codes had been segmented into themes and subthemes, the proposed themes were discussed with the second researcher and refinements were made until agreement between researchers was achieved.

**Results**

Based on a thematic analysis, nine broad themes were identified across the entire data set. These themes were: Ethics and professional practice, Knowledge of the profession, Diversity, Reflective practice, Supervisory alliance, Structuring supervision, Facilitating learning, Supervision research, and Evaluation.

Figure 1 provides a diagrammatic representation of these themes.
Ethical and professional practice

The theme of Ethical and professional practice describes ethical and legal issues within the context of clinical supervision. The theme comprises of four subthemes, including personal and professional boundaries, ethical principles, modelling ethical behaviour and professional guidelines/standards and statutory regulations. Extracts pertaining to this theme featured across the entire data set, indicating a strong level of consistency across the different competency frameworks. Extracts within this subtheme were as brief as “Knowledge of legal and regulatory issues in supervision” and as specific and detailed as “An ability to draw on knowledge (and relevant professional codes) regarding the potential problems that can arise when the supervisor occupies more than one role in relation to the supervisee, e.g., When the supervisor has had or develops a relationship with the supervisee which could make it difficult for them to maintain a neutral supervisory stance (e.g., a close friendship, previous contact in which there were significant difficulties)“.

Diversity

The theme of diversity describes various aspects of working with difference (e.g., race, culture, religion, gender, sexuality, disability, age, etc.). This theme comprises of three broad subthemes including diversity issues within the supervision dyad, diversity issues within the supervisee’s clinical practice, and cultural supervision. Extracts pertaining to this theme featured across the entire data set, indicating a strong level of consistency across the different competency frameworks. Extracts were as broad and generic as “Responsible for sensitivity to diversity in all its forms” and as specific as “An ability to ensure that supervisees are appropriately supported in working with interpreters, by: Alerting them to procedures for ensuring best practice and identifying potential difficulties; Reviewing work undertaken with interpreters and identifying and discussing any issues which emerge”.

Knowledge of the profession

This theme describes content relating to knowledge of the profession and knowledge of the area in which supervision is being provided. The semantic content of each of the data extracts were similar across the entire data set, explicitly emphasizing knowledge of the profession, e.g., “Knowledge and understanding of the profession” or knowledge of the particular area within the profession for which supervision was being provided, e.g. “Knowledge of area being supervised (e.g. CBT, other psychotherapies, research, assessments and client-related components)”.

Reflective practice

Reflective practice is a purposeful way of learning from experience, challenging assumptions and biases, and questioning personal behaviour (Bolton, 2010). It has also been described as a process for reviewing,
challenging and repositioning professional practice (Frost, 2006). This theme comprises of three broad subthemes including clinical supervisors engaging in reflective practice, promoting reflective practice in supervisees, and a commitment to lifelong learning. Elements of this theme were evidenced within other themes, such as supervisory alliance and diversity, calling attention to the interwoven nature of competencies and some of the difficulties in attempting to establish distinctly separate competency domains. The majority of extracts featured within this theme were broad, generic statements such as “Demonstrated skills in reflective practice” or “Ability to facilitate reflection” and “Commitment to lifelong learning and professional growth”.

**Supervisory alliance**

This theme describes issues relating to the supervisory alliance. It comprises of two broad subthemes, including establishing and maintaining the supervisory alliance and structuring the supervision relationship. All documents made reference to establishing and maintaining the supervisory alliance, and all except one document made references to encouraging feedback from supervisees. Example extracts include: “Ability to foster and maintain a supervisory alliance”, “Ability to recognise and address strains in the supervisory alliance”, “An ability to recognize, and to take appropriate action, when the working alliance has broken down irretrievably”.

**Structuring supervision**

Structuring supervision is a broad theme that describes supervisor attempts to create clarity around goals, expectations, roles and responsibilities. Most documents made at least some reference to structuring clinical supervision, however there was considerable variation in how much this was emphasised. This theme comprises of three subthemes, including negotiating goals and contracts, establishing expectations about: roles, responsibilities, procedures and practices, and structuring sessions. Example extracts include, “Identifies goals and tasks of supervision related to developmental progression”, “Basic knowledge of expectations for supervision”, “Knowledge of how to manage the process of supervision”.

**Supervision research/ theory**

The translation of science into practice is a key aspect of the psychologist role and the supervision research/ theory theme within this analysis is characterised by content relating to clinical supervision research and theory. This theme comprises of three subthemes including supervision research, translating science into practice and theories and models. Example extracts include “Knowledge of research and evaluation, including systematic identification, critical appraisal and application of relevant research evidence” and “Ability to link theory to practice, and relate practice to theory”.

**Learning**

The transfer of learning is one of the key functions of clinical supervision and this theme describes the various aspects of this component of supervision. This theme comprises of four subthemes, including identifying and applying appropriate supervision techniques, learning principles, assessing learning needs and providing formative feedback. While all documents made reference to elements of the learning theme, there were large discrepancies regarding the different elements that were focused on, and in the amount of focus given to this broad theme. Only one document highlighted modelling and rehearsing clinical skills or teaching and didactic skills, and only two documents made reference to assessing learning needs, learning principles or observing supervisee practice. The subtheme with the most consistency across the data set was the provision of feedback to supervisees. Example extracts include “An ability to apply the principles of adult learning, incorporating active learning and promoting supervisee’s reflection on their learning”, “An ability to set up and conduct exercises which allow the supervisee to practice/ rehearse implementing therapeutic procedures (e.g. exploring ways to phrase questions, implementing specific techniques etc.)”.

**Evaluation**

The evaluation theme describes issues relating to the assessment of supervisee competency and the management of competency issues in supervision. It comprises of two subthemes including assessing supervisee competency and managing competency issues/ gate keeping. Example extracts include “Ability to assess the psychological competencies of the supervisee” and “An ability to develop criteria for gauging competence”.

**Future research**

The next stage in the broader research project which this thematic analysis is part of entails delineating a list of competencies from the findings of the thematic analysis. The competencies will then be submitted to a panel of Australian experts in clinical supervision, as part of a Delphi Survey. The purpose of the Delphi Survey will be to examine the level of consensus that exists for the proposed competencies and to refine competencies based on feedback received. Gaining expert opinion about the proposed competencies will be particularly important for the components of competency in which there is currently limited consensus for. Additionally, obtaining consensus from Australian experts in clinical supervision establishes credibility for the proposed framework within the Australian context.

Any psychologists with expertise in clinical supervision, with an interest in participating in this study are encouraged to contact Kirsty Olds, email: kirsty.olds@my.jcu.edu.au, or Professor Russell Hawkins, russell.hawkins@jcu.edu.au
References


Challenges and responses to the changed rules for supervision in applied psychology

Russell Hawkins and Kirsty Olds


Abstract

The move to national registration of health practitioners in Australia (Health Practitioner Regulation National Law Act 2009) has resulted in new policies to guide supervision activities for psychologists. In 2010 the Psychology Board of Australia published a consultation paper "Guideline for Approved Training Programs in Psychology Supervision", followed in November 2011 by another consultation paper "Exposure Draft: Guideline for Supervisors and Supervisor Training Providers". Each document release was followed by a consultation period during which submissions from interested parties were received. In August 2012 a "Fact sheet for supervisors" document was published by the Board http://www.psychologyboard.gov.au/Registration/Supervision.aspx. Notably it described new requirements to take effect from July 1 2013.

As was acknowledge by many of the submissions to the consultative process renewed attention to supervision matters was generally welcomed. Nonetheless many specific concerns were raised by these submissions. It is not yet clear whether the concerns and various fears identified in the submissions will outweigh the potential gains of the revamped supervision policies. The paper will consider some of these issues.

Of particular concern is the commonly reported difficulty that finding good supervisors is already difficult and that the time and cost disincentives of supervision training may add to this difficulty. Many Australian universities have dropped postgraduate training programs in psychology in recent years; usually because of cost issues, thus increased costs for supervision will have a broad salience for the profession. This represents a particular challenge for people interested in the promotion of improved supervision standards and practices.

Complexity and speed of change

Psychology in Australia is a fast changing profession. Quite apart from mastering the applied skills of practice in psychology postgraduate students need to become familiar with various regulatory, registration, accreditation and professional agencies and their policies. Intending practitioners need to become aware of policies and processes promulgated by at least the following groups: the Australian Health Practitioner Regulation Agency (AHPRA); the Psychology Board of Australia (PBA); the Australian Psychology Accreditation Council (APAC); Health Workforce Australia (HWA); and the Australian Psychological Society (APS) and its Colleges (e.g., the College of Clinical Psychologists).

Data from the APS websites showed there to be 2,100 members of the College of Clinical Psychologists in 2008 and 4,212 in August of 2012. This doubling in numbers in just four years is attributable in large part to differential consultation reimbursements for clinical psychologists as compared to registered psychologists since the introduction of Medicare rebates for psychological services in 2006. Not all clinical psychologists are members of the Clinical College though and AHPRA data show that there were 5,134 endorsed clinical psychologists in Australia in June 2012 out of a total of 29,645 registered psychologists.

Some important changes affecting the profession of psychology in recent times include: the shift to national registration of health practitioners (Health Practitioner Regulation National Law Act 2009); the differential Medibank rebate system for differently qualified psychologists and the introduction of a system of endorsement as a particular type of psychologist (e.g., clinical, forensic, health, educational, etc.); requirements for continuing education to maintain registration and APS membership and the introduction of a National Psychology Examination for applicants seeking registration.
Changes for clinical supervision

Clinical supervision too has received attention as part of the shift from state based to national policies and regulation. In 2010 the Psychology Board of Australia published a consultation paper “Guideline for Approved Training Programs in Psychology Supervision”, followed in November 2011 by another consultation paper “Exposure Draft: Guideline for Supervisors and Supervisor Training Providers”. Each document release was followed by a consultation period during which submissions from interested parties were received. In August 2012 a “Fact sheet for supervisors” document was published by the Board http://www.psychologyboard.gov.au/Registration/Supervision.aspx. Notably it described new requirements to take effect from July 1 2013.

On April 30th 2013, in a media release following the consultation process, the PBA announced the new Guidelines for supervisors and supervision training providers. They cover standards for Board approved supervisor qualifications, Board approved supervisor competencies, and Board approved supervisor training.

The media announcement indicated that there were 6,700 Board approved psychology supervisors in Australia (approved under the “old” rules) and that “nearly one in four psychologists with general registration are Board-approved supervisors who are prepared to give back their expertise to training the next generation of practitioners” (PBA media release 30 April 2013).

The supervision rules apply to 5 different types of supervision.
Supervising as part of an accredited higher degree program
Supervising psychological practice in addition to a higher degree program
Supervising the 2+2 internship program
Supervising a one year practice program following a fifth year of training (5+1)
Supervising a registrar program leading to an area of practice endorsement

The supervision of students undertaking practica as part of professional training in psychology used to be managed by universities (who were, though, subject to APAC accreditation standards). This management included the capacity for universities to deem suitably experienced people to be suitable to be supervisors (actually practices varied by state according to different regulatory practices). In some states supervisor training to serve in this role was mandatory). Under the “new rules” to take effect from July 1st 2013, supervisors in university based programs must be approved by the Psychology Board of Australia, following approved forms of training.

Previously approved supervisors who apply to the Board before June 30 will be able to continue as supervisors and will have five years to complete new training requirements. Details on how to become a provider of Board approved supervisor training have just been released (May 23, 2013) http://www.psychologyboard.gov.au/News/2013-05-23-media-release.aspx

Whether sufficient existing supervisors will apply to the Board to be allowed to continue or whether universities will be able to identify sufficient numbers of new Board approved supervisors to supervise their students is an example of the challenges shortly to be faced. Anxiety is evident in various sectors as the implications of some of the new rules and polices become apparent. Psychologists generally applaud the improved recognition of the importance of good quality training for supervisors but many have serious concerns about the implementation of the new policies. Whether the newly released supervisor guidelines will satisfy the concerns raised during the consultation phase is not yet clear and this issue forms the basis for the current paper.

The PBA released a document Consultation Paper 12 - Exposure Draft - Guideline for Supervisors and Supervisor Training Providers on 3 November 2011 and closed responses on 27 January 2012. The present paper has considered the 35 responses independently to the PBA's own review.

Cost emerged as a key concern and many submissions noted that there was a risk that the cost to become a Board approved supervisor serves as disincentive and that many people may simply not be willing to undertake the process because of this. It was noted that universities already face budgetary constraints and may not be any more willing than individuals to accept the cost liability.

It was also suggested that should agencies be expected to incur supervision costs (e.g., by paying for their senior staff to be trained as supervisors) there would be a strong disincentive to employ psychologists compared with other disciplines.

Apart from financial costs there were concerns that the time involved and the assessment process meant that the supervision program was unduly onerous.

There were concerns that supervision training providers will be motivated by profits which will work against cost control. Conversely there was concern that low cost training might not do justice to the task.

There were some concerns too that recurrent training (every 5 years) would be required at all but opposing concerns that the proposed recurrent training was not sufficient.

There were concerns that the generic competencies for supervisors were not agreed and that it would therefore be premature to apply them. Related to this was the notion that the supervision research base was not adequate for policy to be based on it.

An additional concern was that the mooted competencies include some which relate more to registration eligibility than to skills in supervision.
There was resentment in some quarters that training requirements did not allow for recognition of prior learning and would thus alienate and discourage potential supervisors.

There was fear that “the mandating of expensive training of institution supervisors will result in many withdrawing their agreement with universities, drastically reducing the number of placements and supervisors available to the profession.”

It was noted that since supervisors are not paid by the university to supervise and do it as good will the cost imposition will reduce current offers of free supervision.

Some respondents reported existing difficulties finding appropriate supervisors and predicted that the guidelines would make this problem worse.

There were suggestions that even current free training for supervisors is undersubscribed. This may be indicative of attitudes towards the need for supervisor training help by the workforce.

Some responses were more focussed on details within the proposed training requirements such as the balance between the gate-keeping role and critical reflection and some found the guidelines unnecessary arguing that existing APAC guidelines were sufficient.

In summary the concerns of the submissions were very strong. They included broad based concerns focusing on the disincentive aspect of the guidelines in terms of costs or time. An illustrative response which highlights the significance of the concerns noted that “should the results of this initiative have the feared outcomes, the University may not be able to fulfil its obligations to currently enrolled students, and would have to restrict places drastically in the future”. Another respondent feared a resultant workforce reduction risk and thus negative consequences for the public.

The risk context for professional training in psychology

The future of professional training programs Australia is under threat and part of this threat is attributable to the cost burden of the high standards insisted on by the APAC accreditation processes.

Voudouris and Mrowinski (2010) highlighted the plight faced by postgraduate training program in Australia generally. They reported that there had been a net decrease of 49 professional psychology programs across Australia in five years even though 11 new degrees had commenced. This is likely an economic response by universities to the costs faced by postgraduate programs.

James Cook University recently closed down all of its postgraduate forensic psychology programs including MPsych (Forensic) and DPsych (Forensic) degrees. In spite of these programs attracting strong student demand and employer support they were deemed too expensive.

“The average shortfall in postgraduate professional programs funding reaching Schools and Departments was $619,197 per School per annum and the average shortfall in funding per EFTSL per year was $8,426” (Voudouris & Mrowinski, 2010, p. 22).

The cost burden is very much influenced by accreditation rules which, for example, prescribe a staff:student ratio of 1:8. This ratio is far lower than ratios typical of other university programs (e.g., in undergraduate psychology) and is thus seen by managers as expensive. Similarly the mandated ratio of supervision hours to student face to face clinical activity is also expensive in terms of staff time. APAC standards are under review and it is rumoured that some of the existing limits may be liberalised.

It is in this context of tight cost controls that the new supervision rules need to be examined. Broad based support exists for the philosophy of using well trained supervisors but finding ways to respond to the cost imposition of such quality based standards will be important.

Next steps

Voudouris & Mrowinski (2010) asserted that “the first task is to assist the Government and other planners to understand how urgent it is to address the funding shortfall in professional postgraduate training if decline is to be arrested” (p. 23). Advocates for the importance of good quality clinical supervision may need to become involved in the development of cost management strategies. Lobbying for supervision training budgets from Health Workforce Australia, the APS and other agencies may be needed.

Directors of Professional Training Programs in Psychology around the county and Directors of Psychology Clinics and Placement managers attached to professional programs, together with Heads of Departments of Psychology in Australian universities and other interested parties might collaborate to devise strategies to guard against the risks to training programs generally including ways to address the cost disincentives and other difficulties associated with the desirable move towards high standards in clinical supervision.

References


Education and training of counselling supervision within the Australian Qualification Framework (AQF) and the provision of ongoing supervisor support

Veronika Basa

Ref: Basa V. Education and training of counselling supervision within the Australian Qualification Framework (AQF) and the provision of ongoing supervisor support. Conference paper presentation: Advances in Clinical Supervision Conference, Sydney Australia, 4-6 June 2013.

Abstract

How supervision was researched, understood, presented and accredited as a nationally recognised qualification within the Australian Qualification Framework (AQF). How the course design is structured. How students acquire the theoretical knowledge and the practical skills to become effective supervisors. How the supervision process within this course can be contextualised to the fields of Psychology, Psychiatry, Counselling/Psychotherapy, Mental Health Nursing, Social Work, Hypnotherapy, or any other helping profession. How to promote excellence in education of counselling supervisors and emphasize the need for ongoing quality professional development and supervision of supervisors? This paper will consider the education and training of counselling supervisors within the (69795) Graduate Diploma in Counselling Supervision (AQF Level 8), and the International Society of Counselling and Clinical Supervisors (ISOCCS).

Overview

On the 18th of August 2004, I have received the ‘Certificate of Attainment’ from a 3-day Professional Supervision workshop, written by Philip Armstrong from Armstrong Counselling and Consultancy Services, CEO of ACA. This certificate enabled me to register as an ACA supervisor. While the workshop content was interesting content wise, outcome wise, I didn't really know where my boundaries were, I felt totally confused about what supervision is and I felt inadequate as a supervisor. I immediately realised that further studies will be required.

First, I did some research about other training opportunities in supervision. My findings indicated that: there were quite a few face-to-face workshops with very poor content or information about supervision models, evaluation, supervisor competence, etc., and that there was no training that ended up in a qualification.

Second, simultaneously, I was also researching supervision literature. My major findings showed that there were differences in the definitions of supervision due to individual’s/ author’s field of practice (different skills sets), but that there were also commonalities in generic tasks, skills and knowledge, supervision process.

At this point, I realized that a nationally accredited course was needed, in order to provide participants with: a range of knowledge, and skills to perform the functions associated with supervisor competence, and the education outcomes appropriate to a supervisor's job role. Additionally, I also needed to have some knowledge and skills to design, develop and accredit a training program and as a result, on the 29th of November 2004, I obtained the Certificate IV in Assessment and Workplace Training BSZ40198. Simultaneously, I was also piloting the tried model with members of the Federation of Victorian Counsellors, and was engaged in further literature research to gain more knowledge in supervisor competencies.

Two years in supervision literature research I further realized that I needed more knowledge and skills to design, develop and accredit a training program in supervision, and consequently I attended a Vet Course Design and Development Program at Victoria University (May-December 2006). During this course I learnt the five stages involved in gaining course accreditation:

Stage 1—Preliminary research and consultation and intention to accredit
Stage 2—Course development
Stage 3—Course design and preparation of the course accreditation submission
Stage 4—Assessment (accreditation authorities)
Stage 5—Decision (accreditation authorities)

The supervision training program started to develop as part of this training.

Stage 1—Preliminary Research and Consultation

My objectives were:
- To establish the need for a supervision course,
- To engage with stakeholders who have an interest in the supervision course,
- To ensure the intended supervision course will not
duplicate the coverage of an endorsed training package qualification,
- To Research the supervision market.

As a result, identified the Stakeholders as being: the Australian Counselling Association (ACA), ACA members and registered supervisors, and the Community Services and Health Industry Skills Council.

I then, consulted and engaged with the stakeholders via Surveys. At the end 2006, ACA, participants of professional supervision workshops and registered ACA supervisors were surveyed on topics below, to:
- Establish the need and support for the course concept,
- Identify supervisor's competencies in broad terms, including the intended knowledge, skills and attributes and course outcomes, required by the industry, and the training and assessment structures and pathways,
- Establish the course content and its appropriateness to supervisor's job role,
- Statutory, licensing or regulatory requirements, etc.

As my next step, I researched Nationally Endorsed Training in supervision within AQF (2000-qualifications of 80 endorsed training packages over 30 industry areas), to ensure the intended supervision course will not duplicate the coverage of an endorsed training package qualification. I then:
- Established if units of competency in supervision already exist,
- Explored the flexibility provided by the packaging rules, in particularly: 1) the flexibility of units of competency from other training packages (core, electives), and 2) the flexibility available through the contextualising of units of competency to meet the specific training needs of supervisors without requiring a new course to be developed for accreditation.

Further, I researched the market to establish the feasibility of the supervision course, including the possible extent of market demand and the potential size of the employment market for graduates of the intended supervision course.

Stage 1.1–Intention to Accredit a Course

An application for intention to accredit a supervision course was submitted to the Tasmanian Qualification Authorities (TQA), together with evidence that:
- I identified, in consultation with stakeholders, that there was a need for a supervision course. This was supported with a support and confirmation letter from ACA (course needed to establish a college of supervisors), and support letters from ACA members and registered supervisors, and that
- The intended supervision course will not duplicate the coverage of an endorsed training package qualification. This was supported with a conformation letter from the Community Services and Health Industry Skills Council.

Permission was given to go ahead with the design and development of the counselling supervision course.

Stage 2–Course Development

During this stage, my objectives were:
- To ensure the industry and all relevant stakeholders were fully engaged in the development and the design of the supervision course and that consultation is ongoing throughout the development stage.
- To validate the intended skills and knowledge outcome of the course and the training and assessment structures and pathways.

Using literature results, data from consultation with ACA, and survey results from ACA members and registered supervisors, I then:
- Identified the supervisor's competencies (knowledge, skills and attributes),
- Chose the content of supervision,
- Chose the units of competency which roughly reflected supervisor competencies and the content of supervision.

This involved: 1. mapping supervisor's competencies against existing relevant units of competency standards, 2. mapping key competencies/employability skills, and 3. mapping units of competencies against AQF levels. This turned out to be level-4,
- Decided on packaging rules: total number of units, core units + elective units and the Training Package/s:

\[
\text{Refer: Table 1: Packaging Rules}
\]
- Contextualised/benchmarked the elements and the performance criteria of each units of competency/employability skills to suit the chosen topics of supervision and to reflect the dimensions of competency of a supervisor in the workplace as identified by literature and the stakeholders.

Stage 3–Course Design and Preparation of the Course Accreditation Submission

I designed the course and prepared the documentation for course accreditation submission using the template called 'the course document' - the legally recognised specification for the course and provides the basis for development of strategies for training and assessment by each RTO.

The course document is in 3-sections: Sections A, B, and C.

Section A: Copyright and Course Classification Information - (accreditation or renewal of accreditation).

Section B: Course Information – I gave details of the industry need, course structure, and the rules under which the course may be accessed, delivered and assessed, and monitored/evaluated for ongoing improvement.

Evidence included were: support, acceptance, and
Table 1: Packaging Rules (13-Units)
Total Units 12 = 11-Core Units + 1-Elective Unit

<table>
<thead>
<tr>
<th>Units Sourced From:</th>
<th>PSP04: Public Sector Training Package</th>
<th>TAA04: Training and Assessment Training Package</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CHC02: Community Services Training Package</td>
<td>PRS03: Asset Security Training Package</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit Code</th>
<th>Unit Name</th>
<th>Core (C) OR Elective (E)</th>
<th>Nominal Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSPGOV414A</td>
<td>Provide workplace mentoring</td>
<td>C</td>
<td>40</td>
</tr>
<tr>
<td>PSPGOV415A</td>
<td>Provide workplace coaching</td>
<td>C</td>
<td>40</td>
</tr>
<tr>
<td>TAADEL403A</td>
<td>Facilitate individual learning</td>
<td>C</td>
<td>15</td>
</tr>
<tr>
<td>TAADEL402A</td>
<td>Facilitate group based learning</td>
<td>C</td>
<td>20</td>
</tr>
<tr>
<td>PSPGOV406B</td>
<td>Gather and analyse information</td>
<td>C</td>
<td>30</td>
</tr>
<tr>
<td>CHCCOM3C</td>
<td>Utilise specialist communication skills to build strong relationships</td>
<td>C</td>
<td>50</td>
</tr>
<tr>
<td>CHCCS301A</td>
<td>Work within a legal and ethical framework</td>
<td>C</td>
<td>50</td>
</tr>
<tr>
<td>PSPGOV411A</td>
<td>Deal with conflict</td>
<td>C</td>
<td>30</td>
</tr>
<tr>
<td>TAAENV403A</td>
<td>Ensure a healthy and safe working environment</td>
<td>C</td>
<td>10</td>
</tr>
<tr>
<td>TAAENV501A</td>
<td>Maintain and enhance professional practice</td>
<td>C</td>
<td>40</td>
</tr>
<tr>
<td>CHCADMIN2B</td>
<td>Provide administrative support</td>
<td>C</td>
<td>20</td>
</tr>
<tr>
<td>TAADEL404A</td>
<td>Facilitate work based learning</td>
<td>E</td>
<td>15</td>
</tr>
<tr>
<td>PRSSM402A</td>
<td>Implement effective communication techniques</td>
<td>E</td>
<td>20</td>
</tr>
<tr>
<td>CHCCS405A</td>
<td>Work effectively with culturally diverse clients and co-workers</td>
<td>E</td>
<td>30</td>
</tr>
</tbody>
</table>

Nominal hours for core units = 345hrs. Nominal hours for full qualification = 360 or 365 or 375 hrs, depending on the Elective Units you choose.

recommendation letters from ACA, its members, and registered supervisors; and data collected from validation processes of skills and knowledge outcomes of the course, the course structure, and delivery and the assessment strategy.

Section C: Units of Competency—contained in the course.

Stage 4—Assessment

The accreditation authorities, during this stage, asked for some alterations of the course title: professional/clinical/counselling supervision. At this stage, as the course outcomes were aligned to AQF level 4, the Community Services and Health Industry Skills Council rejected it as they disputed the supervisor's competency being level 4 only.

Stage 5—Decision

In June 2007 however, the Tasmanian Qualification Authorities (TQA) considered the application for accreditation and its decision was to approve the accreditation for 3-years at AQF Level 4: 'Certificate IV in Counselling Supervision (national code 69828)', and got listed on the National Training Information Service (NTIS).

The course was delivered/piloted for 1 and ½ years. The evaluation of the course was in accordance with the Australian Qualification Training Framework AQTF. ACA and the students (from: ACA, FVC, PACFA, CAPAV, APS, and PCA Tasmania), were involved in the evaluation and validation processes of the:

- Industry need for the course,
- Choices of Units,
- Course structure,
- Unit/course content (part of the content was piloted for a year prior to accreditation with FVC members),
- Literature research,
- Unit/s contextualisation,
- Unit/course competency levels and outcomes,
- Unit/course Employability skills levels and outcomes,
- Dimensions of competency,
- Training and assessment strategy for this qualification.
Early 2010 – Preparation for Re-accreditation

Stage 1 – Preliminary Research and Consultation (for renewal of accreditation)

My objectives were:
- To establish if the need for the course was still there,
- To stay engaged with the same stakeholders (ACA, graduates and students of the (69828) Certificate IV In Counselling Supervision),
- To ensure the intended course will not duplicate the coverage of an endorsed training package qualification – engaging with the Community Services and Health Industry Skills Council.

Stage 1.1 – Intention to Re-Accredit a Course

An application for intention to re-accredit the (69828) Certificate IV In Counselling Supervision course was submitted to the Tasmanian Qualification Authorities (TQA), together with evidence that:
- It was identified, in consultation with stakeholders, that the need for the supervision course was still there (confirmation letter from ACA - this course was needed to form a college of supervisors, and support letters from graduates and students of the (69828) Cert IV In Counselling Supervision (members of ACA FVC, PACFA, CAPAV, APS, and PCA Tasmania), and that
- It was identified, in consultation with the Community Services and Health Industry Skills Council, that the intended supervision course will not duplicate the coverage of an endorsed training package qualification (conformation letter from the Community Services and Health Industry Skills Council). Permission was given to go ahead with the re-accreditation.

Stage 2 – Course Development for Renewal of Accreditation

Re-accreditation of a course involved evaluating the existing course and identifying any need for any change. The consultation involved: ACA, graduates and students of the (69828) Certificate IV in Counselling Supervision (members of ACA FVC, PACFA, CAPAV, APS, and PCA Tasmania), data available from monitoring and maintenance of the existing course, and for continuous improvement of training and assessment.

Relevant data was collected from:
- Learners and graduates questionnaire,
- Complaints,
- Annual course review validation survey of learning delivery and assessment strategies, and course content by course participants and the Australian Counselling Association (ACA),
- Moderation/validation of the assessment decisions in conjunction with the RTO.

Significant changes to the course resulted from course monitoring and evaluation procedures were:
- Repetitive content,
- Course outcome should be higher than AQF level 4.

Using results from literature and consultation with stakeholders, there was a need:
- To prevent repetition of content - reduced the number of Units of competency,
- To re-validate the supervisor’s competencies in terms of knowledge, skills and attributes with new units,
- To re-validate the content of supervision with new units,
- To choose the units of competency / employability skills which would roughly reflect supervisor competencies and the content of supervision researched from literature and the data from stakeholders consultation
  ◊ Mapping of supervisor’s competencies against existing relevant unit competency standards,
  ◊ Mapping of key competencies/ employability skills,
  ◊ Mapping units of competencies against the AQF levels (5, 6, 7, and 8).
- To decide on packaging rules: total number of units, core units + elective units and the Training Packages Refer Table 2: How the Course Design is Structured and Table 3: Delivery and Assessment.

Course Content – Major Topics

- Working within a counselling supervision framework,
- Metaphors and definitions
- Goals of supervision
- Processes and task of supervision
- Roles and responsibilities
- Dimensions of supervision
- Phases of counselling supervision
- Developmental stages
- Supervision models:
  ◊ Psychotherapy Theory Base Supervision,
    - Psychoanalytic/psychodynamic supervision,
    - Person-centered supervision,
    - Cognitive - Behavioral supervision,
    - Narrative approaches to supervision,
    - Solution-focused supervision
  ◊ Functions Model:
    - Kadushin, (1992),
    - Inskipp and Proctor, (1993) Supervision Alliance Model,
    - Hawkins and Shohet, 2007 function model;
  ◊ Developmental Models of Supervision:
    - Littrell, Lee-Borden, & Lorenz Model (1979),
    - Integrated Developmental Model IDM (Stoltenberg and Delworth 1987),
    - The Skovholt and Ronnestad Model (1992),
  ◊ Social Role Supervision Models:
    - The Discrimination Model (Bernard 1979),
    - System Approach Supervision Model (SAS)/ Holloway Model (Holloway 1995, 1996),
    - The seven-eyed/double matrix supervision model.
  ◊ Eclectic & Integrationist Models.
- Models for supervisor development
Table 2: How the Course Design is Structured

<table>
<thead>
<tr>
<th>Packaging Rules</th>
<th>Total Units = 3 - Core Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Units Sourced From:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PSP04: Public Sector Training Package</td>
</tr>
<tr>
<td></td>
<td>CHC08: Community Services Training Package</td>
</tr>
<tr>
<td>Units of Competence/Employability skills</td>
<td>Core (C)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Unit Code - Unit Name</td>
<td>Benchmarks</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>PSPGOV414A - Provide workplace mentoring</td>
<td>Individual Counselling Supervision (with a qualified counsellor)</td>
</tr>
<tr>
<td>PSPGOV415A - Provide workplace coaching</td>
<td>Live counselling supervision (with a novice)</td>
</tr>
<tr>
<td>CHCGROUP806B - Plan group interventions</td>
<td>Group Counselling Supervision</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
</tr>
</tbody>
</table>

Table 3: Delivery and Assessment

<table>
<thead>
<tr>
<th>Classes</th>
<th>Face-to-face</th>
<th>Skype</th>
<th>36-hrs /6-days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tutorials</td>
<td>Face-to-face</td>
<td>Skype</td>
<td>6-hrs/ 3 X 2hrs</td>
</tr>
<tr>
<td>Workplace visits</td>
<td>Face-to-face</td>
<td>Skype</td>
<td>6-hrs/ 3 X 2hrs</td>
</tr>
<tr>
<td>Practicum</td>
<td>Face-to-face</td>
<td>Skype</td>
<td>Video of performance</td>
</tr>
<tr>
<td>Independent studies</td>
<td>364-hrs/ 12-hrs a week</td>
<td>424/ 36-weeks</td>
<td></td>
</tr>
</tbody>
</table>

- Supervision interventions (Individual, Live, and Group supervision);
- Ethical and legal issues and response frameworks
- Supervision relationship issues and response frameworks
- Initial criteria for choosing an intervention within a group setting
- Group management frameworks: (leadership flexibility, style/type, interventions)
- Supervisor general roles and responsibilities in group settings
- Transference and Countertransference
- Parallel processes
- Defense mechanisms
- Intra-psycho and interpersonal learning
- Cognitive learning
- Evaluation/revision techniques
- Ways to apply interactive technologies
- Common supervisor mistakes
- Supervision tools/instruments

- Simulated workplace:
  - Classes (face-to-face or virtual class via Skype),
  - Distance,
  - Recognition of Prior Learning (RPL),
  - Combination of all of the above.

**Flexible Assessment**

- Workplace,
- Simulated Workplace,
  - Classes and practicum - (face-to-face or virtual via Skype),
  - Distance and Practicum - (virtual via Skype / video performance),
- Recognition of Prior Learning (RPL),
- Combination of all of the above.

**Assessment Process**

The assessment strategies and procedures for accredited training outcomes comply with the relevant training package requirements, Australian Quality Training Framework (AQTF), the industry requirements, and this accredited course/qualification outcomes.

The assessment is competency based with a focus on the gathering and judging of evidence in order to decide if the student has achieved the required competence to meet the standards for each unit of competence/
employability skills. The focus is on the application of the knowledge and skill to the standard of performance required by the industry.

The assessment tools assess both, the theoretical component and the practical component of various different elements of counselling supervision sessions in a workplace/simulated training environment.

Assessment consists of:

- **Independent studies** (workplace/simulated workplace) – are designed to enhance students' understanding and knowledge in supervision and cognitive, problem-solving, and research skills, as well as skills in reflective practice and self-reflection through:
  - **Projects:** (research, reflective journal, self-critique of a counselling supervision session).
  - **Case Studies and Scenarios** as a basis for discussion of issues and strategies to contribute to best practice to assess cognitive, analytical and problem-solving skills to relate theoretical concepts to practical real-life situations of ethical issues and dilemmas in particular organisations or educational institutions.
  - **Practicum** – practice of skills application in the workplace/simulated workplace in a range of 3 or more occasions over time to ensure consistency.
  - **Portfolios** (learning and/or RPL) a formal or informal collection of student work completed over a period of time.
  - **Authenticated evidence** from workplace/training courses.
  - **Questioning** (verbal) to assess understanding, knowledge and skills where there is a need to find out about learning which has not been directly observed/demonstrated, what did not happen, seeking an explanation for particular practices, checking understanding of underlying principles, challenging practice, or other aspects of supervision.

The theoretical and the practical components are integral part of the course curriculum and must be completed to achieve competency in both workplace and simulated workplace.

**Educational outcomes of the course**

Graduates at this level have:

- Advanced specialised technical and theoretical knowledge and skills for professional or highly skilled supervision work (counselling/clinical) in a complex and specialised field of counselling/clinical supervision (counselling/clinical), and further learning.

- Specialised cognitive, technical and communication skills to select and apply methods and technologies to:
  - Critically evaluate and transform supervision (counselling/clinical) related information to complete a range of supervisory tasks and activities.
  - Analyse, generate and transmit new understanding and solutions to complex unpredictable issues within the supervision context (counselling/clinical).

- Transmit knowledge and ideas to supervisees within individual, live and group formats in contextual development, conceptual development, and counselling independence; and organisation in developing policies for the provision of supervision program (counselling/clinical).

Autonomy, judgment and responsibility in often complex and unpredictable supervision context (counselling/clinical) that require self-directed work and learning and within broad parameters to provide professional advice and functions.

**Course outcomes and Qualification level**  
**(consistent with AQF level 8)**

Graduates of this qualification will:

- Be able to apply a body of knowledge and a broad range of skills: in a range of specialized professional and highly skilled supervision context (counselling/clinical) as they relate to individual and/or group supervision (counselling/clinical) both with novice and qualified counsellors, and as a pathway for further learning.

- Have a broad and highly specialised skills and theoretical knowledge within the supervision context (counselling/clinical) that are built on prior counselling knowledge and skills.

- Have cognitive skills to critically review, analyse, consolidate and synthesise knowledge gained through thematic and reflective dialogues with counsellors and other stakeholders and identify and formulate response frameworks/solutions to a broad range of complex supervisory relationship and ethical and legal issues within the supervision framework (counselling/clinical).

- Have cognitive and communication skills to generate and evaluate complex ideas relating to ethical and legal counselling and supervision practices (counselling/clinical) demonstrating and understanding of counselling supervision skills, theoretical concepts, and interventions using intellectual independence.

- Have specialised technical and creative skills in reflective practice, problem solving, visualising, thinking laterally, mind mapping to create new understanding in a field of highly skilled and professional practice of supervision (counselling/clinical).

- Have communication skills to present knowledge and ideas to: supervisee and a range of other stakeholders such as organisation, educational institution, professional bodies, etc.

- Be able to make high level, independent ethical judgments/decisions in a range of complex ethical and legal issues within the supervision framework (counselling/clinical).

- Be able to initiate, plan implement, and evaluate a broad range of complex supervisory interventions to protect the welfare of clients, supervisees, own and organisation, within a range of varied specialised skills and creative context of supervision (counselling/clinical).
• Be able to demonstrate:
  ◊ Full responsibility and accountability for personal outputs for ethical decision making and executing judgements;
  ◊ Full responsibility and accountability for all aspects of supervisee's performance and counselling outcomes in individual counselling supervision;
  ◊ Full responsibility and accountability for group counselling supervision outcomes of authoritative, participative and co-operative styles/types, within broad parameters;
  ◊ Partial responsibility and accountability for peer group supervision types/styles outcomes, within broad parameters.

How the Course Design Can Be Contextualised to the Fields of Psychology, Psychiatry, Counselling/Psychotherapy, Mental Health Nursing, Social Work, Hypnotherapy, or any other helping profession

Using the flexibility provided by the Packaging Rules - in particular:
• Flexibility available through the contextualising of units of competency to meet the specific training needs of supervisors without requiring a new course to be developed for accreditation – the same Units of competency can be used due to generic skills.
• Contextualising/benchmarking of the elements and the performance criteria of each units of competency/employability skills to suit the chosen topics of supervision and to reflect the dimensions of competency of a supervisor in the workplace (contextualising to specific skills/skills of the field of practice).

Thus, the course can be varied to reflect the needs of learner groups with clinical skills through: the contextualisation of unit elements that involve the educative component/task of counselling supervision from counselling skills to clinical skills. Refer Table 4: Example - Tasks of Supervision

How to Promote Excellence in Education of Counselling and Clinical Supervisors and Emphasise the need For Ongoing Quality Professional Development and Supervision of Supervisors

The International Society of Counselling and Clinical Supervisors (ISOCCS) represents a membership of qualified counselling and clinical supervisors, student counselling and clinical supervisors, their educators, and anyone who contributes in some way to the counselling and clinical supervision field; and plays a crucial role in advocating and advancing the counselling and clinical supervision profession.

The society was founded to promote excellence in education of counselling and clinical supervisors in Australia and internationally and to emphasise the need for ongoing quality professional development and supervision of counselling and clinical supervisors, in all work settings to protect the client welfare. General membership is based on Australian AQF levels of qualifications, at minimum Level 8. BECS students of the (69795) Graduate Diploma of Counselling Supervision, automatically become members of the society.

The Code of Ethics
The code of ethics is an initial guideline for counselling and clinical supervisors to aid them in their supervision practice and shall be formally reviewed every year in collaboration with the heads of counselling industry, their members, and by peer supervisors.

The Standards
These standards for counselling and clinical supervisors are about areas that characterise an effective supervisor in terms of skills and knowledge, competencies, and personal traits, as they have been consistently identified in supervision research and literature. They are initial standards that will be regularly reviewed, on an annual basis, by the peak professional bodies in the counselling industry in Australia and peer supervisors.

<table>
<thead>
<tr>
<th>Table 4: Example–Tasks of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Developmental-Formative-Educational tasks can be contextualised to the field of practice</td>
</tr>
<tr>
<td>Developmental</td>
</tr>
<tr>
<td>Resourcing</td>
</tr>
<tr>
<td>Qualitative</td>
</tr>
<tr>
<td>Holloway (1992) and Lanning (1986)</td>
</tr>
<tr>
<td>Evaluative</td>
</tr>
<tr>
<td>Bernard and Goodyear 1998</td>
</tr>
<tr>
<td>Evaluative</td>
</tr>
</tbody>
</table>

Advances in Clinical Supervision Monograph, NSW Institute of Psychiatry, 2013
Some of the benefits of being a member:

- Monthly opportunities for networking
- Conferences and seminars
- Professional development workshops
- Newsletters,
- Website.
- Email interchange to facilitate communication.

Through the accreditation process, professional development activities, and consultations with the counselling industry, ISOCCS strives to continue to improve education, credentialing and supervision of counselling supervisors.

ISOCCS also strives to encourage publications on current issues, relevant research, proven practices, ethical standards and conversations on related counselling supervision issues. People engaged in the academic preparation of counselling supervisors will find leadership through ISOCCS.

**Education and Training of Counselling Supervision**

**Supervision within the Australian Qualification Framework (AQF) and the Provision of Ongoing Supervisor Support**

**Summary**

While supervision has not been researched, understood and presented on training courses adequately (Feltham and Dryden 1994, 2004; Bernard and Goodyear 1996), supervision workshops/courses have increased both in number and length. A number of professional bodies have been established for supervisors, and supervision has become a profession in its own right (Hawkins and Shohet 2006).

The design and structure of the (69795) Graduate Diploma of Counselling Supervision, a nationally accredited course within the Australian Qualification Framework (AQF), embraces a generic approach to the supervisor’s knowledge, key competencies/employability skills, and attributes as described in supervision literature.

Due to one of the flexibilities available through contextualising of units of competency (elements and performance criteria) the specific training needs of supervisors from different schools of thoughts across the health sector can easily be contextualised to their own specific knowledge, competencies and attributes in consultation with appropriate stakeholders.

The International Society of Counselling and Clinical Supervisors (ISOCCS) plays a crucial role in advocating and advancing the counselling supervision profession across the health sector by emphasising the need for quality education, ongoing professional development, and supervision of supervisors in all work settings.

Ultimately however, the level of professional maturity of the health/(allied health) industry will be the true measure of the implementation of these standards.

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Stoltenberg C.D., Mcneill B. and Delworth U. IDM supervision: an integrated developmental model for supervising counselors and therapists, 1998

Users' guide to the standards for VET accredited courses 2011

National register of nationally endorsed training package qualifications, units of competency and accredited courses - training.gov.au

National industry skills councils - www.isc.org.au

State or national regulatory and/or licensing bodies applicable to the industry


Data elements and classification codes for AVETMISS data - www.ncver.edu.au

AQF first edition, July 2011 - www.aqf.edu.au

Training package development handbook: coding and titling of units of competency; coding and titling of training packages; coding and titling for qualifications - www.deewr.gov.au

Information on the 'free for education licence' - www.aesharenet.com.au
Introducing clinical supervision in an acute mental health setting

Terence Froggatt and Julie Duncan


Abstract

Clinical supervision (CS) may be loosely defined as an exchange between practising professionals to enable the development of professional skills (Butterworth & Faugier 1992). Proctor (1986) suggested that it has three main functions: to enhance professional accountability (normative), to increase skills and knowledge (formative), and to facilitate collegial and supportive relationships (restorative). Recent reviews confirm that CS can realise these functions (Brunero & Stein-Parbury 2008; Butterworth et al. 2008). CS has also been associated with reductions in staff burnout (Edwards et al. 2006), increased job satisfaction (Hyrkäs et al. 2005) and the improved mental health of nurses.

Clinical supervision in mental health nursing is commonly perceived as a good thing (Mullarkey et al. 2001); however the empirical evidence supporting this claim is limited. Empirical research studies of clinical supervision in mental health nursing are inconclusive when it comes to identifying the most critical factors in the successful implementation of clinical supervision in this area.

This paper discusses the introduction of clinical supervision in an acute inpatient setting in Sydney Australia. The most critical factors concerning the introduction of clinical supervision are identified and discussed in detail. The discussion incorporates the perspectives of mental health nurse supervisee's, clinical supervisors and managers on clinical supervision.

The perspectives of the supervisees, supervisors and managers provide a comprehensive account of the critical factors that facilitate effective and sustainable clinical supervision in an acute mental health setting. These factors include: how supervision is organised; the level of expertise and experience of the clinical supervisor; formal documentation of an agreement; consistent and planned sessions; the place that supervision occurs; small group or individual arrangements; record keeping and the management of privacy, confidentiality and potential of conflict of interest.

The paper argues that when these critical factors are managed well, then clinical supervision provides the opportunity for the supervisee and clinical supervisor to reflect on: issues associated with practice; developing new insights and perspectives; improving knowledge, skills and competence; enhancing the support for staff while improving consumer care and carer outcome and professional accountability and autonomy.

Mental health nursing is experiencing major challenges at this time, for example; the rise of the consumer and carer voice, the pressures to reduce or eliminate out dated models of practice and the ever increasing demand for evidence based best practice. These major reforms are akin to a paradigm shift as profound as the de-institutionalisation reforms of the late sixties and seventies.

De-institutionalisation did not take much account of the views expressed by mental health nurses and as a consequence was probably more problematic than it needed to be. Mental health nurses have a major role to play in the new paradigm of person-centred approaches, collaboration and recovery. To be proactive, mental health nurses require the professional support offered by effective clinical supervision. This paper demonstrates a successful introduction of a clinical supervision in an Acute Mental Health Setting from the perspectives of supervisees, clinical supervisors and managers.
Introduction

This paper discusses the introduction of clinical supervision for mental health nurses in an acute mental health setting in Sydney Australia. The most critical factors concerning the introduction of clinical supervision are identified and discussed in detail. The discussion incorporates the perspectives of mental health nurse supervisees, clinical supervisors and managers on clinical supervision.

Recent reports have indicated that mental health staff have added stress, which arose from poor working conditions, heavy workloads, and lack of resources, within a culture in which there was a large degree of burnout, low morale, and lack of job satisfaction, poor status, insensitivity and indifference (White and Roche 2006). This is particularly so for mental health nurses, who create the ambience in clinical settings (White and Roche 2006). Research has shown clinical supervision to be efficacious in respect of many of these issues (Cassedy 2010; Lynch et al 2008). Although it is acknowledged that a central challenge for empirical research of clinical supervision is how to measure its effectiveness. This paper focuses upon the pragmatic operational aspect of implementing clinical supervision in a dynamic clinical setting.

Implementing Clinical Supervision in Mental Health Nursing

Cross sectional survey studies of mental health nurses in Denmark participation in clinical supervision indicate that 33-81% (median 73%) of the survey’s respondents participated in clinical supervision (Buus and Gonge 2009). There is a general view that rates of participation in Australia are much lower. Implementing clinical supervision in the mental health nursing setting has proven to be problematic.

Qualitative research in mental health settings has identified difficulties and benefits related to nurses’ participation in clinical supervision (Buus, Angel, Traynor and Gonge 2010b). A number of studies have indicated that clinical supervision is problematic due to timing, incorrect focus and that it was not needed.

Benefits of clinical supervision are recorded as being; time for reflection, confirmation of thoughts and feelings, new perspectives and an increased sense of collaboration enabled then to related better to patients.

Critical factors which influenced the implementation of clinical supervision in an acute mental health setting

The first step towards implementing a program of clinical supervision involved a four hour workshop to review the current situation and identify innovative and contemporary ways of providing clinical supervision. The workshop began by asking the participants what they felt was currently working and not working in the provision of clinical supervision.

What worked?

From the workshop, supervisees attending had the same vision about why they believed that supervision was failing; the supervisees also had the same vision about how supervision should be conducted.

A review of the factors that have been impacting on the implementation of the supervision groups was assessed, and issues that are related to group supervision were discussed.

The purpose and focus of the sessions

Common themes that were identified were; how clinical supervision was going to be valued amongst staff and that the supervisors had acknowledged that this must be delivered in the launch presentation.

The aim of the a launch presentation was to enhance the value of the quarantined time to reflect about practice and to appreciate the importance of clinical supervision to effective mental health nursing

This required a review of the current structure of the group approach, determining the barriers and overcoming them.

What is not working?

The current program of clinical supervision offered to the nurses involved open groups. An open group is defined as: an impromptu meeting held on the basis of who is available at the time, the supervisor may be any one of a number of senior staff. This type of clinical supervision had been offered for a few years. Attendance was usually low and it was felt that it was extremely difficult to develop trust in an open group situation.

Roster practice

Staff need to take carriage of requesting supervision on their roster requests. Staff were attending these groups due to the capture of the cross over shift time. There is was still no request allocation on the roster for the shift, to attend supervision for both inpatient units.

Groups that have had transitional nurses allocated which meant a change in attendees, due to the nurses either leaving or moving to another hospital ward in their rotation. Depending upon numbers a review will need to take place on placing transitional nurses in a current clinical supervision groups.

An alternative option would be to provide transitional nurses with their own supervision group, the negative of this being the valuable experience of nursing staff that have been in the mental health area for several years.

Another issue that has been raised is that of transitional nurses on rotation, wishing to stay in their clinical supervision group when they leave mental health area of the hospital.
The suggestion was that they could stay in their current group even though they are not in mental health setting. This raised further issues, for example if transitional nurses on rotation remained in groups there may be a lack of accommodation in the groups for new mental health staff. This issue will be reviewed at the six monthly reviews.

**Moving Forward**

A working party has been developed to review how the group would implement clinical supervision for the mental nurses currently working in this in patient setting.

The working party developed a questionnaire for the mental health nurses to complete concerning clinical supervision. The questionnaire consisted of the following questions:

1. How would you rate your knowledge of clinical supervision?
2. Have you attended clinical supervision in the past 12 months?

If the answer was yes for Question 2 staff were to continue to respond to the question:

3. How would you rate your experience of clinical supervision in the past twelve months? (excellent, good, poor, don’t know) required to circle.

Results of the 12 surveys that were completed:

**Question 1**
- 2 stated that they had excellent knowledge of clinical supervision.
- 8 stated that they had good knowledge
- 1 stated they had poor knowledge
- 1 stated that they didn’t know

**Question 2**
- 4 indicated that they had attended supervision in the past 12 months
- 8 indicted that they had not attended supervision in the past 12 months.

**Question 3 (if yes to question 2)**
- 1 response rating their supervision was excellent
- 4 responses were good
- 1 response was poor
- 2 responses were don’t know
- 4 nil response

Overall the responses to the questionnaires to Question 1 demonstrated that majority of staff had a basic understanding of what clinical supervision was. It was also evident that these staff had been in the workplace significantly longer that other staff, so they had had exposure to supervision and the concepts.

The majority of staff that had attended the launch had been attached to inpatient facilities, this maybe a result in the numbers impacting on the lack of attendance.

The staff that had stated they had attended clinical supervision were community staff, which it may be considered to be easier to obtain the time to attend supervision or could be believed that they found the time to attend a forum to obtain support (i.e. clinical decision making in the community). Reviewing the responses to finding the clinical supervision experience beneficial, majority of the surveys demonstrated this.

**Next steps**

The working party decided to hold the launch in our nurse’s forum. A PowerPoint presentation was developed. The launch provided an opportunity to provide staff with knowledge about supervision, benefits. It also outlined what supervision was not. Benefits of supervision were outlined from the perspective of CPD points, quarantined time away from the workplace, forum for staff to discuss relevant issues. Nursing clinical supervision packs were also developed for the forum, and to be given to staff when joining a supervision group.

Packs included:

- Sign off sheet for supervisees to prove attendance. (For CPD) points.
- Local TSH briefing on Supervision for Mental Health nurses.
- Clinical Supervision Background paper from the Australian College of Mental Health nurses.
- South Eastern Area Policy Clinical Supervision.
- CPD Activity/Learning Outcomes sheet.

**Implementation Strategies**

Supervisor group lists were developed for the four groups. Two supervisors were allocated per group. There were four groups in total. Group numbers varied, for 3 of the groups they consisted of 8 staff members. These groups were held on a Wednesdays, Thursday. 2 groups are run on different weeks) 1 group consisted of 3 staff members (Tuesday Group)

Dates, days and times were provided of all the groups. The mental health nurses were required to indicate 2 preferences to join a group.

The mental health nurses were able to submit their preference list. For mental health nurses that were unable to attend the forum, supervision lists were forwarded. Supervision lists were circulated to all managers to put up in their areas.

It was also discussed at managers’ meetings how we could launch the new program and obtain the managers support to release staff to attend clinical supervision on a regular basis.

Allocation lists were developed from the staff’s supervision preference requests. Clinical Supervisors were provided with their group lists, and expected to email their group with the venue for their group meeting.
Group Clinical Supervision Meetings

Initial supervision groups discussed house-keeping rules. Rules were agreed around closed groups and issues of privacy and confidentiality. The discussion that groups had around privacy initially, allowed the group supervisees a "Safe Space" to reflect upon clinical matters. Supervisors have noted that the supervisees in the groups have started to disclose more about their practice and opinions.

Venues were also reviewed so that there were no interruptions from; phone calls, alarms or other distractions were to occur, ensuring that the time was properly sanctioned. Mobile phones, pagers were to be switched off. The areas that clinicians were based were informed of this protocol.

Supervisors have continued to meet bi-monthly. Supervisors have noted that staff that are unable to attend have been sending apologies prior to the group being held.

Topics that have been raised at clinical supervision in the various groups have discussed the following topics:
Stress and its relation to staffing levels and skill mix.

How to manage the death of a patient

How to manage clients of the service when they are known to you personally
Career development
Prevention of “burnout”
Staff as a group have worked through the above issues in a problem solving manner, not just providing problems and wanting them solved by the supervisors.
Supervisors have also noted that the groups have become more cohesive as a group, and have the ability to discuss sensitive issues.

Current Situation

Supervisors have continued to meet bi monthly. Supervisors have noted that staff unable to attend have been sending apologies prior to the group if unable to attend. This was not the practice previously and was viewed as significant. Attendance numbers have significantly increased with a current 60% attendance rate. The previous attendance was estimated at between 5 and 15 per cent.

Statistics for attendance continue to be recorded at Clinical Supervision meetings. They are reported back at the monthly Clinical Supervision Meeting. Apologies are also recorded in the meeting notes.

Future Directions

Follow up for clinical supervision will include; staff to be re surveyed (6 month period) about the supervision groups and reviewing access to the groups. For new staff entering the mental health area, a bi-monthly email to team leaders will be sent to capture new nursing staff and offer clinical supervision.

Regular PowerPoint presentations have been arranged to be delivered throughout the year, thus capturing new staff members that have joined the organisation. Bi-monthly supervisor meetings are scheduled to oversight the implementation of the new clinical supervision program.

At these meetings an agenda has been set to review, numbers of attendees, apologies (reflecting each month's figures), and a new agenda item is an overview of topics each group has discussed, but not going into detail about content. A review of clinicians that may not be attending will also be considered.

Constant reminders are sent to managers in the Inpatient/Community areas to discuss the clinical supervision that is offered for nurses and referring new staff to the clinical supervision co-ordinator and ensure that managers are discussing supervision at staff performance appraisals.

The coordinator continues to provide each area of the mental health service with the Clinical Supervision sessions/dates that will be held for the year. The staff and supervisors will participate in further research with a quantitative focus to empirically validate these qualitative impressions. The authors are currently exploring appropriate tools or instruments to conduct this quantitative research study.

Conclusion

The implementation of Clinical Supervision is generally perceived as a good thing amongst clinical mental health nurses and their managers. The managers of acute mental health units need to be seen as supportive and proactive in the implementation and planning of their clinical supervision programs. When done well, it can be seen that mental health nurses, clinical supervisors and managers can work together and create a positive and rewarding experience for all concerned.

This brief account of a process employed in an acute mental health setting is a credit to nurses, supervisors and managers in introducing clinical supervision into a demanding workplace. Together they have overcome many of the perceived and real barriers experienced by mental health nurses more generally as reported in the literature concerning clinical supervision and mental health nurses.

References


Long distance group supervision in infant observation

Noela Byrne and Laurie Lovell-Simons


Paper presented by Noela Byrne at the Advances in Clinical Supervision Conference, Sydney, 4-6 June 2013.

Noela Byrne is a Psychoanalytic Psychotherapist and Family Therapist in Sydney. She has been involved in teaching and as a supervisor of Infant Observation groups for many years and is currently Coordinator of the Infant Observation Unit for the NSW Institute of Psychiatry’s postgraduate Perinatal and Infant Mental Health courses.

Abstract

Infant Observation was first used as part of Psychoanalytic Psychotherapy Training in Britain and is now used by the NSW Institute of Psychiatry in Perinatal Infant Mental Health courses. It has proved useful to clinicians in improving their understanding of the development of the mind of the infant as well as the development of the relationship with the mother and or father, that is the primary carer.

Supervision groups with a maximum of four members meet weekly to discuss their observations of an infant over the course of its first year of life. These meetings are held by means of teleconferencing, but two face to face meetings are also provided during the course of the year. The supervisor endeavours to provide a secure environment in the group which allows for the students to express their feelings about what they are observing. This is based on the theory that the most effective learning occurs when affect is involved.

Conducting these groups long distance is a challenge for the supervisor who acts more as a group leader, encouraging all members to participate in thinking about their observations without judgement or preconceptions. Facilitating open and frank discussions is initially difficult as participants may not have met face to face and trust takes time to establish. In addition, without visual, non-verbal clues, the supervisor can struggle to be aware of anxieties and emotional reactions to the material being presented.

The majority of students find infant observation to be a profound experience which provides them with an appreciation of the struggles of the new mother-infant dyad. It also increases their self awareness as well as their observational skills and may alter their approach to their clinical work thereafter.

Introduction

The method of Infant Observation was first introduced by Esther Bick as part of psychoanalytic psychotherapy training in Britain in the late 1940s. It involves observing the infant with the mother or primary caregiver in their own home once a week during the infant's first year of life. A child cannot be understood in isolation. Therefore, this method of observing the infant in its family environment, was found to be useful in learning about the development of the mind and the emotional life of the infant in the context of the developing relationships between the infant and others. This includes the intense emotions and unconscious processes communicated in family interactions from the very beginning of the infant's life.

In addition, it was discovered that this method assisted the observer to become more self aware as she is encouraged to observe her own feelings and thoughts as responses to what she is observing.

The method of Infant Observation, has now been used more broadly than as part of a psychotherapy training. This paper is about the use of Infant Observation as part of the Perinatal and Infant Mental Health course. The course was begun by the NSW Institute of Psychiatry in 1998 and from its inception, Infant Observation was included as part of the course. The rationale was that:

- Students would be able to observe normal development processes as they unfolded
- Students were encouraged to sit with the mothers and babies without judgement and to develop their skills as an observer rather than a problem solver.
- Students coming from a range of disciplines who were all required to complete an Infant Observation in the first year of the course were offered a shared common experience and a good grounding in learning to be attuned to their clients, and to think before reacting.
- Students are therefore given an opportunity to think about the development of the infant in a different way to the way in which the physical and emotional development of the infant is dealt with in other theoretical parts of the course.

In recent years, a briefer certificate course has been added by NSWIOP and students on that course complete a six month observation rather than one of 12 months' duration.

The method of Infant Observation has now been used more broadly than as part of a psychotherapy training. This paper is about the use of Infant Observation as part of the Perinatal and Infant Mental Health course. It is offered
as part of this course to assist students to fine-tune their observational skills and to think about the development of the infant in a different way to the way in which the physical and emotional development of the infant is dealt with in the theoretical parts of the course.

As might be expected, there have been many developments and variations in the way infant observation has been used over the last sixty years, providing current supervisors with a range of problems and challenges. For instance, today fewer mothers remain at home with their babies for a year or more, which means there is a smaller pool of families to draw from when a student is looking for a baby to observe for a year. Students are instructed to find a “normal” family to observe. However, society has changed since the days of Esther Bick, and the different perceptions of what constitutes a “normal” family reflects this change. In recent years, as well as observing a family where the father is the stay-at-home carer, a few students have observed a same sex couple with an infant.

Ethical issues are also of more concern in our society today. NSWIOPI provides the student with a letter of introduction before she visits a prospective family. Two further documents are provided: a letter of information to the parents stressing the confidential nature of the observations, and a consent form that both the student and the parents sign before the observation visits begin. The consent form serves as a contract that clearly states the terms of the undertaking between the observer and the family.

**Beginning the observation**

Students registering for the Perinatal and Infant Mental Health courses come from a variety of professional backgrounds including social workers, psychologists, occupational therapists, nurses, psychiatrists and GPs. Probably the majority will come from a nursing background. Geographically, they might be located anywhere in Australasia.

At the beginning of the semester, students are allocated to a group with a maximum of four members and with a group leader or supervisor. The group meets weekly by teleconference and students take it in turns to present a detailed account, written after their last visit to the family.

The first task of each student is to locate a suitable expectant mother who is in what could be termed a “normal family” situation. The requirement is for there to be two parents, preferably with some extended family and/or good supports in the community and who are not known to the student. This can be a difficult task in several ways. For instance, in small country towns, finding a family to which the observer has no social connections can be difficult. In addition, it is not easy to define what a “normal” family is. There is a great variety of cultural and familial ways of child rearing and relating. Who is to say what is “normal”? Prospective families found by group members are discussed and suitability considered before any meeting with the expecting parents takes place. The supervisor is aware of the need to provide as satisfying and trouble free an observation experience as possible for each student and with this in mind, will guide the group in these discussions and in the decisions which are made.

For example, where the mother has no family living locally to offer regular support, or where twins are expected, the student could be faced with an anxious and inexperienced mother who may struggle to manage. Therefore, she may have greater expectations of the student and may pressure her to step out of the observer role, to offer advice or even give hands-on assistance. There may be complex motivations involved when a mother agrees to be observed. It may not always be possible to know what they are, but it can nevertheless be helpful to think about it together in the group, and to take this into consideration when discussing a potential family.

Once the observation visits begin, the group plays a vital role in holding and processing the experience, thus enhancing the learning.

**The role of the supervisor**

All the Supervisors are trained psychotherapists who have themselves completed at least one infant observation. While it is desirable for the experience of observing to be as free of theory as possible, inevitably the seminar leader will respond to the material, and the group with her own set of beliefs, ways of thinking and experiencing. These will be heavily influenced by psychoanalytic psychotherapeutic theory. The supervisor’s skill will therefore lie in being able to translate these ideas into simple language in order to give each one of the students a sense of the unconscious and of the developing inner world of the infant.

In “Tuning the Therapeutic Instrument”, Scharff and Scharff state that “the most effective learning occurs when there is an affective component involved, where intellectual and emotional components can be integrated.” This means the supervisor must ensure that the group provides a secure environment in which students can begin to explore their emotional responses to what is being observed. The function of the supervisor is different from the supervision role in a case consultation, which is more didactic. Here, the supervisor’s role is to facilitate exploration and discussion, leading to a deepening of both emotional and intellectual understanding in the group.

Although I have said that the supervisor’s approach will be largely theory free, one central concept of psychoanalytic theory that will be introduced to the group is the phenomenon of projective identification. It is explained that this is an early, non-verbal means of communication from the baby to the mother, but which the mother might also use as a way of projecting difficult and powerful feelings onto others to make them experience what she is struggling to manage. The group is encouraged to be open to these powerful emotions and anxieties and to consider their origins. Are they from the mother, from the baby or from the observer herself? The more the student is able to develop an openness to her own state of mind, the more she will be able to ponder this question.
The supervisor will relate to both the individual student and to the group as a whole. Each group will have its own unique patterns and group mind. The supervisor will look for recurring themes in the material that is presented. For instance, if a student regularly reports on her worry that the baby is not being well cared for, the supervisor tries to ascertain whether this is in fact the reality or whether the student’s perceptions are being coloured by the anxieties of the new mother or by her own anxieties.

The supervisor will also note repeating patterns of interacting within the group, conceptualizing them in terms of their possible defensive function against anxiety.

A parallel process occurs between the containment function provided by the observer to the mother and infant, in terms of the regularity of time and place of the visits, and the holding function provided for the group by the regularity of the group meetings, that helps to contain the anxiety of the students.

The role of the group

Over time, a sense of trust develops between the group members and the supervisor which facilitates greater freedom for the students to be more self-revealing about the feelings that are evoked in them by their observation experiences. As the observations progress, the group develops a sense of each others babies, the differences and the similarities. Most members also deepen their capacity for attunement and observation as to what they are observing. The group provides a transitional space in which concepts can be played with, avoiding the temptation to rush to premature conclusions. The role of the group is vital in providing a shared thinking mind to constantly examine and reflect on the observation experience.

The supervisor and the group also help to contain the anxieties that may be aroused by the observation. Initially, these anxieties can feel overwhelming for the student, as she struggles to find her place as an attentive non-judgemental observer in the family. She is aware of what a privilege it is to be present in the family at this crucial time and may question how the family might benefit. She might also worry about being intrusive and struggle with what is stirred up in her by what she sees. The observer might also pick up on the anxiety of the inexperienced mother by feeling a strong pressure to step out of her observer role and provide reassurance and advice or even hands on assistance. Discussion in the group aims at helping her process what might be happening.

My role as co-ordinator of this unit is to support the supervisors in their difficult task and to provided a link between them and the organization offering the course. It is important for the supervisors to have their own supervision space and to also feel supported and held by the organization in this complex and sometimes challenging work. On occasions, I am called upon to act as a go-between and to advocate for the supervisor if some difficulty has arisen which is affecting her group.

Long distance supervision

Because the majority of the group meetings are conducted by teleconference supervision, it is important for there to be a face to face orientation meeting before the groups start, as well as several face to face meetings several times during the year. This, together with receiving regular emails with students’ detailed notes, assists the supervisor in holding the group in mind over the long distances. The face to face meetings are also important to the students in helping them establish a sense of belonging and connection in the group. This could be equated with the sense of connection with the family which the student achieves by meeting them prior to the birth of the baby.

As each student finds a baby and begins the observation, the supervisor needs to stretch herself to be able to think about what is happening with each one. Without face to face contact, and non-verbal cues, the supervisor may struggle to make sense of what is happening in the group, to understand the significance of silences. Does a silence reflect incomprehension or does it reflect anxiety in the group? If the latter, how much silence can be tolerated before it increases the discomfort and anxiety in the group?

It is remarkable that over time, the group can become such an effective, cohesive unit, in spite of the minimal face to face contact offered.

When the observation does not go to plan

On occasions when the supervisor senses that a current personal crisis or past experience is affecting a student’s ability to observe, it may be necessary to arrange a one-on-one phone contact in order to confidentially explore this with the student. Observing an infant can stir up strong emotions from one’s own infancy or one’s own experiences as a new mother. For instance, if the student was adopted or perhaps suffered from post-natal depression after her own baby’s birth, these are deeply personal issues that it may not be appropriate to discuss in the group.

Troubling observations will arouse anxiety not only in the observer but also within the group. For instance, when the observer reports behaviour in the mother or carer which borders on abuse or neglect, she may feel pressured to step out of the observer role. Discussion in the group requires the supervisor to contain the anxiety so that the group can carefully consider what might be happening, what is the observer’s duty of care, and how best to respond. It may be that the observer will need to modify her technique or role, perhaps to be more interactive, if the observation is to remain viable. In extreme cases, the observer may conclude that she needs to suggest that the mother seeks professional help. Alternatively, it may be necessary to terminate the observation.

Observations may also be terminated prematurely when unforeseen circumstances require the family to move away from the area or for the mother to return to work. This is distressing for the observer who will then be required to...
find a second infant, preferably around the same age as the first one, in order to complete her observation experience. The role of the supervisor and the group will be to support and encourage the student through that difficult process of change.

**Termination**

As the baby approaches his or her first birthday, discussion in the group will begin to focus on preparation for finishing. Students are helped to express their feelings about the loss as they are guided to consider how they might deal with the ending with the mother and infant. Understandably, a strong bond will have developed between the observer, the infant and the mother and there will be sadness at the relationship coming to an end. On occasions, there might be an attempt to avoid the grief by trying to transform the relationship into one of ongoing friendship. The observer may be invited to attend family events or to continue to meet the mother for a coffee. Other families may request a written “report” from the observer as a way of comforting themselves with a concrete reminder of her. All these eventualities will need to be brought to the group for careful consideration.

Similarly, students may need to express their sadness at the loss of the group and the supervisor, of relationships that have provided such vital and valuable support throughout the observation experience.

At the conclusion of the observation, as part of their assessment, students are asked to provide a summary of their experience and what they feel they have gained from it. Most will describe their initial anxieties at being faced with an unfamiliar and challenging situation. However, the majority then go on to express their surprise and delight at the richness of the experience and how deeply it has personally affected them. Almost without exception, all report how much the experience has altered the way they now approach their work with mothers and babies. They find they have developed an ability for what the poet Keats described as “Negative Capability”, that is the capacity for being in uncertainties, mysteries and doubts, to observe and resist the impulse to act and advise prematurely.

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A reflective practice model of clinical supervision

Christine Senediak

Abstract

A core aim of clinical supervision within health services is to maintain standards of client care, ethical practice and the encouragement of independent reflective thinking. Encouraging reflective practice enables clinicians to develop conceptual problem solving skills to sustain lifelong learning and the ability for self-care. The reflective practice approach to clinical supervision teaches supervisees how to critically analyse and improve their work-practice. This paper provides an overview of the core concepts of supervision incorporating reflective practice.

Introduction

A review of the literature finds a great deal written about clinical supervision as a distinct practice (Barnett, Cornish, Goodyear & Lichtenberg, 2007; Falender & Shafranske, 2007; Hawkins & Shohet, 2006). A core aim of supervision is to provide a forum allowing for the development of professional values, identity and clinical competency (Bernard & Goodyear, 2002; Holloway, 1995). Supervision supports the process of professional development so that ultimately, the health professional can work more effectively within their clinical role.

Clinical supervision has long been an integral part of professional training in health services, and more recently is increasingly recognised as an important component for the ongoing maintenance of competent clinical practice and self-care for practitioners once graduated. Historically, clinical supervision was slow to take hold across the health care system as it was considered costly to invest in setting up processes to review the clinical skills of already graduated practitioners. Today clinical supervision is practiced actively within health services and is seen as an integral part of the ongoing development and maintenance of clinical knowledge and skills (Bernard & Goodyear, 2004; Clarke, 1993; 1999; Kavanagh, Spence, Wilson & Crow, 2002; Cousins, 2004; Gonzalvez, Oades, & Freestone, 2002; Carroll, 2007).

Definition

In its broadest definition, clinical supervision is a professional activity involving a practice-focused relationship between a designated supervisor and supervisee. The aim of this collaborative interpersonal process is to maintain and promote standards of care by developing theoretical knowledge and skills (Falender & Shafranske, 2004). Supervision is a regular facilitated meeting where supervisees discuss their work practice issues in a protected individual, group or team setting which allow them to review their practice and learn from that discussion which takes place. The object of the working alliance between supervisor and supervisee is to enable the supervisee to gain ethical competency, confidence and creativity so as to give the best possible service to their clients (Livni, Crowe, & Gonsalvez, 2012; Inskip, 1999). For the purpose of this paper, the term supervisee will refer to health practitioners such as psychologists, social workers, occupational therapists and nurses as it is believed that many of the concepts discussed in this paper can be equally applied across disciplines.

Clinical supervision is an intervention with its own theory, framework and techniques which requires training before a person can be in a position to fulfil the role of supervisor. Typically, health professionals in the past have often ‘fallen into the role of supervisor’, taking on students on placements from university after graduation or as interns in training (Scott, Vitanza & Smith, 2000). More recently, specific training programs have been developed to train health professionals to be a supervisor covering knowledge about registration, supervision guidelines and reporting requirements (e.g. AHPRA Psychology; HETI). Much attention has been focused in the literature on the supervisory relationship (Holloway, 1995), tasks of supervisor and supervisee (Baker, Exum & Tyler, 2002; Campbell, 2000; Carroll & Gilbert, 2005; Inskipp, 1999), models of practice (Carroll, & Holloway, 1999; Stoltenberg, 2005) and best practice regarding how to deliver supervision in the field. Supervision is an ongoing process encompassing a range of facilitative and evaluative functions involving both supervisor and supervisee (Proctor, 1997). As such the supervisory alliance is integral in making the process effective allowing the supervisee to grow and learn (Ramos-Sanchez et al, 2002; Bambling & King, 2001).
Setting up good supervision practices

“The literature on supervision is heavy on opinion, theory and recommendations, but very light on good evidence. Problems with the research that does exist include a paucity of randomised controlled trials, inadequate sample sizes and the use of measures with unknown reliability and validity…There is little direct observation of supervision or examination of the impact on clinical practice, and most studies rely on the perceptions of supervisors or supervisees, despite evidence that this is often inaccurate” (Kavanagh, Spence, Wilson and Crow, 2002. p.248).

Past investigations have identified good supervision to be based more on the question of satisfaction with supervision rather than the outcome of supervision on client care (Bambling & King, 2001; Falender and Shafranske 2004). Supervision research unfortunately is plagued with poor methodologies, often based on self-report dependent on whether the supervisee ‘like’ their supervisor ( Ellis & Ladany, 1997; Worthen & McNeill, 1996).

Two core factors have generally been identified with positive supervision, these being a good supervisory relationship and attention to the task of developing clinical skills for the supervisee. Other salient features of good supervision are seen to be based on role induction, the establishment of clear goals and tasks outlining roles and responsibilities for the supervisor and supervisee (McMahon & Patton, 2002), clear contract setting and developmentally appropriate feedback to facilitate learning (Gard & Lewis 2008). Also valued in supervision is the quality of the supervision relationship, supervision environment (Worthen & McNeill, 1996), supervisor motivation, enthusiasm and interest in supervising and regular and clear feedback and monitoring (Haynes, Corey & Moulton, 2003).

The Working Alliance

Whether supervising trainees, new graduates or experienced clinicians, the fundamental most important aspect of the supervision process is the establishment of a working alliance as it is widely recognised that without a good working relationship supervision will not proceed smoothly and effectively (Bambling & King, 2000; Borders, & Brown 2005). However, it is not an end in itself. Some supervisees approach supervision with little knowledge about what is involved in supervision, whereas others have considerable experience and knowledge about the tasks, roles and structure of the process. The beginning step therefore for establishing a working alliance requires that time is spent on role induction explaining and discussing roles and responsibilities of the supervisory relationship, expectations, tasks and processes for smooth supervision practice.

Feltham (2000) report that one of the first questions to ask a prospective supervisee is “what do you know about supervision” in order to gauge their experience and knowledge. From here, the discussion can proceed to establishing a contract with clear and focused goals (i.e. what the supervisee wants to get out of supervision), based on mutually negotiated expectations, styles and processes that both the supervisor and supervisee feel are appropriate for their working relationship. Following clear guidelines in establishing supervision can greatly enhance the quality and process of supervision, as both supervisor and supervisee have clear expectations of the roles and responsibilities in this dynamic working relationship. Clinical supervision requires an explicit framework and method to initiate, develop, implement and evaluate the processes and outcomes of supervision (Bernard & Goodyear, 2004; McMahon & Paton, 2002; Stoltenberg, 2005). Table 1 summarizes guidelines to be addressed in establishing a supervisory working alliance at the contract stage of supervision.

Table 1: Supervision Working Alliance

<table>
<thead>
<tr>
<th>Negotiation of a mutually acceptable contract</th>
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<tbody>
<tr>
<td>Explicit recognition of responsibilities within the supervisory relationship, including how clinical issues will be presented and discussed</td>
</tr>
<tr>
<td>Clear boundaries in supervision – differences between supervision, training and ‘personal support’, especially considering the pressures of advanced training requirements</td>
</tr>
<tr>
<td>Recognition of the ‘power’ difference between supervisor and trainee and of the supervisor’s responsibility for the trainee’s satisfactory progression to the next developmental stage. Discussion of how this may influence the supervisor-supervisee relationship (for example, trainee masking of their vulnerabilities) (Holloway, 2000)</td>
</tr>
<tr>
<td>Providing supervision congruent with the trainee’s developmental understanding and skill level – not over- or under-extending the trainee; judgement of readiness to tackle clinical issues</td>
</tr>
</tbody>
</table>
It is important that the supervisee know as much as possible about the supervisor's orientation and way of working as the supervisor plays a significant role in influencing supervisee professional development. Lizzio, Stokes & Wilson (2006) note learning goals need to be clearly articulated at the early stage of supervision which enables the establishment of an empowering and systematic learning process. The supervisor needs to be aware and deal with supervisee anxiety, be clear about dealing with 'emergency' issues and clearly discuss the expectations for both the supervisor and supervisee in how they will work together and monitor progress. Supervisees change and develop over time, and each need to be aware of how these changes can influence the supervisory relationship (Bambling & King, 2000; Overholser, 1991; 2005).

**Personal Qualities of the Supervisor**

Research purports that good clinical supervision requires that the clinical supervisor be confident in their approach, well organised and that the supervisor be able to deal effectively with conflicts that might arise within their relationship (Holloway, 1995). Driscoll (2000; 2007) note that there are a number of essential supervisor skills including:

1. **An open emotional supervisory account**
   A supervisor needs to be able to work on the emotional content of the relationship, to notice 'micro' and 'macro' changes within the supervisee and help them to understand the meaning behind their thoughts, beliefs and behaviours as it relates to client management. This is similar to the notion of being able to use conceptualisation and personalisation skills in supervision which help the supervisee become more aware of processes within the client session (Bernard & Goodyear, 2004). Driscoll (2000) note an open emotional supervisory relationship provides opportunities for the supervisee to discuss details of the client session and discuss how the supervisee feels about the session and provide opportunities for new learning.

2. **Willingness to mutually learn in supervision**
   An enquiring approach to supervision allows both the supervisor and supervisee to discuss what is happening both within and outside the client and supervision sessions. Traditional models of learning in supervision imply a hierarchical relationship whereby the supervisor is granted 'structural power' to evaluate, oversee and in many instances, report on professional development. It is not possible to remove power differentials in supervision, so therefore it is important to clearly articulate the relationship of power within the supervisor-supervisee dyad.

Hewson (2002) purports that in order for learning to take place effectively within a supervisory relationship, structural power must be made transparent and fully negotiable in order for all parties to be aware of requirements. 'Social power' or the power to be influential must be earned by the supervisor. Hewson describes three power bases which have relevance to supervision, legitimate power (perceived appropriateness or right to hold potential influence), referent power (perceived as being a role model which is based on respect and shared values) and expert power (perceived as being able to provide knowledge and skills in supervision). In order for supervision to work effectively, both the supervisor needs to earn all three forms of power and the supervisee must earn these social powers in the eyes of the supervisor. In essence, there must a willingness to learn and develop cooperatively within the supervisory relationship.

3. **Attentiveness to what is going on in the session**
   Hewson's (2002) supervision triangle which provides a template to address client, counsellor and relationship issues in supervision similarly provides a framework for examining focal points within the supervisory relationship. These are client, counsellor and relationships (which addresses the relationship between client and counsellor and the counsellor and supervisor). Depending on the supervisor's orientation, the focus of discussion using this triangle may differ, such that a behaviourally oriented supervisor might focus more on client issues such as technical problems, goal setting and problem identification. Alternatively, a more psychodynamically oriented supervisor may focus more on the relationship focused dimension, reflecting more on transference issues. This model provides a structured and visual framework and further descriptions of client, counsellor and relationship focused cells offer the supervisor the necessary framework for ensuring attentiveness to what is going on in the session.

4. **Effective questioning style which facilitates learning**
   Driscoll (2000) notes that questioning by the supervisor holds the key to investigating the work of the supervisee. By asking the 'right' questions, it allows the supervisee to open up and critically consider the implications of their clinical encounters. Through the systematic process of critical enquiry the supervisee can pose their own questions which, in turn, allow further examination and refinement of clinical work (Holloway, 1991; Horvarth, 2001). By allowing the supervisee to investigate her/his own practice, a range of perspectives regarding case management can be developed with the trainee moving towards developing greater capacity for independent practice. Effective questioning using reflectivity encourages the supervisee to focus on their actions, feelings and thoughts in relation to the therapy context. For this to happen, the supervisor must allow space for the supervisee to focus their attention on the interactions within the therapeutic context, without offering direction or instruction, thus allowing a process of contemplation and review.

Whilst it can be a challenge for the supervisor to allow the
supervisee to initially develop alternative interpretations of the situation under review, it is through this process of contemplation that the supervisee develops new ways of thinking and working (Stoltenberg, 2005).

5. Summarising of content and openness for reciprocal feedback
By definition, supervision aims to maintain and enhance standards of client care which requires effective feedback by the supervisor. Structured sessions along with a negotiated and clearly articulated agenda allows for clear review of case material and clinical issues (Falender & Shafranske, 2004; Feltham, 2000; Kavanagh et al, 2002). Feedback needs to be balanced and it needs to be meaningful to the supervisee. That is, the supervisee must be able to take on board aspects of their work they have done well, and learn from what they could have done better. Critical enquiry into one’s own practice to examine and refine clinical work is a skill that supervisees most often need to learn. In clinical practice counsellors most often need to ‘think on their feet’ and be able to work quickly and wisely within the clinical context. Feedback needs to be needs to be consistent, objective, timely in response, and based on standards that are meaningful to the supervisee and supervisor. It should not just be linear: supervisor to supervisee, but rather allow for dialogue between the supervisor and supervisee about the process of supervisory relationship.

To ensure feedback can be acted upon, it must be clear as depending on the message, it can either ‘affirm, encourage, challenge, discourage, confuse, or anger a supervisee’ (Bernard & Goodyear, 2004. p. 31). It is recommended that a supervisor use a variety of means to monitor the supervisee’s clinical work, including the use of role play, video tape, audio tape and clinical case review. A supervisor needs to be able to actively review the clinical content of the session or task at hand in addition to reviewing organisational issues and any interpersonal or professional development issues that may arise (Driscoll, 2000).

The following questions can be used when reflecting on your role as a supervisor:

- Do I want to supervise?
- What are the practical issues that I need to consider (availability, individual, group)?
- What do I expect from my supervisee?
- What is my structural approach to supervision? How do I communicate this?
- What is my role as a clinical supervisor?
- What are my strengths/restraints as a supervisor?
- What is my orientation – what do I feel confident/comfortable to offer in supervision?

Promoting deeper reflection in supervision

What is reflective practice?
The role of reflective practice in enhancing critical thinking and problem solving has been described in depth in the education literature and more recently extended to the counselling and supervision arenas (Belton, Gould & Scott, 2006; Ronnestad, & Ladany, 2006). Dewey (1938) defined reflection as an ‘active, persistent, and careful consideration of any belief or supposed form on knowledge in the light of the grounds that support it and the further conclusions to which it tends’ (cited in Ward, 1998 p. 2). He saw reflectivity as a way to generate solutions using carefully considered problem solving strategies through experimentation. Schon (1994) further developed the theory of reflective practice describing reflectivity as a means of enhancing understanding through ‘empirical or scientific knowledge’ based on skills learnt through education and training and ‘tacit knowledge’ or taken for granted knowledge (Driscoll, 2000). While a practitioner may develop sound theoretical knowledge, drawing from experience creates some uncertainty which can create a theory – practice gap. Using a reflective practice approach allows the practitioner to review their experience, allowing for a deeper understanding in thoughts, feelings, behaviour and action.

Schon (1994) defined two main types of reflection: reflection-in-practice and reflection-on-action. Reflection-in-action occurs while events are happening. By observing, recognising, intervening and making adjustments to practice, the practitioner is able to respond to making a change in the way they are responding to a dilemma, draw from their theoretical and clinical knowledge to improve the situation at hand. Reflection-on-practice occurs after the event and is retrospective (Driscoll, 2000). In a sense, reflection provides a ‘looking glass approach’ to clinical practice, allowing the health practitioner to become more self-aware, harness self-knowledge and influence a deeper understanding in thought and action. Reflective practice helps the health professional to integrate and make sense of their clinical practice, deciphering the possible multiple and often conflicting responses to a situation.

An important element of reflective practice is the depth of the reflection. The full potential of reflection can only be achieved when the practitioner can deconstruct the experience and is able to see the various layers to the situation at hand. Reflection is not simply, ‘I can see that I could have done things differently’. Reflection requires deconstruction and reconstruction, ‘I can see what happened, why it happened, and how I can change it in the future’. Reflective practice in supervision allows the practitioner to create new openings for different thinking outside of what is already known and practiced. Reflection in supervision allows the supervisee to ‘step back’ and ‘consider alternatives’ so that change can take place in that situation and be generalised to other situations as well.

Within supervision, reflection happens all the time but it is often descriptive and ‘presentation specific’ where the supervisee does not extend their reflection to other aspects of their clinical work (Safran, Muran, Stevens, & Rothman, 2008 ). The real value of reflective practice is when supervisees learn from the presentation and extend to other contexts, either past, present or future. When this occurs independent thinking and responsibility is promoted in the counselling and supervision contexts. Its value has been so well recognised for professional development that many have recommended training in reflectivity to enhance...
practitioner professional development and within structured formats for teaching (Moffett, 2009; Regan, 2008; Wright & Griffiths, 2010).

Five levels of reflection can be identified which progress from descriptive to analytical to critical thinking (Betts, 2004). The further down the hierarchy the supervisee explores the issue the greater the level of reflection on content, process and context.

These levels include:

| Level 1: Reporting focus on a recount of the situation only |
| Level 2: Responding some thoughts on what happened |
| Level 3: Relating review of the events through existing lens/frameworks of thinking |
| Level 4: Deconstruction in-depth analysis (challenge to existing frameworks of thinking). Here there is a challenge to existing frameworks of thinking an some alternative explanations are generated |
| Level 5: Reconstruction application of learning based on new frameworks of thinking. |

Extending on this framework, questions can be used in supervision that fosters the deconstruction and reconstruction of understanding the material presented in supervision. The questions provided in Table 1 are used as a guideline for supervisees to consider within the supervision session which encourages the supervisee to deconstruct and establish new meaning in supervision. It is envisaged in the first instance that supervisors would use the form by asking the questions in a fairly structured way and as both the supervisor and/or the supervisee became more familiar with reflective questioning less reliance on the form would be required.

**Table 2: Reflective Supervision guidelines**

1. What do you have for today’s session?
2. Which aspect/s are you most interested in focusing on?
3. What do I need to be aware of to help you?
4. What are you most pleased about the way you worked?
5. What weren’t you pleased about/concerned about?
6. What would you like to do (to have done) differently?
7. What do you think got in the way of you being able to do that?
8. I noticed that ……..(positive or problematic behaviour).
9. What was helpful or not helpful to you/your clients? Why? How? In what ways?
10. What do you want to do about ……?
11. How might you apply (practical/behavioural) what we have discussed today? What do you need to do more/less of?
12. What might you take from today’s session (personal reflections/cognitions/new insights)?
13. How will you go about implementing ‘X’?

**Self-supervision**

A common issue for many supervisees is dealing with a question or dilemma outside the supervision session. As a result the self- supervision handout was developed which extends on the idea of promoting independent practitioners. This form has a series of questions that the supervisee can ask themselves as a way to 'self-supervise'. For example, the supervisee uses all or some of the questions to work through the issue at hand and it is through the use of prompt questions that the supervisee can ponder on the issue and do some problem solving around the question they might have taken to supervision. This handout acts as a reflective supervisory framework and the supervisee can bring all or some of their questions or responses to their next supervision session to review with the supervisor.

**Conclusion**

Clinical supervision is a powerful and effective process allowing clinicians to critically think about the work they do in the clinical context. Preparation is crucial on both the part of the supervisor and supervisee and should always be provided in a trusting and safe context, especially when reflective practice is encouraged. The supervisor should encourage the supervisee to take personal responsibility of their learning process and identify goals for knowledge
and skill development. Reflective supervision promotes critical thinking which encourages the supervisee to ask questions about their learning and open up different perspectives/lens of the presenting concern. By using a conversational and strengths based approach to supervision, the supervisor can prepare a reflective and mindful space for contemplation of issues. A balance of information giving, support and challenge then can lead to independent practitioners who can not only be reflective within the supervision session but in every clinical encounter.

Table 3: Self-Supervision Guidelines

The following questions provide a guide for self-reflection for use in between supervision sessions or for preparation for supervision. It allows for reflection on 'past interactions, in the present for the future'

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>1. Describe the interaction(s) (e.g. write in a few descriptive lines what occurred, what was my involvement, describe the inter-relatedness of those involved , NB: is it helpful to be specific)</td>
</tr>
<tr>
<td>2. What is my question? (e.g. what am I stuck on, what do I need help with at this time, if I were to take this to supervision what would I be asking for help with?)</td>
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<tr>
<td>3. What are my thoughts, assumptions and expectations about the interaction at that time? What are they now (and why do they differ)? (e.g. how do I make sense about the interaction at the time and if changed, why)</td>
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<tr>
<td>4. What was I feeling? How do you understand those feelings then and now? What was the emotional flavour of the interactions? Was it similar to or different from my usual experience with this client? (e.g. what were my feelings at the time; are the same/different now; why the change?)</td>
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<tr>
<td>5. Consider my actions during this portion of the session. What did I want to happen? (On reflection what theoretical framework guided my intervention at the time; what were my expectations/hopes; consider transference)</td>
</tr>
<tr>
<td>6. Consider the interaction/interrelationship between you, the client and wider system/s. (Why do I think what happened, happened? How does the therapeutic relationship impact what occurred?)</td>
</tr>
<tr>
<td>7. To what degree do I understand this interaction as similar to the client's interactions in other relationships? How does this inform my experience? (As there parallels for the way client presented in session compared to other contexts? What might this tell me about the client and what work I need to do on the future)?</td>
</tr>
<tr>
<td>8. What theories do I use to understand what is going on? (What guided my thinking and therapeutic intervention at time – should I consider alternatives)?</td>
</tr>
<tr>
<td>9. What past professional or personal experiences affect my understanding? (Consider any personal/professional restraints both past and present and how these might impact both on my theoretical knowledge and the application of clinical skills at the time)</td>
</tr>
<tr>
<td>10. How else might you interpret this event and interaction in the session? (If I were to view this situation through a different lens how might I see things differently? How might this influence what I do next)?</td>
</tr>
<tr>
<td>11. How might I test out the various alternatives? (Summarize where to from here; what steps do I need to take; who/what can help me to do this)?</td>
</tr>
<tr>
<td>12. How will the clients’ responses inform what I do next? (What do I need to be 'on the lookout' for when I see the client next).</td>
</tr>
</tbody>
</table>

References


Overholser, J., 1991 The Socratic method as a technique in psychotherapy supervision. Professional Psychology: Research and Practice, 22, 68.


On becoming a psychotherapy supervisor: Triadic systems in the microanalysis of the supervisory process

Joan Haliburn

Abstract

I propose a developmental systems model of supervision involving triadic systems of supervisor/therapist, therapist/patient, patient/supervisor within which a complex relationship occurs. Drawing on my own experiences of being a supervisee and then a supervisor, I will describe the phases of developing as a supervisor, and advocate training courses, with some similar model. Fictitious names have been chosen to mask the identity of supervisees and their patients described in this paper. Some details have been changed for the same reason.

Introduction

As I reflect on the process of becoming a supervisor, I remember my own curiosity about my experiences as a supervisee and my supervisors’ attitudes to my work during my 3-year training in psychoanalytic psychotherapy using the Conversational Model. I was exposed to three different supervisors during that period, and one continuing supervisor for the entire three years. Audiotaping of sessions of two patients was compulsory and snippets of recordings were listened to and discussed at weekly supervision with each supervisor. I believe that audio-recording of patient sessions was hitherto not done. This was in the early 1980s. A small snippet of tape seemed sufficient to generate a wealth of information about me, my patient and inadvertently, or so I thought, my supervisor too. It intrigued me at the time and continues to do so as I keep an eye on myself as supervisor.

A Supervisee First

The following are my thoughts which had begun to percolate while I experienced being a supervisee and have continued to build on those thoughts through peer supervision and individual supervision and as a supervisor until the present time. I was not trained to be a supervisor. I learned from good supervision; read about supervision; and took an interest in the impact patients have on us, and how we communicate that impact, bearing in mind that I didn’t and still do not have answers to everything. To focus more on the process rather than merely on the content both in therapy with one’s patients as well as a supervisee and as a supervisor is the most important advice I have ever had – and I have tried to impart that message to my supervisees with good effect. I treasured supervision as an integral part of my training and guarded that time for myself; continuing it even after training had finished. However, the most important thing that I have learned is that experience alone does not make one a good supervisor. Training to be a supervisor, with both didactic and supervisory components over a period of time; followed by supervision of the supervisor would be the way of the future, if the profession is to survive in a positive manner. The supervisor training programs which I helped start with the Australia & New Zealand Association of Psychotherapy (ANZAP) in 2002 were an example of such a program – however the continuing supervision of supervisors is an area that has yet to be undertaken.

There was no training for supervisors – you were expected to supervise no sooner had you finished your training – yet I would say that supervisor training is essential. There was no ritual to mark the coming of age of the supervisor; instead the transition occurred with no acknowledgement or validation. Efficacious supervisor training programs are a scant resource; and continuing supervision of supervisors is virtually unknown. Research in supervision is in its infancy.

Triadic Systems – A Developmental Systems Model

What is it like being a psychotherapy supervisor? This is how I see the process. Inner and outer worlds of three people – supervisor, supervisee and patient – co-mingle in the supervisory process in intensive psychoanalytic psychotherapy. I aim to discuss firstly the supervisory process as a fluid and changing triadic system influenced primarily by the patient, yet requiring a certain regulation on the part of the supervisor for an equal though asymmetric relationship; and will then discuss the development of the psychotherapy supervisor as he/she takes on further responsibilities in the growth of therapists and their patients.
It is my view that each of these three systems – supervisor, supervisee and patient, reverberate in a multiplicity of ways. The supervisor and supervisee interact at both conscious and non-conscious levels. While the supervisee draws attention to the therapeutic process occurring between herself and her patient (both consciously and unconsciously) she seeks to convey her understanding, or lack thereof, of the patient and in so doing she engages the supervisor with the patient (in absentia) in a triadic system of relatedness.

**Supervision in the Conversational Model**

Having my audio-recorded patient sessions supervised in the Conversational Model makes me interested in the process from which I had gained so much – not only in my understanding of the process, but also in the conduct of psychotherapy with my patients. I began to see supervision as involving a triadic system, a system not unlike a family system which interacts in a multiplicity of ways, intersecting and reverberating in and among the many units of the system with implicit and explicit consequences for each member of the system. The patient, in my opinion, though physically absent, is pivotal, as around her/him the supervisor/supervisee system operates.

Having put my thoughts down on paper, I set out to do a literature search, and found one other reference to the ‘triadic system’ of psychoanalytic supervision, which according to Gediman and Wolkenfield is a complex, multidirectional network, ‘parallel to what happens in analysis, and which they re-consider as a ‘triadic system’. Gediman and Wolkenfield are credited to be the first to use the term triadic to describe the systemic interplay of supervision and psychoanalysis and proposed that it is ‘the structural and dynamic similarities’ of the two dyads that create a complex, multidirectional network of parallel processes.

Berman in writing about inter-subjectivity and supervision makes reference to the analytic/supervisory triad, in an attempt to integrate the ‘one-person psychology’ and ‘two-person psychology’. McKinney wrote on ‘Relational Perspectives and the Supervisory Triad’ and acknowledged Gediman and Wolkenfeld conceptualizations as foreshadowing relational outlooks. However, she added ‘they still explained parallel process in ego-psychological language’. Frawley who describes supervision as ‘relational too’, takes into account the patient’s dynamics, but does not involve herself further in the triadic interaction, paying more attention to each dyad on their own.

**Process Versus Content**

Interaction in supervision is tri-directional. I hear the supervisee telling me about her interactions with her patient – the process is what I would attend to first, not that the content is unimportant, but that I would keep track of content far more easily than I could recapture the moment with a patient that a supervisee is telling me about in supervision. There is the manner in which the supervisee talks about the session or part thereof, that when considered on its own, tells us so much more about the patient, than we would learn by merely listening to the story and its content. Of course it is a lot easier when we listen to audio-recorded sessions – we can go back on parts of sessions; the same is true of videotapes; but in my opinion when neither is available and we have to be content with process notes, we can still glean from the supervisee’s presentation something about the patient. Listening to how the supervisee experiences her patient and describes their interaction gives the supervisor a snap-shot of the possible effect that the patient has on the therapist, and her reactions to this. This to me is the focal point – the back-bone of my work in supervision. It is at this level that triadic systems are in full play, and the supervisor is in a unique position to help the supervisee listen for what he/she is looking out for in the patient.

**On Being a Supervisor**

As a supervisor it became obvious that, like myself, the supervisee takes back to therapy some of her own reactions to her supervisor i.e. the supervisory relationship has an effect on the patient too, as in the case of Lee, who in our next supervision said ‘I remembered our supervision last week, and when M began to shout at me as if I had done something to wound her, I was better able to hold her anger and not react as if she had attacked me personally’. Pete on the other hand had recently started supervision, and was unhappy about his previous experience. He came in one day and said ‘my patient asked me if I have a new supervisor, because I sound very different’. He then added that his patient felt more comfortable and acknowledged that their relationship felt better. In this case, Pete said that what had made the most difference to him was my question ‘tell me about your experience of T’ and he listened to himself and his experience of T; was able to reflect back to T how her difficulties left her feeling stuck and helpless, and thereby got out of the impasse they had been struggling with. In contrast, Jo felt that my style of supervision was confusing for her – she had not been used to pondering on her own feelings, while she talked about her patient, so was not able to link up with her experience of her patient. Picking up the underlying feeling that was coming through made her feel frustrated. “I know you are trying to tell me something, but I do not know what it is you’re trying to tell me” she said. I felt her frustration and my own, but listened to Jo and apologised for my lack of clarity, assuring her that I would pay more attention to making myself clearer. Jo was surprised by my lack of defensiveness. This led to us being able to see together that her patient was “stimulus entrapped” and therefore could not be readily understood, rather could only be listened to and her confusion accepted, so as to help her see Jo as capable of being with her in spite of confusion.

The use of audio-tapes makes tracking of affective shifts easier and more accurate; replaying certain moments helps the supervisee even further; giving her further opportunity to try out various other responses if need be. The sense of relatedness in the therapeutic dyad and shifts in relatedness involving transference/countertransference is referred to
as the Expectational Field’ in the Conversational Model. Audio-taping the supervision conveys the sense of the triadic relationship in this Expectational Field even more closely. The use of videotapes though they capture considerably more of the non-verbal aspects of the therapy, in my opinion have the effect of detracting from the interactional process, and require the supervisory dyad to become accustomed to the process of watching/listening to the process. Supervision of process notes of the therapeutic session can be fraught with difficulty; however if it is found to be the only way that the therapist is able to present her therapy sessions; then the triadic systems model must in my opinion be used to full effect. Whatever mode is used in supervision, it is important to take into consideration the non-verbal aspects of the therapy.

The Edge of the Triadic System

The supervisor needs to be contained in order to contain the supervisee who may be concerned and anxious about her patient, or anxious about not making a good impression. The environment must offer safety and containment, in fact a ‘secure-base’ or else it has the potential to traumatize the therapist. The supervisor is both participant and observer in the supervisory process, and her focus needs to be on herself, her supervisee and the patient, and what is happening between them. The aim is to help contain by interacting with and regulating the supervisee who in the early stages of her career may be very anxious about her work and her knowledge. It would be unhelpful to become too involved in participating in the therapy, or in the supervisee's personality or personal experiences.

The controversy about ‘teaching or treating’ in psychoanalytic supervision is not new, neither has it diminished. There is a fine line between supervision and therapy, and it is the supervisor's ethical responsibility to maintain that demarcation, even while processing this almost seamless interaction, in an effort to regulate the process where the supervisee has come to learn, to better understand herself and her patient, and thus better able to deal with her patient's difficulties. The supervisor is there to help her do so, while making an effort to understand her and also understand her patient, oscillating attention with her, between foreground and background. Repeated lack of awareness needs to be empathically pointed out by the supervisor in order to help the supervisee work on her 'blind spots' in her own therapy or seek that therapy. The micro-analysis of the therapist-patient interaction in the supervisory process makes this possible.

Didactic teaching in my opinion seems to take away from the valuable time that the supervisee has to work with her patient in supervision, and therefore references to aid the supervisee in her understanding and learning would be my preference. Psychoanalytic supervision is neither teaching nor therapy.

To approach the patient from a position of not knowing is a difficult concept to follow, particularly for new therapists, and for medically trained therapists, who have primarily been in the role of diagnosing and treating accordingly. The fear of failure, of coming across as less than competent or of being shamed, often makes therapists impatient in therapy – the supervisor's linguistic style, acceptance and understanding serve to regulate and modulate anxiety, thus helping the supervisee transport the experience into the therapeutic situation, containing and modulating the patient's experience. The implicit nature of this process, referred to by Lyons-Ruth as implicit relational knowing, operates out of unawareness and outside of verbal consciousness and is often un-noticed. The reverse can also happen where a supervisor is solely instructive and educational the supervisee leaves with the message to 'do what I do' and feels powerless and out-of-control, transporting that experience to the therapy with negative consequences.

Understanding and accepting that each therapist has his/her own style of working with patients is an important step towards establishing flexibility in the supervisory relationship, with clearly demarcated lines of responsibility of what is expected of the supervisor and what is expected of the supervisee. In my opinion every supervisee must have a fairly good idea of what they want from supervision and from their supervisor. The supervisor on the other hand must be respectful of those needs and let the supervisee know what his/her own expectations are; validating and acknowledging progress as it occurs while also taking into account any short-comings on the part of the supervisee. A supervisor should be in a position where he/she can vouch for his/her own competence, without which it would be extremely difficult to be of help to a supervisee. Maintaining these ethical attitudes and therefore defining the boundaries of supervision at the very outset is of paramount importance.

Phases of Developing as a Supervisor

I have described above the need for the supervisor to have a well-defined notion of what his/her role needs to be. This is often/always learned from one's own supervisor/s. I have largely drawn from my own experience of being a supervisee and the transition to being a supervisor in writing these phases of development.

Doubts about one's own capacity to help another through supervision figured hugely for me – what entitled me to supervise? What did I know about supervision? What if the supervisee does not like the way I supervise? Being responsive versus assuming responsibility for one's supervisee's work is an important aspect of being a supervisor. What if I found that difficult to do? These are just some of the questions I grappled with in the early days of becoming a supervisor.

Role Definition

- Holding/Containing
- Teaching/Treating
- Understanding/Relating
- Responsiveness/Responsibility
The awareness of necessary boundaries in the relationship while bearing in mind a certain flexibility of approach is required. The ‘young’ supervisor requires an awareness of himself/herself and the experience of personal therapy, so that there is knowledge of what it is like to be a patient, as well as what it is like to be a supervisee. Supervision also carries with it the responsibility for shaping a young therapist and helping her to care for her patient.

Defining Boundaries

• Clear/Flexible
• Flexible/Ethical
• Competent/helpful
• Validating/Acknowledging.

Identifying one’s strengths and weaknesses is helpful as experience accrues. There is always opportunity to correct or modify as well as to capitalize on one’s strengths. Reading the literature and having one’s own supervision, equips one to develop confidence in oneself and acquire a sense of competence.

Identifying Strengths and Weaknesses

• The ability to hold therapist anxiety
• The ability to hold therapist/patient anxiety
• The experience of a successful personal therapy
• Experience as a practitioner
• Awareness of blind-spots.

Confidence in one’s ability and competence in the role are conveyed in several ways – both in the supervisor/supervisee dyad and as well as the supervisee/patient dyad.

Acquiring Confidence and Competence

• The ability to identify transference issues in the supervisor/supervisee dyad
• The ability to talk with supervisee about this
• The ability to identify countertransference issues in the supervision
• The ability to talk with supervisee about this
• The ability to identify both these issues in the therapeutic dyad & talk about them
• The ability to direct supervisee to relevant reading material
• The ability to discuss own experience of issues with papers as helpful examples.

These are important in developing an identity as a supervisor, and to maintain that identity requires continuing supervision and learning and possibly belonging to a supervisor group.

Forming One’s Identity as a Supervisor

• Continue further reading/education on supervision
• Form supervisory group
• Seek consultation with another supervisor when in doubt
• Maintain continuing supervision.

Conclusion

To return to the literature, much has been written about supervision; however as Watkins\textsuperscript{11} has pointed out:

“despite a generation of inquiry, the psychotherapy supervisor still remains the largely unknown party in the supervision experience. But that long-standing reality can be changed, and the promise of a supervisor development study will be seen to be an ever-inviting hope that awaits realisation”.

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Parallel processing in clinical supervision incorporating professional development coaching

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Ref: Crowe T. Parallel processing in clinical supervision incorporating professional development coaching. Conference paper presentation: Advances in Clinical Supervision Conference, Sydney Australia, 4-6 June 2013.

Paper presented by Trevor Crowe at the Advances in Clinical Supervision Conference, Sydney, 4-6 June 2013.

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Abstract

The concept of “parallel process” involves actual enactment of processes that are transferred from one interpersonal context to be re-enacted in another. The primary aim of this paper is to describe how parallel processing used in clinical supervision can incorporate professional development coaching protocols to develop and/or hone clinician skill and relationship competencies. The paper argues that the greater the number of parallels being engaged consciously (i.e., the exploration of interpersonal relationship patterns as well as the personal use of parallel change facilitation protocols by clinicians) the greater the normalising and empathy building functions clinician coaching will serve. This paper argues that the benefits of clinical supervision could be enhanced with more purposeful use of parallel processing, including a direct focus on the interaction between supervisory alliance, transference/countertransference and real relationship dialogue.

Key words: parallel process, mental health, transformational, interpersonal, supervision

This paper argues that the benefits of supervision could be enhanced with more purposeful use of parallel processing and professional development coaching. Parallel processing has a tradition in clinical supervision. However, effectively working with parallel process and adult learning principles requires further clarification, exploration and activation. Therefore, this paper recommends an expansion of the conceptualisation of parallel processing (i.e., exploration of transferred relational dynamics) to include a coaching framework in clinical supervision that utilises experiential learning protocols that are consistent with change enhancement protocols used with clients. This increases the potential of tracking the parallel journeys of the client’s recovery and the clinician’s professional development. It is argued that the greater the number of parallels being engaged consciously (i.e., the exploration of repeated interpersonal relationship dynamics as well as the personal use of parallel change facilitation protocols), the greater the likely competence of supervisees to work effectively with clients within these processes. At the relationship level this involves purposeful engagement in exploration of the relationship phenomena (e.g., feelings, expectations, behaviours) “in the room” to increase conscious contact with potential transference related or un-accessed material. This level of processing aims to facilitate access to more of the clinician-client interactional material via the immediacy of the supervisor-clinician (supervisee) encounter than is likely to be carried via the clinician “story of the interaction” alone into clinical supervision.

Parallel processes in clinical supervision

Traditionally “parallel process” within clinical supervision relationships involves instances where the dynamics of the relationship between a clinician (supervisee) and a client are re-enacted with the supervisor. Whilst in clinical contexts this “transference” refers to the re-enactment by the client of his/her unresolved relational needs with the clinician (Luborsky & Crits-Christoph, 1998; Book, 1998), in the context of supervision this is subsequently re-enacted by the clinician with her/his supervisor.

In many respects parallel process in clinical supervision might be thought of as the momentary blurring of client and clinician experiences. Searles argued that, “the parallel process behaviour of both the supervisor and supervisee rests upon ‘transitory unconscious identification occurring as a function of the relationship with the client’” (Searles, 1955, p. 161). Further, Morrissey and Tribe (2001) refer to this as the clinician having “the experience briefly of being like a client whom s/he does not actually resemble” (p. 104). However, parallel process should not be thought only as the transfer of a relationship dynamic travelling “up the line” from the clinical relationship to the supervisory relationship, as it is possible for interactional experiences and learning to also travels “down the line” from the supervisory relationship to the clinical relationship (Mothersole, 1999; Doehrman, 1976). Purposeful parallel processing then aims to heighten the awareness and experiencing of these transferred dynamics to such an extent that effective learning and potential resolution of relational dynamics within the supervision context will lead to effective learning and resolution within the clinical context (Morrissey & Tribe, 2001).
The development and maintenance of relationship management competence extends beyond a supervisor just being able to establish a good enough supervisory alliance (Crowe, et al 2011; Gonsalvez, Oades & Freestone, 2002). In relation to parallel processing supervisors need to develop sufficient mindfulness skills to notice when such (unconscious) re-enactments might be occurring and their own reactions to the presenting relational dynamics (i.e., potential counter-transference) (Book, 1998; Hayes, Gelso, Van Wagoner & Diemer, 1991). If transference material is overlooked there may be an increased chance that the supervisor responds to the clinician in a similar way as the clinician did with the client, thus continuing the pattern (Mothersole, 1999; Grenyer, 2002). For example this might resemble the clinician trying to get the supervisor to “fix” the problem by making all the decisions about clinical interventions and supervision directions in a similar way to how the client tries to get the clinician to play the dominant, directive role. In turn the frustration the supervisor may feel with the clinician’s “resistance” to taking ownership of the supervisor’s recommended strategies may directly resonate with the clinician’s frustration with the client for similarly not taking ownership of his/her recovery (Mothersole, 1999; Cassoni, 2007). Similarly, ruptures in the supervisory alliance (Safran, Crocker, McMain, & Murray, 1990; Shulman, 2005) are likely to negatively affect the clinician’s professional development in manner that mirrors client disengagement from the clinical process and retreat to well used coping mechanisms when there is a rupture in the therapeutic alliance (Safran & Muran, 2000).

Supervisors require sufficient alliance rupture management skills to: 1) resolve counter-productive tensions in the relationship, 2) understand how the dynamic might be worked through by the clinician with the client, and 3) help the clinician feel empowered enough to move forward (Safran & Muran, 2000; Crowe et al, 2011). Therefore, the supervisor needs to be able to understand and work with clinician’s motivational tensions, collaborate with clinicians to find ways through ruptures, and manage his/her own countertransference. Once again this parallels what the clinician needs to do to manage alliance ruptures in his/her clinical work, thus providing modelling opportunities for “down the line” benefits for clients. Further, when supervisors use more empowerment-focused practices (e.g., supporting autonomy, strengths focused) during supervision it is likely these practices will transfer to the therapeutic relationship with clients (Lombardo, Greer, Estadt & Cheston, 1998).

Coaching and clinical practice

Adopting a coaching framework to operationalize an “objectives based approach” within clinical supervision (Gonsalvez et al 2002) has several advantages. These include: a) having overt goal striving and action planning protocols to direct attention to and activate specific objectives (e.g., skills and relationship objectives), and b) providing direct experiences of using change enhancement protocols “first hand” for clinician-supervises that puts them in touch with their own strivings, resistances and interpersonal relationship patterns, with client empathy building functions and increased self awareness benefits (Crowe et al, 2011). Using parallel change enhancement protocols in both supervisory and clinical contexts may increase the likelihood that positive “down the line” transference occurs via shared experiences.

Transformation coaching has considerable overlap with clinical practice in terms of the aims to empower and help the person activate her/his potentials, attain specific goals, and reorient his/her life. Hawkins and Smith (2010) suggested that transformational coaching is “more involved with enabling the coachee to shift levels of ‘action logics’ and thereby make a transition from one level of functioning to a higher one” (p. 242). Adjusting levels of “action logics” involves a type of existential re-orientation of one’s learned or preferred ways of responding to situations particularly when under pressure. In many respects this is a kind of “mindfulness of being, relating and doing” or the practice of being a non-attached observer of one’s own reaction roles (e.g., rescuer, persecutor, martyr, individualist, tyrant etc, Hadikin, 2004). The “default” reaction roles reflect both the decisions one makes when faced with complexity of choices (Rooke & Torbert, 2005), and the dynamics of one’s family of origin. In relation to clinical supervision and parallel processing, transformational coaching “enables coachees to create fundamental shifts in their capacity through transforming their way of thinking, feeling and behaving in relation to others” (Hawkins & Smith, 2010, p.231).

Hawkins and Smith further suggest that transformational coaching involves: 1) shifting the meaning scheme (i.e., changing specific beliefs, attitudes and emotional reactions); 2) working on multiple levels at the same time (i.e., physical, psychological, emotional and purposive elements) to the point that the coachee embodies these changes (i.e. thinks, feels and behaves differently); 3) shifting in the room (i.e., overcoming stickiness usually through enactment and integration – thus directing the parallel process to authentic “real relationship” interactions – Gelso, 2002); and 4) maximising engagement (i.e., working directly with motivational dynamics). Therefore, the aim and practice of transformational coaching with clinical supervision contexts creates significant opportunities for “down the line” transfer of coaching skills and interactional experiences.

Parallel processing – what’s in the room?

Effective use of parallel processing involves a careful observation (mindfulness of being, relating and doing) of how the clinician “tells the story” of his/her encounter with the client. The telling of the story is much more that just the words or the content (Rennie, 1994). It is alive with the feelings and gestures, expectations and desires, of both the clinician and the supervisor. Parallel process is the energy exchange in the room, perhaps as much about what is hidden, left out or absent as that which is figural and overt (Resnick, & Parlett, 1995), as much about what is “between” the participants as within them (Hycner, 1993). It is the Here-Now, I-Thou and What-How phenomena alive within the immediacy of the contact between the supervisor and the clinician that points to the There-Then of the clinical context (Yontef, 1993).
Mindfulness refers to one's practice of non-attachment, non-judgement or elaboration, and commitment to staying present with moment-to-moment awareness (e.g., Kabat-Zinn, 2005). Practicing mindfulness is practicing taking a step back from enactments in the relationship dynamics long enough to observe and reflect upon them in terms of the roles being played, the potential motives behind the roles, and associated thoughts and feelings. In taking a step back from the process for a moment (i.e., observing the process as it is happening), useful questions for the clinician and supervisor to ask themselves are, “what am I trying to do here...how am I contributing to this dynamic...what is most important for me now in working with this person?”

It is often easier to notice transference of more difficult interactions with clients into the supervisory context. Where a client's relating style is difficult, it is more likely to elicit negative responses from the clinician (Klee, Abeles, & Muller, 1990). Reciprocally, the clinician's relating patterns can also elicit negative responses from the client. A paternalistic relating pattern will more likely elicit either a submissive or resistant reaction from a client (i.e., role reciprocity or concordance, Mothersole, 1999). The parallels within the supervisory relationship might in turn show up as either paternalistic, submissive or resistant relating from the clinician to the supervisor or vice versa. Where clinical supervision encourages positive and interpersonal reflection (Safran & Muran, 2000; Fox, 1998; Mothersole, 1999; Shulman, 2005) and “corrective” relational encounters as a way of processing transferred interpersonal dynamics and feelings, client outcomes are likely to be better (Foreman & Marmar, 1985).

It is also important to note that how a clinician reacts to a client's relating style, can reflect the clinician's own reciprocity or concordance tendencies, unresolved interpersonal issues, and/or anxiety issues (i.e., countertransference) (Fox, 1998; Shulman, 2005). Purposeful parallel processing in clinical supervision combines both interpersonal reflection and behavioural experiments designed to increase conscious contact with unresolved strivings, unfulfilled wishes and associated feelings. Each of these processing strategies is helpful in regards to identifying and managing countertransference reactions (Gelso, Latts, Gomez & Fassinger, 2002; Hayes & Gelso, 2001). It could be argued then that the broader the range of reflection activities engaged in by the clinician (e.g., exploring his/her own reactions and contributions to the interpersonal dynamics in clinical and supervision contexts, reflecting on what it might be like to be the client engaging with the clinician etc) the greater the normalising and empathy building functions clinical supervision will serve (Crowe et al, 2011).

**Summary**

In this paper it has been argued that the incorporation of coaching practices within clinical supervision provides valuable additions and structures to enhance traditional parallel processing work. Purposeful parallel processing involves: 1) observational or awareness skills (mindful reflection), 2) interpersonal relationship management skills (parallel relationship patterns), 3) change facilitation skills (parallel protocols), and 4) behavioural experiments aimed at increasing conscious contact with more of the participants' interactional experiences in the room (authentic, real relationship encounters). Each of these practices may increase the supervisor's empathy for his/her supervisees and in turn supervisees' (clinicians') empathy for clients. This in turn may lead to higher rates of transfer of these structural coaching interventions into coaching practices with clients. Working directly with the immediacy of personal experience in clinical supervision may increase the clinician's capacity to remain more present and mindful with clients.

This integration of transformational coaching principles and practices with clinical supervision helps expand the conceptualisation of parallel processing as the interpersonal re-enactment of relationship dynamics to include the use of parallel change facilitation protocols in both coaching for clinicians and with clients. In this way, personal transformation appears to serve key normalising and empathy enhancement functions reflecting both the personal/professional development of the clinicians and the recovery journeys of clients.

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Practice issues for remote professional counsellors – and how these can be effectively addressed in clinical supervision.

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Ref: Kingston A., Aitken J., Jimenez I., Thomson G. Practice issues for remote professional counsellors – and how these can be effectively addressed in clinical supervision. Conference paper presentation: Advances in Clinical Supervision Conference, Sydney Australia, 4-6 June 2013.

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Abstract

Life is rapidly changing in the way we choose to connect with one another and the world around us. While the merits of face-to-face counselling are unquestionable, remote professional counselling breaks through geographical, financial, social and other barriers to provide high-quality services for many Australians who might otherwise be unable to access professional services. Remote professional counselling services have proven to increase uptake and engagement by offering anonymity, immediacy and 24-hour availability while different counselling modalities present unique practice issues for clinicians and their clinical supervisors.

On the Line is Australia’s leading provider of professional remote counselling services, operating 24 hours a day, seven days a week, and employing over 100 professional counsellors. Specialising in the areas of men’s relationships and wellbeing, suicide prevention and mental health, the services provided include MensLine Australia, Veterans Line, the Australian Defence Force All-Hours Support Line, the Suicide Call Back Service, SuicideLine Victoria and the Access to Allied Psychological Services (ATAPS) Suicide Support Line. On the Line’s remote services range from national and state-based helplines to call back services, video counselling and online text-based counselling. These modalities ensure that people across Australia are able to access vital support.

At the core of client engagement, remote professional counselling modalities are similar to face-to-face counselling in that they seek to establish a dialogue between two people dependent on the therapeutic alliance they are able to establish. All remote modalities provide unique challenges and benefits. The provision of supervision in this context also provides challenges based on client characteristics, the organisational setting, the counselling approach and counsellor characteristics.

One of the perceived benefits of remote professional counselling for clients is anonymity; this also provides unique challenges for counsellors. Anonymity can be associated with lowered inhibitions of clients and with increased likelihood of the disclosure of trauma, inappropriate sexual content in sessions, malicious/prank clients and fictitious presentations. These issues can be difficult to challenge in the absence of visual cues and collateral information about a client. These matters commonly present in clinical supervision and present challenges to both the counsellor and their clinical supervisor.

There are also the associated demands arising from working on remote services with low control over the issues that clients present with along with at times high client demand. There can be challenges for counsellors in managing frame transitions that naturally occur in face-to-face counselling that may not be as clear in telephone counselling. Counsellors also have to manage the risk issues of clients in an uncontrolled environment, as the client is not in the same room as the counsellor.

There is further the difficulty in providing services at a professional level throughout a twenty-four hour operating cycle.

There are a number of issues that clinical supervisors must address in this context that will be examined in this presentation.

These will include:

- Supervising counsellors establishing a remote therapeutic relationship and how this differs from supervision provided in face-to-face counselling.
- Client issues specific to the remote professional counselling setting, the supervisee issues arise as a consequence and how clinical supervisors need to adapt their practices to manage these common issues.
- Managing supervisee burnout in providing remote professional counselling services.
- Vicarious trauma in remote professional counselling.
- Broadening the perspective, experience and task satisfaction of counsellors who receive low feedback on client outcomes.
On the Line services

On the Line is Australia's leading provider of professional remote counselling services, operating 24 hours a day, seven days a week, and employing over 100 professional counsellors. Specialising in the areas of men's relationships and wellbeing, suicide prevention and mental health, the services provided include MensLine Australia, Veterans Line, the Australian Defence Force All-Hours Support Line, the Suicide Call Back Service, SuicideLine Victoria and the Access to Allied Psychological Services (ATAPS) Suicide Support Line. On the Line's remote services range from national and state-based helplines to call back services, video counselling and online text-based counselling.

Professional remote counselling

Remote counselling in Australia offers counselling services that were previously difficult to access due to geographical, financial, and social barriers. The provision of counselling has continued to adapt to the advances in technology and the changes in health seeking behaviours in Australia.

There are currently many terms in the literature that have been used to describe remote counselling and the terms remote counselling and online counselling are used interchangeably. Mallen and Vogel (2005) defined online counselling as:

Any delivery of mental and behavioural health services, including but not limited to therapy, consultation and psychoeducation, by a licensed practitioner to a client in a non-face-to-face setting through distance communication technologies such as the telephone, asynchronous e-mail, synchronous chat, and video conferencing. (p. 764)

This definition encompasses the counselling modalities that are utilised by remote professional counsellors at On the Line. The remote counselling services that are provided by On the Line include 'open line' telephone counselling, brief telephone counselling, online synchronous text based counselling (single session and brief counselling), and videoconferencing (single session and brief counselling).

With increasing uptake of remote counselling services there is an increasing evidence base to support the efficacy of remote counselling. Remote counselling has been found effective for such issues as depression, anxiety, quitting smoking, and suicide prevention (Chester & Glass, 2006).

Benefits of professional remote counselling

The benefits of professional remote counselling include the immediacy of response, wide availability, low cost, high level of client control, and anonymity (Gould, Kalafat, Manfakh, & Kleinman, 2007; Mishara et al., 2007; Taylor & Furlonger, 2011).

Client anonymity has been identified as one of the salient benefits of remote counselling modalities. Clients that would not otherwise engage in help seeking because of the fear that they may be identified access remote counselling for many issues. One of the impacts of client anonymity has been described as the online disinhibition effect (Suler, 2004). For many people the ability to be anonymous in telephone and online counselling results in an increased level of comfort in disclosing personal information including private thoughts and feelings (Mishara et al., 2007).

Professional remote counselling offers immediacy of response in telephone and synchronous chat modalities. This is seen as helpful for clients who are experiencing immediate distress, suicidal ideation and want immediate support for these issues. Telephone counselling has been well established as a modality for managing for suicidal clients in crisis in many countries across the world. There is now increasing use of email and chat services to provide support to suicidal individuals such as the Samaritans programs based in the United Kingdom and the SAHAR program in Israel (Barak, 2007; Lester, 2008).

Professional remote counselling also enables access to counselling for clients who may have difficulty accessing face-to-face counselling due to physical or psychological impairment. Text based counselling options may be more attractive to clients with speech or hearing impairment (Coman, Burrows & Evans, 2001).

Professional remote counselling gives clients in rural and remote areas of Australia increased opportunity to access professional counselling services that may not be available to them in face-to-face services because of their geographical isolation or the lack of services in some rural and remote communities (Mallen & Vogel, 2005).

Challenges of professional remote counselling

Remote professional counsellors work in the absence of the visual cues and important non-verbal communication that is an integral element of face-to-face counselling. There is increased opportunity for miscommunication, time delays when using email, differing computer and typing skills either the counsellor or the client and the inability to directly intervene in a crisis situation (Coman, Burrows, & Evans, 2001; King, Bambling, Reid, & Thomas, 2006).

Remote telephone counsellors have the added benefit of hearing audible cues from the client but still must contend with the absence of visual cues. The audible cues in the background can also become distracting or distressing to the counsellor. The counsellor at times must assess and manage clients at risk of suicide and self-harm in an uncontrolled environment (O'Sullivan & Whelan, 2011). The reduction in client inhibition in telephone and online counselling also presents a variety of unique challenges for professional remote counsellors. Clients can experience fewer barriers to self-harm (Barak, 2007). This at times can lead to increased disclosure of trauma, inappropriate sexual material and personal information. There is also the potential for clients to view the remote counselling forum as a ‘confessional’ and disclose information pertaining to criminal intent or past criminal acts.
Clients also have increased control over sessions compared to face-to-face counselling. It is much easier for a client to end the contact by hanging up the telephone, exiting a video session, or disconnecting from a chat room than to walk out of a counselling session. Counsellors may experience increased levels of anxiety knowing that a client can end the contact at any time with little warning (Lester, 2008).

Counsellors that work on ‘open line’ telephone or online text counselling services can experience high demand associated with the number of incoming calls or clients registering for chat sessions. This can also be combined with low control associated with ‘open line’ work due to the inability to plan for sessions or know who their next client is or what the presenting issue may be. This inability to plan is in contrast to face-to-face work where it is often an ability to screen clients and plan the amount of time between sessions.

On the line operates a number of remote counselling sessions across the 24-hour cycle. This can pose challenges for counsellors in regard to their sleep/wake cycle and the ability to provide counselling at varying times of the day. The presentation of clients can also differ across the 24-hour cycle. Clients that seek services in the early hours of the morning often present as substance affected and aggressive, or may have called because of sleep difficulties and loneliness.

Counsellors often are working in the absence of feedback about client outcomes. This due to the nature of many remote services being single session paired with client anonymity. This can be a challenge for counsellors to judge their effectiveness with clients and maintain a sense of task satisfaction in their work.

The amount of content that can be covered in a synchronous chat session is significantly less than in telephone or face-to-face counselling sessions. This can be affected by the speed of the phone or the internet. Counsellors can find it difficult to address the clients’ issues unless a clear focus is gained early in the session (Williams et al., 2009).

**Establishing a therapeutic alliance in remote counselling**

Despite the numerous theoretical orientations and debates about the most effective counselling approaches, there is one unifying factor in counselling – the relationship between the counsellor and the client. This relationship has been defined as the therapeutic alliance. Bordin (1983) defined the therapeutic alliance with three facets: goals, bond and tasks. The goals describe the targets of the intervention that are agreed upon mutually by the client and the counsellor. The tasks describe the agreement between the counsellor and the client about “what is to be done” in counselling and how it will contribute to the resolving the clients problem. The bond describes the quality of the interpersonal attachment, liking and trust between the counsellor and the client.

The value of the therapeutic alliance in face-to-face counselling has been researched across different therapeutic approaches and has found the quality of the therapeutic alliance is a robust predictor of treatment outcome (Hovarth and Symonds, 1991). More recent research on the nature of the therapeutic alliance has shown that the client perception of the quality of the therapeutic alliance is a more accurate measure of the therapeutic alliance, and in turn predictor of treatment outcome (Duncan et al. 2003).

There is an increasing body of evidence of the efficacy of online counselling, despite this there is continuing debate about a range of clinical, ethical, and legal issues (Robson & Robson, 1997; Pelling & Renard, 2000). One of these issues is the ability to develop a therapeutic alliance in remote counselling. Theorists have argued that it would be difficult to develop a therapeutic alliance in the absence of non-verbal cues. Despite the perceived limitations of online counselling there is now growing evidence that demonstrates an effective therapeutic alliance can be established and that the strength in the therapeutic alliance in remote modalities is comparable with face-to-face counselling (Hanley & D’Arcy, 2009).

Research has shown that counsellors’ perception about the ability to build a therapeutic alliance increases significantly after they have conducted an online counselling session (Mallen, Jenkins, Vogel, & Day, 2011). It has also highlighted the need for counsellors to be trained in remote counselling to ensure that they have an understanding of the strategies that can be used to build the therapeutic alliance. Williams et al (2009) found that rapport building processes are used more frequently, and have a greater impact in online sessions than in face-to-face counselling.

**Client issues specific to remote counselling**

Remote professional counsellors must be adept at managing client risk in often challenging circumstances. Clients seeking contact with remote counselling services often do so in the midst of a crisis. These clients can present with high levels of suicide risk, report that they are in the process of self-harming, and can present as highly distressed (Barak, 2007). In some cases clients who are at risk from violence contact services while at risk of being harmed by another person. This can increase the level of anxiety experienced by remote professional counsellors working with these clients with the absence of collateral information, or ability to manage the environment that the client is in while engaged with the service.

Another client group that remote professional counsellors must manage well, particularly on the open line telephone counselling services, are chronic presentations or regular callers (Lester, 2008). These clients often have presentations consistent with Borderline Personality Disorder, Schizophrenia, and other mental health issues. These clients will often call the services multiple times a day, often stating they are at risk of suicide or self-harm.
Clients with mental health issues can also present challenges for remote professional counsellors when they are providing services to these clients without the assistance of collateral information, the client history or formal diagnosis. The counsellor is required at times to assess the client and provide interventions in a short period of time. These clients will at times present seeking assistance for the first time or will be seeking support when they are in crisis.

Clients that contact remote counselling services seeking advice about a person they are concerned about are referred to as ‘third party’ clients. The challenge for the counsellor is to provide support for their client who is worried about another person whilst also assessing the risk of the third party and the client. Many of these clients call hoping for a ‘magic solution’ that will enable them to assist the person they are concerned about.

From time to time people attempt to misuse remote counselling services for sexual gratification, often on open line telephone counselling services. The combination of anonymity and disinhibition associated with telephone and online counselling services creates a potential for clients to attempt to abuse these services (Lester, 2008; Suler, 2004). Remote professional counsellors must be adept and recognising sexually inappropriate material and setting appropriate boundaries with these clients, and if necessary terminating contact with these clients. To support counsellors in this process it is important that the support structures, policy and procedures of the organisation assist the counsellor in managing these clients.

Fictitious presentations or pranksters also present from time to time in remote counselling modalities. These presentations can be a challenge to assess in the absence of visual cues and collateral information about a client. Counsellors are often presented with incongruent information from a client that must be assessed and managed in a short space of time.

Substance affected clients pose unique challenges for remote professional counsellors. Clients who are substance affected can present as aggressive or abusive, are difficult to contain, and can present as a risk to themselves or others. Substance affected clients can also over disclose previous trauma because of the lowered inhibitions associated with substance use and the online disinhibition effect. Counsellors must balance managing the immediate risk of the client, the effectiveness of engaging with a person who is substance affected and the clients lowered inhibitions.

Vicarious trauma and burnout

Burnout has been described with three distinct features: emotional exhaustion, detachment from the job, and feelings of ineffectiveness or lack of personal accomplishment (Maslach & Jackson, 1981). Burnout in counsellors has been linked to organisational and interpersonal factors such as workload, limited support, role conflict, rigid hierarchical systems, number of years in a counselling role, and level of education.

Although Vicarious Trauma (VT) is often associated with counsellor burnout the conceptual difference is that VT is associated with the impact of working therapeutically with traumatised clients (Devilly, Wright, & Varker, 2009). The impact of VT on the counsellor has been conceptualised as a change in the counsellor’s beliefs and systems of meaning leading to a reduced sense of safety and control in an unsafe world.

Vicarious Trauma in counsellors has been linked with level of experience; research has indicated that counsellor with less than two years experience had increased levels of VT. Counsellor’s personal trauma history and number of contact hours with trauma related clients has also been associated with increased symptoms of VT (Dunkley & Whelan, 2006).

Remote professional counsellors are often exposed to trauma related client work or traumatic events through engagement with clients in an uncontrolled environment. Clients who are substance affected or have lowered inhibitions may more readily disclose past trauma than in face-to-face counselling (Suler, 2004). Remote professional counsellors can also be exposed to trauma if clients are reporting that they are self-harming or are about to attempt suicide. For example, a client may call a suicide crisis line stating that they are about to attempt suicide by stepping in front of a train. The counsellor may be able to hear the train in the background, significantly increasing the anxiety a counsellor may experience during a session.

Dunkley and Whelan (2006) investigated VT among telephone counsellors, looking at the influence of coping style, supervision and personal trauma history on VT. They found non-productive coping was associated with disruptions in cognitive beliefs and that a strong supervisory working alliance was associated with lower levels of disruptions in cognitive beliefs. This highlights the importance of quality supervision in the provision of telephone counselling.

Supervision of remote professional counsellors

The establishment of an effective supervision alliance has been identified as a factor that increases counsellor willingness to engage in supervision, increases ratings of work satisfaction, and reduces the impact of vicarious trauma (Bambling, 2000; Dunkley & Whelan, 2006; Sterner, 2009). An effective supervisory working alliance provides the foundation to allow counsellors to safely explore the anxieties and challenges associated with remote professional counselling. On the Line has separated line management functions from Clinical Supervisors roles to promote a safe space for counsellors to reflect on their work and develop their skills.

At On the Line all remote counselling sessions are recorded, allowing supervisors and counsellors greater access to the client work for review and reflection in supervision. This promotes a focus on skill development and the ability to track themes that arise in the counsellor’s
practice. The ability to focus on skills specific to remote counselling modalities can improve counsellors' task satisfaction as their confidence in the effectiveness of online counselling increases. For example, the amount of content that can be covered in an online chat session with a client is significantly less than in face-to-face or telephone counselling (King, Bambling, Reid & Thomas, 2006). Through review of online sessions in supervision counsellors have been able to develop strategies to provide a clearer focus is sessions and develop strategies to more effectively engage clients in online chat counselling.

A supervision task in remote counselling that contributes to counsellor development and increases their awareness of the effectiveness of remote counselling interventions, is broadening their perspective of theory based approaches. It has been helpful for counsellors working with chronic clients to place the client within a theoretical context and treatment framework. For example, counsellors working on 'open line' suicide helplines often work with chronic clients with presentations consistent with Borderline Personality Disorder. It can be frustrating for counsellors to have regular contact with these clients in the absence of feedback or signs of improvement from the client. Placing the client within the context of Dialectical Behaviour Therapy treatment can assist the counsellor in viewing the longer term process of change, and focus on the emotional regulation and coping skills of the client (Linehan, 1993).

A common theme that arises in clinical supervision of remote counsellors is the challenges associated with engaging clients that are in an uncontrolled environment. It has proven helpful for supervisors to role model the importance of setting the counselling frame for clients. This includes establishing a safe space for supervision and setting boundaries with supervisees, counsellors can transfer this learning across to the remote modalities. Counsellors have recognised the value of having overt discussions with clients about the environment that the client is in during sessions, and the expectations and limitations of counselling.

It has been useful for counsellors to reflect on the differences between face-to-face counselling and remote counselling within the supervision context. It has highlighted for some counsellors that the frame transitions that may naturally occur between sessions in face-to-face counselling, when a client physically leaves the counselling room, may not always be as clear in remote counselling. Remote counsellors have been able to develop their own strategies for making these transitions clearer, such as closing off case notes, standing up between sessions or even visualising the client leaving a counselling room. In doing so, counsellors have noted that they have been able to separate clients more effectively, reducing the likelihood of taking countertransference reactions from the one session into the next session with a client (Lester, 2008).

Remote counsellors often work with client presentations that are at high risk of self harm or suicide or have experienced recent trauma on a daily basis. It is important that the potential impact of this work acknowledged and addressed in supervision. At times there is an important focus on the restorative aspects of supervision for remote counsellors. Remote counselling can present unique differences in how counsellors may be exposed to trauma. For example, remote counsellors working on telephone crisis lines do not attend to the visual cues of a client's presentation that a counsellor would in face-to-face counselling. When listening to a client discussing a traumatic event, counsellors created their own vivid image of the event in their mind, as they were not attending to any other visual cues. When discussing the impact of the work in supervision counsellors have been able to develop an awareness of the need to attend to other visual stimuli when clients are describing traumatic events.

Awareness of counsellor self-care and wellness is an important aspect of supervision assisting with the prevention of burnout, and assisting counsellors to work effectively across 24-hour cycle. Self-care and wellness is a fixed agenda item in supervision at On the Line and is combined with access to the Employee Assistance Program, if counsellors need further support for issues that can not be addressed appropriately within the limits of supervision.

Remote counselling modalities provide unique challenges and benefits for counsellors and their clinical supervisors. In this growing area of professional counselling it is important that supervisors are able to identify and respond to the emerging issues and trends. Supervisors with the knowledge and skills specific to remote counselling provide the necessary support to counsellors working in the challenging and rewarding area of remote counselling.

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Teaching to teach
Catherine Hickie, Louise Nash, Brian Kelly


Paper presented by Catherine Hickie and Louise Nash at the Advances in Clinical Supervision Conference, Sydney, 4-6 June 2013.

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Background

Teaching is an important role for psychiatry registrars who play a major part in teaching medical students during their clinical attachments (Dang et al 2010). In addition to this, registrars have a role educating families, patients, peers and health colleagues from other disciplines. The authors experience in New South Wales is that psychiatry trainees regularly provide clinical teaching - including tutorials for medical students, journal article discussion groups for peers and psychiatrists, case based discussions for multidisciplinary colleagues as well as having medical students attached on clinical placements (Hickie et al 2013).

Providing good clinical teaching to all medical students on clinical placement is important. Those with an interest in mental health may seek further skill development as junior doctors, including a rotation through psychiatry, and some will choose to train as psychiatrists. However doctors who chose to work in medical/surgical sub specialities and in general practice will also encounter people with mental health problems. Basic psychiatric consultation skills are needed by all medical graduates. The medical student years are a crucial learning opportunity.

The teaching – learning continuum

There is a continuum of teaching and learning in medical practice that begins in the student years, continues after graduation for junior doctors and into specialty training years. A commitment to continuing medical education is a part of medical practice throughout a career. Inter professional education is a part of this continuum. The training years provide a good opportunity to learn the skills needed for these roles (Post 2009). Good teaching encounters bring benefit to both student and registrar, and teaching sharpens focus for learning (Polan 2010).

Psychiatry registrars are not only teachers but are the recipients of teaching and supervision. During their five years of training, registrars are required by the Royal Australian and New Zealand College of Psychiatrists (RAZNCP) to have one hour of individual supervision with their supervising psychiatrist each week (for 40 weeks of the year), with the content of the session focussed on the trainees learning needs. (RAZNCP Fellowship Program). These sessions are in addition to psychotherapy supervision. Clinical issues are often chosen as the theme for discussion, but teaching issues fit within the parameters. Further, in the first three years of psychiatry training it is mandatory for registrars to attend a Formal Education Course (FEC). In NSW there are two accredited FECs. One of these (Hunter New England Psychiatry Training) has recently included a program to address teaching skills as part of the curriculum.

Are psychiatry registrars using current opportunities to improve their teaching skills or is a specific program needed? What are registrars’ preferences for a program aimed at improving teaching skills?

NSW Psychiatry Registrar Survey

The authors undertook a study to investigate NSW psychiatry registrars’ experience and confidence as teachers. A brief questionnaire was developed and included demographic data as well as prior experience in teaching, confidence in this role, and perceived support from supervisors. Further, we asked registrars their preferences for a program to improve their teaching capacity. All registrars in the two Formal Education Courses in NSW were approached at the commencement of their mandatory lecture programme in February/March 2012 and invited to complete the survey and participate in a focus group. Three groups were held, two in Sydney and one in Newcastle. Most respondents reported having medical students with them on clinical placements but few had had formal training in how to teach. Respondents were able to identify areas where they felt most confident teaching. Registrars commencing their first year of training were less confident teaching than second and third year registrars. A minority of respondents discussed teaching issues in supervision.

In focus groups, registrars said that sharing knowledge was an integral part of the medical culture. They saw teaching as a welcome part of their role, and an aid to their own
learning. (Hickie et al 2013) Most respondents reported that a program to learn teaching skills would be welcomed.

In response to the survey results we are developing workshops to increase teaching capacity.

Teaching Skills Workshops

There is evidence in the international literature that introducing a program to build teaching capacity has benefits for both registrars and medical students. (Lehman 2010) We have developed a teaching workshop using the one minute preceptor model, a structured approach that identifies five micro skills for clinical teaching. (Neher et al 1992) It was developed for use in general practice but adapts to teaching in psychiatry.

While workshops aimed at improving teaching skills have been reported to improve registrar confidence in teaching and self-assessed competence, most studies lack robust measures such as direct evaluation of teachers or learner outcomes (Hickie et al 2013). In addition, there are particular challenges for registrars teaching medical students in psychiatry. For example, in our focus groups registrars identified overcoming students' prejudice against mental illness as an additional challenge.

Conclusion

Students value good teaching and registrars value being able to teach well. Registrars need a supportive environment to teach, as well as the skills to do so. A program to improve teaching capacity should target specific skill development in the areas of least confidence. Strategies to increase the perception of support from supervisors are needed including encouraging psychiatrists to promote discussion of teaching experiences in supervision.

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When supervision resembles a trainwreck

Graham Barker

Ref: Barker G. When supervision resembles a trainwreck. Conference paper presentation: Advances in Clinical Supervision Conference, Sydney Australia, 4-6 June 2013.

Paper presented by Graham Barker at the Advances in Clinical Supervision Conference, Sydney, 4-6 June 2013.

Dr Graham Barker Psy.D is a semi retired clinical psychologist and academic whose major focus these days is providing supervision and depleting NSW fish stocks.

Abstract

This paper explores the damaging practice of mismatching clients, supervisees and supervisors of differing competency and experience levels as portrayed in the works of Stoltenberg, McNeill, and Delworth (2010) and the US National Institute of Health (2003). Stoltenberg et al., have identified three levels of supervisee development and three levels of supervisor development to which I propose the addition of three levels of clients based on readiness for therapy: referral status; motivation for therapy; focus of therapy; current functioning and previous mental health issues. Stoltenberg states that level one supervisees are generally entry-level trainees who are high in motivation, yet high in anxiety and fearful of evaluation; level two supervisees are at mid-level and experience fluctuating confidence and motivation, often linking their own mood to success with clients; and level three supervisees are essentially secure, stable in motivation, have accurate empathy tempered by objectivity, and use therapeutic self in intervention. The damaging effects of the mismatches are identified for client, supervisee and supervisor and demonstrated though case examples. Suggested preventative measures are presented.

According to Bernard and Goodyear (2009), the qualities of a good model of clinical supervision need to be rooted in the learning and developmental needs of the supervisee, the specific needs of the clients they serve, the goals of the agency in which they work, and in the ethical and legal boundaries of practice. Stoltenberg et al., (1998, 2008, 2010) would expand on these imperatives to include the developmental needs of the supervisor.

Developmental Factors

Levels of Supervisee Development

Stoltenberg et al., (2010) after Hogan (1964), have identified three levels of supervisee development and three levels of supervisor development to which I propose the addition of three levels of clients based on readiness for therapy. Stoltenberg et al (2010) states that a level one supervisee is generally an entry-level trainee who is high in motivated, yet also high in anxiety and fearful of evaluation (see Figure 1 overleaf); a level two supervisee is at mid-level and experience fluctuating confidence and motivation, often linking their own mood to success with clients (see Figure 2 overleaf); and a level three supervisee is essentially secure, stable in motivation, have accurate empathy tempered by objectivity, and uses therapeutic self in intervention (see Figure 3 overleaf).

Levels of Supervisor Development

The level one supervisor tends to be overly anxious in her or his role, is focused on correct process and does not provide consistent constructive feedback. A level two supervisor often concentrates on correcting a therapist’s weaknesses and can more easily slide into a therapeutic role while a level three supervisor is comfortable with her or his role and can provide objective, constructive evaluation and feedback.

Levels of Client Readiness for Treatment

It is my experience that the level one client is predominately self-referred, highly motivated, focused on a single issue, is functionally stable and has no prior history of psychological problems.

A level two client comes to therapy as a recommended referral from a medical or allied health professional, is semi – motivated, dealing with more than one issue, is functionally unstable and has an erratic history of psychological problems.

A level three client is a mandated or “coerced” referral, lacks motivation, has a dual diagnosis and/or multiple issues, is intermittently or regularly non-functional and has a recorded history of psychological problems.

It is my belief that a mismatch across any of these three levels constitutes a risk for a supervision “train wreck”.

Permit me to relate an account provided by a level one supervisor regarding their experience with their level one male intern who was allocated a level two female client.
Figure 1

<table>
<thead>
<tr>
<th>Developmental Level</th>
<th>Characteristics</th>
<th>Supervision Skills Development Needs</th>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>• Focuses on self • Anxious, uncertain • Preoccupied with performing the right way • Overconfident of skills • Overgeneralizes • Oversuses a skill • Gap between conceptualization, goals, and interventions • Ethics underdeveloped</td>
<td>• Provide structure and minimize anxiety • Supportive, address strengths first, then weaknesses • Suggest approaches • Start connecting theory to treatment</td>
<td>• Observation • Skills training • Role playing • Readings • Group supervision • Closely monitor clients</td>
</tr>
<tr>
<td>Level 2</td>
<td>• Focuses less on self and more on client • Confused, frustrated with complexity of counseling • Overidentifies with client • Challenges authority • Lacks integration with theoretical base • Overburdened • Ethics better understood</td>
<td>• Less structure provided, more autonomy encouraged • Supportive • Periodic suggestion of approaches • Confront discrepancies • Introduce more alternative views • Process comments, highlight countertransference • Affective reactions to client and/or supervisor</td>
<td>• Observation • Role playing • Interpret dynamics • Group supervision • Reading</td>
</tr>
<tr>
<td>Level 3</td>
<td>• Focuses intensely on client • High degree of empathic skill • Objective third person perspective • Integrative thinking and approach • Highly responsible and ethical counselor</td>
<td>• Supervisee directed • Focus on personal-professional integration and career • Supportive • Change agent</td>
<td>• Peer supervision • Group supervision • Reading</td>
</tr>
</tbody>
</table>

Source: Stoltenberg, Delworth, & McNei, 1998

Figure 2

<table>
<thead>
<tr>
<th>Developmental Level</th>
<th>Characteristics</th>
<th>To increase Supervision Competence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>• Is anxious regarding role • Is naïve about assuming the role of supervisor • Is focused on doing the “right” thing • May overly respond as an “expert” • Is uncomfortable providing direct feedback</td>
<td>• Follow structure and formats • Design systems to increase organization of supervision • Assign Level 1 counselors</td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>• Shows confusion and conflict • Sees supervision as complex and multidimensional • Needs support to maintain motivation • Overfocused on counselor’s deficits and perceived resistance • May fall back to being a therapist with the counselor</td>
<td>• Provide active supervision of the supervision • Assign Level 1 counselors</td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>• Is highly motivated • Can provide an honest self-appraisal of strengths and weaknesses as supervisor • Is comfortable with evaluation process • Provides thorough, objective feedback</td>
<td>• Comfortable with all levels</td>
<td></td>
</tr>
</tbody>
</table>

Source: Stoltenberg, Delworth, & McNei, 1998

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**Case Example 1**

The level one clinician was interning at a facility that catered for a variety of clients including adolescents. To this point the intern had been a co-therapist with an experienced clinician. This particular day the intern was allocated a female adolescent assessed to be at risk for suicide. The intern would, on this occasion, be the only clinician present. The intern walked into the client’s room to conduct the initial interview and after introductions and formalities the young client began to relate her story and then, without warning, climbed on the desk and began to dance and remove her hooded sweater revealing her bare body. The intern was taken aback and immediately vacated the room leaving the client alone.

At supervision that week the supervisor, whose experience with adolescent borderline clients to this point was zero, could only empathise with the intern and ask what would be their approach to treatment. The intern felt inadequate and ill-equipped to provide the necessary treatment as he had already lost control of the first session. The intern was subsequently replaced by a more experienced clinician. This train wreck may have been averted had the level one intern been allocated a level one client or, at the very least, a level two supervisor rather than the combination of a level two client and a level one supervisor.

**Accurate matching is a matter of “Duty of Care”**

The correct matching of client, clinician and supervisor across all levels is a matter of duty of care. There are a variety of ways duty of care is addressed.

The Queensland Government Human Resources Policy G5 (2008) addressed this issue when it stated that:

“Developmentally, the supervisor will have at least the same or higher level of practice skills than the supervisee in the majority of specific competencies that are the primary focus for supervision. Whenever possible, at least fifty percent of the minimum contact levels will be obtained from a supervisor with at least five (5) years of experience in mental health practice and advanced practice skills.”

It is apparent that therapists at more advanced developmental levels have different learning needs and require different supervisory approaches from those at less advanced levels and theoretically the developmental levels can be applied for different aspects of a therapist’s overall competence e.g., Level 2 mastery for individual therapy and Level 1 for couples and family therapy.

The developmental model presented in Figure 2 provides a framework to explain the actions of supervisors at the various stages of their development. It is expected that someone new to supervision would be a Level one supervisor. In addition, The Centre for Substance Abuse Treatment (CSAT), (2008) advises that a “level one supervisor should be at least at the second or third stage of counsellor development. If a newly appointed supervisor is still at Level one as a counselor, he or she will have little to offer to more seasoned supervisees.” (TIP) Series 52.

Unfortunately, most role descriptions or descriptions of supervisory responsibilities do not address the issue of correct matching of levels of client need and levels of counsellor competency. I assume this imperative is ignored or considered irrelevant, likewise the necessity of matching supervisor and supervisee levels.

When Proctor (1986) outlined the key purposes of clinical supervision as: “Formative”, “Restorative” and “Normative” she also stated that both supervisor and clinician share the responsibility for a safe, ethical and reflective process that creates the environment for the purposes to be achieved (pp.21-23). A more refined statement regarding safe and ethical practice is noted in the Queensland Government’s Human Resource Policy (2008) where it provides its staff with the following directive: “Supervisors also need to take appropriate steps to safeguard themselves, the clinician and the organisation by ensuring that:

- they are appropriately trained to provide clinical supervision
- their clinical supervision practice remains within their level of competence and capabilities (p.13)”.

If such a directive is not given by an agency, the supervisor and supervisee are still responsible for safe and ethical practice as covered in their association's ethical statements. The Australian Psychological Society’s Code of Ethics (2004) in its "Guidelines for Supervision" states: General Principle II (b): “Members must refrain from offering advice or undertaking work beyond their professional competence” and again in: Article 5.3. “When members provide supervision, they must be competent to do so. This requirement includes having content knowledge for the type of supervision being sought and skills related to the process of supervision.”

**Issues impacting the matching of parties**

**Power**

The interaction between a supervisor and their supervisee can be influenced by both parties’ developmental level and by the supervisor’s ability or inability to promote growth by developing an appropriate environment (Quarto 2003). Campbell (2006) found that power also plays an important role in the development of the supervisory relationship, where differing levels of experience or training and the evaluative nature of clinical supervision creates a dynamic in which the power differential is inherently unequal. Beginning supervisors may be more likely to exert excessive control over the supervisory relationship and environment.
and be more sensitive to perceived threats to their authority (Quarto 2003). Conflict can also erupt from the supervisee’s negative feelings toward the over controlling supervisor and from the power struggle.

**Unresolved conflicts**
Ramos-Sanchez, L, E Esnil, A Goodwin, S Riggs, L O Touster, I K Wright, P Ratanasiripong and E Rodolfa. (2002) found that unresolved conflict over clinical and personal issues in supervision deteriorates the supervisory alliance, has a negative impact on supervisees’ confidence with clients and leads them to develop a negative view of supervision and counselling in general. The authors advised that such a negative experience can have a significant impact on supervisees’ quality of therapy, their career goals and impede their clinical development.

**Case Example 2**
Joan was the senior member of the agency treatment team by virtue of natural attrition. Only recently there had been two more-senior clinicians on staff who had resigned and moved on. Joan was only two years post-internship and still feeling her way when she was given the supervision responsibility for one of the replacement psychologists. Her supervisee was a former mature entry student she knew from University who had been working in the UK and now returned. The classmate’s resume from the UK stated he had been working with dual diagnosis clients in a government-run refuge environment. Joan recalled he had a background in addiction counselling and had worked at a rehab centre during his studies. She also knew he had been hired because of his expertise in the area of substance abuse.

During their second supervision session Joan was challenged on her understanding of the issues involved in the psychologist’s presented client. Acknowledging her lack of knowledge Joan continued to direct the session to the client’s stated needs. This did not go down well with the clinician who continued to challenge Joan’s position as his supervisor. Joan ended the session and spoke to the agency manager who said that she would take over the supervision until they could find someone suitable.

Joan was relieved but soon found her clinical sessions were wandering and her confidence waning. She realised she was thrown unprepared into the situation and has since taken supervision studies in an attempt to regain her position.

**Recommended Solution**
It is obvious to this author that the solution to the problematic mismatching of clients with clinicians and clinicians with supervisors across levels is to provide a solution matrix to which those responsible for allocating the clients to clinicians and supervisors to supervisees can refer and minimise the potential for train wrecks.

The one foreseeable impediment to an effective application of the matrix is the accuracy with which clinicians are classified into the three levels. According to Chagnon and Russell (1995) the task of classifying level 1 and level three clinicians is accomplished consistently well among supervisors yet the classification of level 2 clinicians is more difficult because most clinicians at that level display characteristics of both level 1 and level 3 since they are transitioning between them. The authors of the research conclude that a clinician who demonstrates inconsistent level 3 qualities be classified as level 2 and likewise a clinician who cannot demonstrate consistent level 2 qualities be classified at level 1. Once the classifications are complete the allocations can be made according to the matrix in Figure 3. Where the optimum matchings are marked by the letter (X). E.g. A level 2 supervisor is approved to supervise clinicians on level 1 and 2 but not level 3. Similarly a level 1 clinician is approved to work with a level

![Figure 4: SOLUTION MATRIX](image)

**Conclusion**
The mismatching of clients with clinicians and clinicians with supervisors across levels can pose threats to the clinical outcomes for clients and personal and the professional growth of clinicians and supervisors. The resulting train wrecks can be avoided by individuals and agencies considering the developmental stages of their clinicians and supervisors and matching them with the appropriate clientele.
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Understanding clinical issues in student supervision: A psychodynamic practitioner researcher approach

George Karpetis

Abstract

As a result of the professional dichotomy between 'micro' and 'macro' social work practice (Maschi, 2011), a multi-theoretical or even a-theoretical framework is often suggested for the field practice supervision of social work students. This framework employs sociocultural and/or administrative theoretical approaches in order to assess and deal with client psychosocial problems; often at the expense of a deeper understanding of clinical issues (and ultimately of the psychopathology) of the clients (Karpetis, 2010; Karpetis, 2011). In the present study, the author presents critical incidents from his group student supervision practice, aiming to underlie the importance of the clinical understanding of the clients’ psychosocial problems. A further aim of the study is to evaluate the effectiveness (students’ learning experience) of the clinically minded supervision practice.

The author employs the psychodynamic approach in order to understand the causes of the clients’ psychosocial and mental health problems. Psychodynamics accept the primacy of emotions on human behaviours (Rustin, 2003) and regard client psychopathology as the developmental outcome of the internalized experiences of the clients’ primary relationships. In fact, client psychopathology is understood as the effect primary relationships have on the personality structure, defensive patterns and ultimately the ways clients relate to other people. Psychopathology is further understood through direct or passive forms of aggression (usually unconscious) directed against one’s relationships bringing about problems in the accomplishment of the developmentally appropriate social roles (Karpetis, 2012). The provision of a ‘therapeutic relationship’ according to which the effects of aggression on the client’s current relationships is understood, reduces client symptoms and leads to improved social role functioning.

The supervision process is illustrated in time sequence and in accordance to the main clinical issues discussed. Students present anamnestic process recordings of an interview with a client. Student mishandling of cases, or failures in dealing with client problems are identified as practice mistakes that need to be corrected. Students are primarily assessed according to their willingness and ability to learn from practice mistakes. Student emotional problems or personality issues are not commented since the supervision setting deter’s therapeutic interventions and there is no student ‘request for therapy’. Supervisor interventions that aim to create and maintain a ‘therapeutic supervision setting’ promote learning and increase the students’ field practice effectiveness.

Student active or passive forms of aggression during supervision are connected to the relationship (absence of trust) with the supervisor as well as to group and institutional dynamics. Students trust those supervisors who feel clinically competent and also take clinical responsibility for the cases the students work with. Both effective and ineffective interventions of the supervisor will be connected to (i) his training and practice experiences (2) the institutional dynamics and (iii) countertransference. Student resistance to learn will be connected to the students’ relationship with the supervisor (unconscious aggression) as well as to their developmental needs that primarily stem from a meta-adolescent idealization of one’s own internalized parental figures (therefore of the supervisor) and of him/herself.
Rationale

Historically, the ‘educational function’ of supervision, also called clinical supervision, had a semi-therapeutic tone and aimed at exploring the way the internal world and the personality structure of the supervisee affect practice with clients. Subsequently, various clinicians employed the “parallel process” according to which the supervisee, owing to unconscious identification with patients, is thought to replicate the problems in his/her relationship with the supervisor. An extensively referred social work scholar (Kadushin, 2002) reported that the ‘therapeutic/educational’ attitude of the supervisor was felt intrusive by students due to blurring of boundaries. Accordingly, many supervision theorists endorsed the “powerful emotions” term to “a-theoretical” or “eclectic” supervision theories. Today, although most authors emphasise ‘relationship’ as the key supervision practice component and many studies on psychodynamic treatment exist; little has appeared on the psychodynamic model of supervision in the helping professions and much less in social work (Ganzer & Ornstein, 2004).

The supervision setting

Students (during their four-year social work training) undertake two field practice placement courses across their fifth and sixth semesters, on a three-days-per-week basis. The final six month full-time placement takes place during the eighth semester. Students are placed in either private or state funded social and health care agencies, which deal with various biopsychosocial problems of children, adults and the aged. A social work practitioner from each field practice agency is appointed as the ‘field practice manager’ to assign and attend to students’ day-to-day work.

The supervisor is a social work academic with clinical training at the Tavistock Clinic and in child psychotherapy, who offered 12 group supervision sessions to 6 students, once a week, for 3 hours per session. Students pass the placement if they score more than 50% in the assessment criteria. The supervisor grades the students. The social work degree was offered by a South Eastern European University.

Method

All the supervisees were in the fifth semester of their studies and they had no previous field practice or supervision experience. I am currently studying my own supervision practice through reflectivity. Reflective practice requires understanding practice and improving effectiveness (Gibbs, 2001). The reflective method currently employed is process reflection (Ruch, 2007) which draws on psychoanalytic theory and concentrates on both conscious and unconscious aspects of practice.

Reflexivity in supervision refers to the containment of the supervisees’ anxieties. The research data include my own process recorded supervision sessions as well as the supervisees’ process recorded sessions they had with their clients. Anonymity was safeguarded, while student and client consents were respectively acquired. Critical incidents will be presented throughout the 12 group supervision sessions.

The psychodynamic perspective views both internalized and real primary relationships (0-2 years) as the cause of the development of emotional problems in people. The provision of the therapeutic relationship (transferential relationship aspects) is regarded the means to understand and treat emotional problems. When the principles of the therapeutic setting are employed while supervising healthcare practitioners, learning is facilitated. Emotions have an enormous influence on learning. In fact, attitudes to learning are shaped in the context of earliest baby-mother relationships. Accordingly, during supervision, each student and teacher brings into the encounter their own history of relationships.

The first supervision session

I was waiting in the classroom for the students to gather. I did not call anyone into the room because supervision attendance is an adult choice. In the exact time the supervision session was due, I closed the door in order to make supervisees feel that their anxieties were to be contained in a secure and safe environment. Student delays were treated as ambivalence towards supervision and the supervisor (trust issues).

Students were informed about the content of their meetings. Each student was expected to present a case in turn, for up to 30 minutes and a group discussion was expected to follow. The supervisor, through time allotment, intended to indirectly convey the message that practice issues and difficulties would have to be presented and dealt with within the given time limits; and also that all students were of equal importance to the supervisor (enhancing positive transference). Towards the end of each session, 15 minutes were provided for students to discuss “urgent” queries. Finally, bibliography was suggested on normal human development and psychopathology.

The role of the supervisor was to identify both with the patient and the supervisee; to verbalise the emotions of each participant so that supervisees feel understood and accordingly enabled to identify with and understand the patients. The supervisor also assisted supervisees to understand the way client emotional needs guide their actions and their life choices. Further, the supervisor identified problems in the environment that exaggerated client problems (Karpetis, 2010). Also he commented on the way social institutions create anxiety through allocating roles and reinforce power relations (Menzies-Lyth, 1988). Furthermore, he safeguarded the boundaries of the supervision setting (Karpetis, 2011) and contained the students’ ambivalence and confusion; emotions that are component parts of learning in the higher education environment (Karagiannopoulou, 2011).
Critical incidents in the introductory supervision phase

Anxious and defensive students regarded observation unimportant and a ‘loss of time’. The supervisor understood this defensive student manoeuvre, as an unconscious attempt from students to solve their own problems. Accordingly, some field placement agencies were characterized as ‘more important’ or ‘better’ from others. The supervisor replied by way of commenting on ethical issues (all clients and their problems are of equal importance); on the developmental causes of client problems (emotional and environmental) and on the need for students to understand individual as well as institutional dynamics, irrespectively of the client problem type or client age group. The supervisor additionally discussed possible student avoidance manoeuvres while dealing with emotionally painful client problems (Waddell, 1989). He further commented on the students’ fear that he might not be caring enough. In that way he employed transference to the setting interpretation (Karpetis, 2012) in order to bring those defences onto the surface and allow learning from experience to take place.

Throughout the supervision process, the supervisees were required to deal with their own idealizations and allow for ‘secondary socialization’ that is unconsciously felt as a betrayal to the ‘primary socialization’ imposed by a supervisee’s parents in the past (Itzhaky and Ribner, 1998). A student was unable to write the process recording notes of the first interview she had with a patient because she “could not remember anything”. Responding to her anxiety, the supervisor commented that engaging with client problems might be emotionally difficult sometimes, because these problems stir anxiety and fears, which might block someone’s ability to think and remember. The supervisor prompted the student to write as much as she could remember. When the process recorded noted were subsequently awarded meaning by the supervisor, the student was progressively able to remember more interview incidents.

Taking process notes safeguards both the supervisor and the supervisee from jumping onto premature conclusions and also helps them to understand the facts and actions; therefore patient choices. In the context of psychodynamic thinking, the content of client’s speech represents thoughts and emotions that (unconsciously) lead to actions.

Problems encountered in the formation of the therapeutic setting

The patient’s request for assistance has sometimes been unclear. An aged woman wanted the student’s company because she felt lonely. The clarification of the client’s request is the bedrock of the establishment of the therapeutic setting. Also, time is another parameter of the setting: Examples include the absence of prearranged appointments with clients, delays in the client’s arrival for his appointments, repeated cancelations of appointments, premature beginnings and endings of the interviews (anxiety), a client’s need for more time, and the student’s inability to finish the interview in the pre-arranged time. When clients repeatedly delay in their appointments, they might unconsciously show their anger or ambivalence on the services being offered. When they wish to depart earlier, they might need to communicate the practitioner’s inability to contain their anxiety/problems. When they resist in arranging an appointment with the social worker and the latter gives in by offering more than two alternatives, he/she allies with the client’s resisting part which fears that the practitioner is unable to help him/her solve problems and accordingly undervalues the professional relationship. Since those aspects of the client’s emotional world often reflect parts of his/her character and emotional life that ultimately contribute to his/her current problem situation, it is essential that they are understood and openly communicated (Karpetis, 2010).

Another setting violation issue encountered was the place of the interviews. The office environment, the home visits, or the hospital wards, are places requiring special consideration if the protecting the therapeutic setting factors are to function effectively. Relevant issues were the “intrusive” telephone calls to patients and the use of letters in case of drop outs. The fear of been abandoned by the client was often the cause of setting violations for the students. Finally, a critical form of setting violation was the absence of identification of the assessment phase in the work with clients. When unclear, the patients were unable to trust the students. An analogous fear has sometimes driven students towards introducing themselves by their first name (small, young and inexperienced).

Critical incidents during the middle supervision phase

Client assessment without taking the psychosocial history (i.e. can you talk a bit about your life?). Such a practice is confusing for clients and strengthens their pathological defences as they feel that they are not understood (their emotional needs). Such an example is the client’s psychosocial history that starts from the latent phase of development (school years onwards). The supervisee’s resistance to understand the client’s primary relationships is often rooted in an unconscious avoidance to deal with issues encountered in his own primary relationships (parents). Another problem has been the attribution of the client’s problem only to environmental factors and the provision of financial or other material help which in fact undermined the client’s own resources and potential. It was as if the verdict of impotence was awarded to the patient. Another student’s defensive tendency was the denial of the patient’s psychopathology (a combination of absence of experience and unwillingness to study the literature). Comments like ‘insecure,’ ‘problematic’ or ‘suspicious’ to describe client personality problems usually denote a defensive student attitude. The supervisor assisted a student to understand the psychotic symptoms in a formerly characterized as ‘suspicious’ client. Finally, another resistance phenomenon was the students’ resistance to realize and accordingly accept the patient’s transferential
needs. Those needs mainly were dependency and gratitude for the care that the students provided to them, as well as anger for abandoning them during vacations or at the end of their work with them. Such a realization can revive the student's own dependency needs in relation to their primary relationships.

The student’s interim assessment of performance

Every supervisee practice problem was named a ‘practice mistake’ that needed reparation. When, despite the supervisor’s warnings, practice mistakes kept on being repeated, the supervisee was cautioned of the possibility of his/her failure in the course. Nonetheless, he/she was offered the chance to think about the personal emotional causes of such situations and decide whether he/she wanted to deal with them or not. For example, the supervisor informed a student during interim assessment of her competitive behaviour that resulted in collaboration difficulties with inter disciplinary practice team members and with the supervisor (refusal to utilize practice suggestions) at the expense of client’s interests. It was made clear to her that she was expected to modify her professional stance. The student gradually managed to change her attitude and improved her relationship with clients and practitioners. Other assessment issues were the supervisee’s ability and willingness to study the suggested literature as well as the ability to form a collaborative relationship with the supervisor, the field practice manager, the supervision group members and the clients.

Critical issues encountered in the last supervision phase

Students asked what is “normal” (against pathological). This was explained by the supervisor as a student’s defensive attempt to deal with the clients’ emotionally painful psychopathology issues and accordingly learn. Issues of trust on the supervisor were additionally brought onto the surface and accordingly connected to the students’ anger of abandonment by the supervisor because the end of supervision was approaching. Students were subsequently able to set boundaries and understand the patients’ aggression and feelings towards the end of the working relationship. Issues of sadness and guilt were also discussed in this supervision phase. The student’s fear of the client’s crying was reframed as a gesture of the client’s trust of his/her emotional pain. Finally, issues of guilt engendered by the client’s handicap and the consequent overprotective student behaviours brought students in touch with their unconscious feelings and strengthened their therapeutic capacity.

The dynamics

The social work school had no control over student enrolments (student psychopathology issues, no specific personality requirements, and inadequate evaluation procedures). Those dynamics undoubtedly affected the supervision group climate (one student apparently had no interest in studying and learning). Another issue was the confusion engendered for the separate roles between the supervisor and the field practice manager. This was directly related to the absence of the field practice educator’s clinical training and her specific personality characteristics. Idealization of some students by the agency seemed related to the mishandling of client cases in the same agency. When no client cases provided to the students or they were offered towards the end of the practice placement this was understood as an indication of antagonism between the practice agency and the supervisor (who was the representative of the social work school). Finally, anti-clinical climate in the School or in the agency often resulted in reduced practice experiences for the students. The gap was filled through the discussion of the other students’ cases.

The intergroup dynamics took the form of students’ behaviours like asking for more supervision, or becoming aggressive/unkind towards other group members (brother/sister transferences). Unwillingness to present an interview or to comment on other students’ cases was understood as a fear of been involved in emotionally painful client problems. Other group dynamics were the student’s identification with the field practice manager and with the patient (against the supervisor – antagonism, absence of trust). Finally, intense transferential emotions for the supervisor either positive or negative have been clearly transferential.

Supervisor countertransference issues

Shares his time unequally between students (identifies with those having the same unconscious needs); is unable to offer praise and encourage students (unconscious envy); becomes overprotective (supervisees become unconsciously his/her children); comments on student personality issues even though no student requested therapy and the setting is far from able to offer therapy; starts the supervision session earlier, or finishes later than scheduled (this indicates either painful avoidance or overinvestment (offers his personal time and the relationship becomes personal rather than professional); and avoids to think about or comment on group dynamics and particularly the unavoidable unconscious transference elements of the students’ behaviours.

Evaluating supervision effectiveness

Indicators are: the students liked it; they trusted their thoughts and feelings to the supervisor; they employed the supervisor’s suggestions in their work with clients; were able to remember progressively more of their sessions with clients during process recording; they were less afraid to make mistakes and learn from them due to their trust in the supervisor’s clinical competencies; the clients improved their social role functioning; most students acquired a good enough picture of their professional self; most students expressed gratitude to the supervisor as well as regret for the impeding ending of the supervision; some students asked future supervision from the supervisor; Students
were supportive enough towards one another; and their feelings for the supervisor did not change over time.

**Grading students in supervision**

There is always the danger for supervisor to grade students higher in supervision due to the intimate relationship developed (countertransference issue). Problems are the student’s resistance to change his professional behaviour; the student’s tendency to repeat the same practice mistakes; the resistance to study and learn from the suggested literature; the student’s ability to utilize the supervisor’s suggestions in order to help clients; and the quality of the relationships the student formed with the supervisor, the field practice manager, the supervision group members and the clients. An interesting supervision process parameter has also been the need for the supervisor to deal with some students’ frustration for not getting the grade they expected. The supervisor resisted changing the student’s grade and two years later the student requested private supervision from the same supervisor.

**Lessons learned**

- When supervising students who work with clients, everything is “clinical”
- The supervisor should be able to build “a therapeutic relationship” with each supervisee and with the group
- Should be able to understand and communicate the student’s individual dynamics while working with clients
- Should be able to communicate supervision group dynamics that impede the work of the group
- Should only employ the “transference to the setting” interpretation (Karpetis, 2012)
- Should avoid commenting on the student’s emotional and personality problems; but only on practice mistakes that require correction/reparation
- Should be able to take responsibility for the cases the students handle (feel competent with his clinical skills and knowledge)
- Supervision is not and cannot be psychotherapy
- Supervisors should be clinically competent in order to be efficient.

**References**


## Conference Program Day 1: Wednesday 5 June 2013
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<td>8.40-8.45</td>
<td>Acknowledgement of Country: Joan Tranter, Elder in Residence, Jumbunna Indigenous House of Learning, UTS</td>
<td>Welcome to Conference: Christine Senediak, Conference Chair, NSW Institute of Psychiatry</td>
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<td>8.45-9.00</td>
<td>Opening Address: Brin Grenyer, Prof Clinical Psychology, Uni of Wollongong: The Value of Clinical Supervision</td>
<td>Keynote Speaker: Maurizio Andolfi: Challenging issues in supervision: How to increase therapists’ competence and self-confidence with client empowerment</td>
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### MORNING TEA: 10.15-10.45

### INVITED SPEAKERS: 10.45-11.15

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<td>Martin Cohen</td>
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<td>Jones Room: Chair: Diba Pourmand</td>
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### SUBMITTED PAPERS AND WORKSHOPS: 11.15-12.45

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<td>Louise Nash: The teaching experience and capacity of psychiatry trainees</td>
<td>Allan Shafer: Observation: The cornerstone of psychodynamic supervision</td>
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<td>Jones Room: Chair: Diba Pourmand</td>
<td>Margaret Pack: The relationship in clinical supervision: Models preferred by health social workers who work with traumatic disclosures from clients</td>
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<td>Broadway Room: Chair: Martha Birch</td>
<td>Craig Gonsalvez: International advances in clinical supervision</td>
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<td>Paul Bailey: The art and craft of assessing clinical supervisors</td>
<td>Graham Barker: When supervision resembles a train wreck</td>
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<td>Natasha Crow: Who offers the best supervision?</td>
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<td>2.30-3.00</td>
<td>Christine Saxby: Does best practice clinical supervision lead to better outcomes? Findings from a Queensland study of community allied health professionals</td>
<td>Russell Hawkins: Challenges and responses to the changed rules for supervision in applied psychology</td>
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**3.00-3.30**

**AFTERNOON TEA**

**3.30-5.00**

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<td>Panel Discussion: Chris Ryan (Panel Facilitator), Maurizio Andolfi, David Denborough, Brin Grenyer: Navigating ethics, obstacles and the relationship in supervision: how to ensure a safe supervisory relationship</td>
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**CLOSE & CONCLUDING REMARKS - END OF DAY ONE**

Kerri Brown, Head of Multidisciplinary Education, NSWIOP

**5.15-6.15**

**CONFERENCE WELCOME RECEPTION - FOYER**
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<td>Jones</td>
<td>Hong</td>
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<td>Paul Rhodes: Why reflective practice? Five studies in profile</td>
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<td>Christine Senediak: Integrating reflective practice and therapist 'awareness of self' in supervision</td>
<td>Shirley Hamilton: Step outside the box: Using creative methods in group clinical supervision</td>
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<td>Trevor Crowe: Parallel processing in clinical supervision and development coaching</td>
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<td>Paul Bailey &amp; Tom Ryan: Creating the Australian Clinical Supervision Association?</td>
<td>Hui-Chi Huang: Constructing a care model for daily living among disabled residents targeting long-term care facilities</td>
<td>Joan Haliburn: On becoming a psychotherapy supervisor: Triadic systems in the microanalysis of the supervisory process</td>
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<td>Alison Strasser: Creating a Register for Supervisors for PACFA (Psychotherapy &amp; Counselling Federation of Australia)</td>
<td>George Karpetis: Understanding clinical issues in student supervision: A psychodynamic practitioner researcher approach</td>
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