Advanced supervision

The CLEAR Model

Contract

Listen

Explore

Action

Review

Contracting

Intent precedes content. Begin with the end in mind.

Time spent on contracting is time well spent. Much contracting is about anticipating potential problems and providing a framework for addressing them so that there are 'no surprises'.

A common failing is to over-support and under challenge. Can you contract for pace or challenge? Raising the level of challenge can raise the level of energy.

Working alliance. Mutual expectations. Hopes and fears. Ask the supervisee: 'what works for you when others help you? What is about your supervision that you would want me for? What would success in your supervision look like?' Asking about previous experiences of supervision can be telling. Contacting is patient partly about engagement: the supervisee will often be worried about exposing their own vulnerability or incompetence or about the boundaries of supervision with personal therapy. This may be expressed as ambivalence about either the process of supervision or you as a supervisor. Ask yourself as a supervisor: why now? Why me? Use the contract as a container for their anxiety.

•Practicalities and meeting arrangements: 'What would we need to achieve that success?' Where? Who pays? Arrangement for missed sessions? What type of supervision (tutorial, training, managerial, developmental)?

•Boundaries: supervision and therapy: a supervision session should start and finish with work, i.e. it should be a work issue, which may bring up *relevant* personal issues, but the end point should be 'what will you do with your patient in the next session?'. Always discuss confidentiality and its limits. How much is confidential? What is not confidential?

•Session format: one case or several? Bring case notes or not? Every patient discussed?

•Organisational and professional context: discuss organisational expectations and expectations of professional bodies. Are there codes of practice you need to apply? Do you know the college and Deanery rules? Will you be using some of the time for CBDs?

•Taking notes: be clear what sort of notes you will take, where you will keep them, what will happen to them, level of detail. Notes are very helpful to review

points of action and to create reconnections, but may be subject to organisational and statutory controls. Supervisee educational portfolios are not confidential: supervisees need to be aware not just of patient confidentiality but also their own confidentiality in what they write in portfolios. Some of the people reading portfolios may have a more punitive approach to minor transgressions than you the supervisor.

Short form contracting

Short form contracting is similar to agenda setting. 'How do you want to use your time? What do you need to achieve in this session? How could I be most valuable to you today? What do you want to focus on? What would success look like for you today? What do you want to have achieved before leaving here?'

Deficit and competence worldviews

Two ways of approaching a supervision session are to think primarily in terms of deficit or in terms of competence. A competence model works well to create the conditions for a more egalitarian balance of power in the relationship, itself favourable for co-creating meaning. A deficit model, particularly where the supervisor is also the line manager with institutional power, is often at the root of a poor supervisory relationship.

Deficit worldview	Deficit worldview intervention	Competence worldview	Competence worldview intervention
The supervisee doesn't see the problem: there is denial or lack of insight.	Provide insight. Hold a mirror up to their faults.	The supervisee has a sense of professional curiosity about his or her practice.	Cultivate professional curiosity and seek the supervisee's insights.
The supervisee doesn't know: there is a knowledge deficit.	Provide facts.	Knowledge is within the supervisee.	Evoke the supervisee's knowledge.
The supervisee doesn't know how: there is a skills deficit.	Teach new skills.	The supervisee already has transferable skills which he or she can apply in his or her work.	Evoke the skills they use to identify them, reflect on them and generalise their scope.
The supervisee doesn't care.	Shame or frighten people in to changing their practice.	The supervisee is highly motivated to develop professionally.	Enhance the supervisee's sense of self efficacy.

In practical terms, a competence worldview suggests making enquiry the principal line of intervention with supervisees. Listening skills are also important. In particular, complex reflections that pick up on supervisee values, affects, strengths and dilemmas are useful interventions.

Which modality of supervision are you most comfortable with? Why? Which modality lies in your supervisees 'zone of proximal development'?

Mode 1: bring the patient into the room

'What did he/she say/do?' Encourage the supervisee to be precise about the language.

'How did they move? How did they speak?'

Gesture, look, language, metaphor can all be useful described as accurately as possible.

'Don't tell me, show me.'

Replay the first two minutes of the session for me. 'What happened before the session really got started?'

Avoid premature judgement, diagnosis, interpretation, attribution of meaning or solution finding. All these are useful skills, but only after the patient has 'fully entered the room'.

Mode 2: Interventions

Think about interventions (e.g. OARS), structures and strategies (what are the change goals?).

Look for the 'either-ors' the supervisee brings ('I could do this...or I could do that'). Integrate them or break the frame of the dilemma: try out different types of interventions in the spirit of brainstorming.

Role play and rehearse different interventions.

The MITI is a sophisticated tool for Mode 2 supervision.

Mode 3: relationship between supervisee and patient

Mode 1 and 2 are technical modes of supervision. they are a good place to start with beginners and are often fruitful places to start the discussion of individual patients with more advanced practitioners. Mode 3 is the beginning of shifting from the technical to the relational and is important for developing more experienced practitioners.

'How did you meet this patient?'

'How and why did this patient choose you?'

'What were your first impressions of him/her?'

'What is the history of the relationship?'

'What did you first notice about your relationship with this patient?'

'Tell me the story of the history of your relationship?'

'Can you think of an image or metaphor to represent your relationship?'

'Imagine what sort of relationship you would have had with this patient had you met under other circumstances'.

'If you were to go to a fancy dress party together, what would you both wear?'

'Become a fly on the wall of the last session: what do you notice about the relationship?

Mode 4: supervisee feelings

Ask about feelings towards the patient, remembering these are likely to be at least in part unconscious and may be denied, minimised or defended against. To begin with encourage your supervisee to 'treat [their] feelings as data', to attend to their emotions and ask themselves if there is any significance. There isn't always. As in psychotherapy, if the supervisee backs away from attaching significance to a feeling or emotion, respect this (though return to the principle of treating feelings as data).

'Have you had feelings like this with patients before?' As a supervisor be agnostic but curious about what the feelings might mean. 'This is what it brings up for me, I wonder what it means for you?'

If a transference reaction has been identified in 3, how does the supervisee respond to this? Paying a corresponding part or a parallel part, resisting or accepting the transference? (Aim to create a space to respond to rather than react to the patient).

Be aware of the 'ideological editor': the supervisee doesn't express things because of their own values ('if I owned up to that feeling it would mean I was racist/sexist/prejudiced').

Mode 4 supervision is the 'gateway' to mode 3: feelings will give clues to relationship issues.

Mode 5: the supervisory relationship

Notice your feelings and feed them back to the supervisee in a non-judgemental way.

'I am experiencing the way you are telling me about this patient as strangely incoherent, and I'm wondering if that is how you felt with the patient'.

"I'm getting this feeling, I wonder what it means'.

Mode 5 supervision can alert you to parallel processes in supervision: something is happening between you and the supervisee that parallels a process between the supervisee and patient. There are two sorts of parallel process to look for, the primary parallel process and the secondary censoring response.

Mode 6: supervisor focussing on their own process

Offer your own feelings as 'data for the session' without ascribing a meaning to them: 'I'm feeling a bit angry by this description and wonder if that has any resonances for you'.

Who am I for the supervisee?

Mode 6 is the gateway to mode 5.

Cultivate your own intuitions. 'I'm feeling rather bored as I'm listening to your account. I've noticed this often happens to me when I'm listening to the wrong thing. Is there something else about this patient you want to tell me about?'

Note any shifts in bodily sensations: fist tightening, heart racing, feeling sleepy.

Mode 7 the wider context

Each of the previous six modes can be considered in the wider context: the patient (e.g. the patient's background and culture), the supervisee's intentions (the context of their profession and organisation), the supervisee-patient relationship (e.g. how are such relationships viewed in their culture), the supervisee (e.g. their stage of professional development), the supervisory relationship (e.g. previous experience of giving and receiving supervision) and the supervisor's own context.

The 'servant of two masters' dilemma

This is one ethical dilemma that is common in supervision and coaching, and for which a mode 7 view can be helpful. You are hired as a supervisor by an agency who have specific aims for the supervision you are to provide. Your supervisee brings you an issue that is outwith this contract or possibly even in conflict with it.

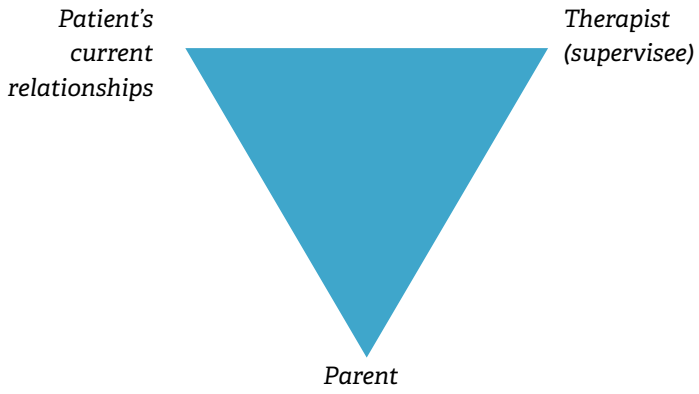
The techniques: (1) *Bring the organisation into the room*. What are the organisation's legitimate goals? What ethical principles underly these goals? Discuss the ethical dilemma using the language of ethics. (2) *Recontract*. Explicitly return to the original contract to re-examine its premises and re-negotiate it.

The principle: ethical subsidiarity ('sleepless nights transfer'). Your dilemma as a supervisor should become a dilemma for the supervisee.

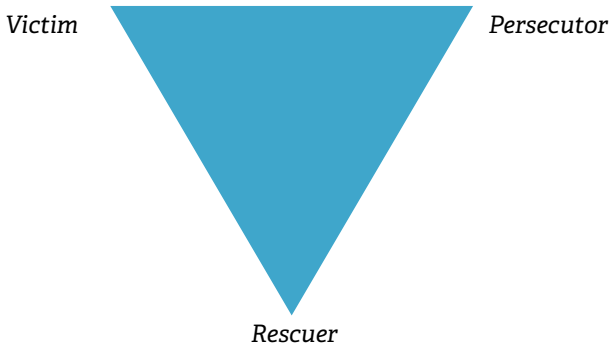
'Practical theory'

Malan's triangles

Triangle 2 is particularly useful in helping make sense of mode 3/mode 4 interventions. Questions might include 'treat you feelings as data' (mode 4). What do your feelings tell you? Is there someone else in the patient's life who might be experiencing these feelings? What does that tell you?



Karpman drama triangles



In using Karpman drama triangles in supervision, it is often enough to recognise the pattern to be able to shift it. Remember that the three roles can shuttle round between therapist and patient very quickly.

If necessary, think of the corresponding health roles and the skill to be developed to make that shift:

Drama triangle	Healthy triangle	Skill to develop
Victim	Vulnerable	Problem solving
Rescuer	Caring	Listening/empathising
Persecutor	Assertive	Assertiveness

Checks for identity

A useful technique from John Heron.

1 Who does this patient remind you of?

2 How is your patient like this person?

3 What would you like to say to the person you discovered in stage 1?

4 In what ways is your patient different from this person?

5 What would you like to say to your patient?

Further reading

The content of this workshop is substantially drawn from the work of Peter Hawkins and Robin Shohet: their book is strongly recommended. Hawkins, Peter and Shohet, Robin (2012) *Supervision in the Helping Professions* (4th Edition). McGraw Hill.

Undrill, G (2012) *Incidental Supervision* in *Clinical Supervision in the Medical Profession: Structured Reflective Practice* Eds Owen, D. and Shohet, R. McGraw Hill