

A reflective practice model of clinical supervision

Christine Senediak

Ref: Senediak C. A reflective practice model of clinical supervision. Conference paper presentation: *Advances in Clinical Supervision Conference*, Sydney Australia, 4-6 June 2013.

Paper presented by Christine Senediak at the *Advances in Clinical Supervision Conference*, Sydney, 4-6 June 2013.

Christine Senediak is a Clinical Psychologist and Chair of the *Advances in Clinical Supervision Conference*. She works part-time at the NSW Institute of Psychiatry (NSWIOP) and coordinates both the Master in Child & Adolescent Mental Health and Family Therapy programs and training in clinical supervision for NSWIOP. She also works part-time in private practice where she provides clinical supervision to individuals, government and non-government organisations.

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 & McNeil, 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

Negotiation of a mutually acceptable contract
Explicit recognition of responsibilities within the supervisory relationship, including how clinical issues will be presented and discussed
Clear boundaries in supervision – differences between supervision, training and ‘personal support’, especially considering the pressures of advanced training requirements
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)
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

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 be a willingness to learn and develop cooperatively within the supervisory relationship.

3. Attentiveness to what is going on in the session

Listening to the supervisee and what is said in supervision allows the supervisor to be in tune with the supervisee. Meaningful communication requires that the supervisor actively listen to the supervisee's words so as to not only hear the verbal, but non-verbal communication (Driscoll, 2000). Hearing and being able to respond to the supervisee provides the basis for effective supervisory alliance (Crits-Christoph et al, 2006) and also enables the supervisor to tune into the specific issues that need to be addressed within the supervision 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 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 and 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'

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)
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?)
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 now, why)
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?)
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)
6. Consider the interaction/interrelationship between you, the client and wider system/s. (Why do I think what happened, happened? How does the therapeutic relationships impact what occurred?)
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 I need to work on in the future?)
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)?
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)
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)?
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)?
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).

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