

Exploring Clinical Supervision to Facilitate the Creative Process of Supervision

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Abstract

Good supervisory practices help students fulfill their potential and contribute to the university's research profile. This article reviews the literature on clinical supervision. It describes best practices in clinical supervision, and set out the rights and responsibilities of both students and their supervisors. It is intended to provide some useful guidelines for students and supervisors (not only for clinical students) to encourage the development of relationship in the first place. Therefore, a review of literature concerning clinical supervision is hoped to assist all participants in the supervisory process to articulate their expectations clearly, and thereby to reduce potential problems and to facilitate the creative process of supervision.

Keywords: Counselling, Clinical Supervision, Psychology, Student, Supervisor

INTRODUCTION

There are a range of supervisory approaches commonly adopted towards students in order to help them achieve their objectives such as mentoring, coaching, research student supervision and clinical supervision. Like any other technique used in human resource development, these approaches have particular strengths and weaknesses, which may prove unsuitable for some people. In establishing the approaches to be used, care must be taken to ensure that each person understands the limits or boundaries of the relationship. Indeed, it may be as important to indicate that there is a way out of the relationship as it is to encourage its development in the first place. Supervisory approaches vary and depend on the people involved, the place of

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meeting and the terms of the relationship. Not only do supervisors have to play their role but the students too, and all this must be placed within the specific institutional context.

Essentially, learning involves two parties, the teacher (also known as the supervisor, mentor, coach) and the student (known as the trainee, mentee, mentoree, coachee, protégé). The relationship between the teacher and student plays an important role in promoting the student's objectives. Many authors have mentioned the importance of the relationship between a student and a supervisor in this context (Acker *et al.*, 1994; Cryer, 2000; Graves and Varma, 1999; Phillips and Pugh, 2000), particularly where the two work closely over a number of years. However, sometimes a problem of compatibility occurs between them and therefore, Hockey (1997) and Wilkin (1992) suggest that they both need to know their roles in order to ensure a good relationship.

This article discusses one of supervisory approach commonly adopted towards student/trainee in order to help them achieve their objectives. In this, roles and practices of supervisor and supervisee are described. Both parties either a supervisor or supervisee should play their roles effectively. Hence, this paper explores a review of the literature on clinical supervision. It focuses on two major areas: the concept of clinical supervision and its theoretical foundations; and the nature of the supervisor-supervisee relationship.

LITERATURE REVIEW AND DISCUSSION

The Concept of Clinical Supervision

Since the early 1990s, clinical supervision has been a common development technique in nursing (Faugier and Butterworth, 1994). Other professions such as psychologists, psychotherapists and social workers also have a well-established tradition of clinical supervision (Morcom and Hughes, 1996). In common usage, supervision means overseeing, and it is a fundamental component of counselling (Carroll, 1996; Fowler, 1999; Hawkins and Shohet, 1989; Holloway, 1995; Page and Wosket, 1994; Simms, 1993; Van Ooijen, 2000). Barber and Norman (1987) describe supervision as an interpersonal process in which the skilled practitioner or supervisor helps less skilled practitioners in relation to their professional growth (Berger and Bushholz, 1993; Butterworth and Faugier, 1992; Holloway, 1995; Rogers, 1957; Sergiovanni and Starratt, 1973; UKCC, 1996; Van Ooijen, 2000; Wright, 1992), as well as personal development of the supervisee (Butterworth and Faugier, 1992; Darley, 1995; Holloway, 1995; Rogers, 1957; Sergiovanni and Starratt, 1973; Stoltenberg, 1981; UKCC, 1996; Van Ooijen, 2000; Wright, 1992). Knapman and

Morrison (1994) take a similar view, adding that the objectives of clinical supervision should also be competence, accountability, performance and personal support. During supervision, the two individuals should meet on a regular basis (Holloway, 1995), to identify solutions to problems, improve practice and increase understanding of professional issues (Fowler, 1999).

Fowler (1996) suggests that clinical supervision provided on an individual basis aims to enable the supervisee to do the job better, and to provide informed, enhancing interactions, such as professional support, role development, improving confidence, intra and inter-professional networking and improved job control and satisfaction with a view to improving clinical outcomes. Cogan (1973) particularly highlights the use of direct observation in clinical supervision approach. A working definition of clinical supervision has been given by Goldhammer *et al.* (1980):

Clinical supervision is that aspect of instructional supervision which draws upon data from direct firsthand observation of actual teaching, or other professional events, and involves face-to-face and other associated interactions between the observer(s) and the person(s) observed in the course of analysing the observed professional behaviours and activities and seeking to define and/or develop next steps towards improved performance.

In summary, clinical supervision consists of three important processes, the monitoring process, the support process and the learning process. The monitoring process is very close to the definition of clinical supervision, which is for an experienced supervisor to oversee the supervisee. On the other hand, the support process incorporates a variety of aspects mentioned by many authors in this chapter (Butterworth and Faugier, 1992; Carifio and Hess, 1987; Fowler, 1999; Holloway, 1995; Page and Wosket, 1994; Proctor 1988). The learning process involved in reflective practice is necessary for the success of the clinical supervision process in the context of client-therapy. So, clinical supervision is a practice-focused relationship involving an individual or a group of practitioners reflecting on practice, guided by a skilled supervisor (Fowler, 1999; Kohner, 1994; UKCC, 1996).

The Role of an Effective Supervisor

The roles and responsibilities of the supervisor and supervisee should be clear to all participants in supervision (Kohner, 1994). Besides, supervisors and supervisee should be aware of the ethical codes for supervision (Butterworth and Faugier, 1992). As Carroll (1996) mentions, good supervisors are able to adopt a multiplicity of roles in relation to the supervisee. Carroll emphasises the meaning of the task and role of the supervisor and states that tasks are the behavioural side of functions and roles. The role is person-centred (teacher/pupil), the task is action-centred (to teach/to learn), and the function is a combination of both roles and tasks. Van Ooijen (2000) argues that, even though a strong notional distinction is made between roles and tasks, in reality they combine.

Traditionally, part of the supervisor's job was to ensure that work was done well and to standard (Fowler, 1996; Rogers, 1957). Hawkins and Shohet (1989) and Proctor (1988) argue that a supervisor can be seen as having three tasks. The administration or normative task examines the management part of practitioners' roles and is concerned with on-going monitoring and quality (Berger and Bushholz, 1993; Carroll, 1996; Goldhammer *et al.*, 1980). The education or formative task involves the process of skill development and the ability to reflect on experiences. Lastly, the support or restorative task involves the supportive and helping function. Goldhammer *et al.* (1980) additionally suggest curricular and instructional components.

Hawkins and Shohet (1989) mention that supervision can be an important part of taking care of oneself and facilitating reflection. Berger and Bushholz (1993), Carroll (1996), Cogan (1973), Department of Health (1993), Fowler (1999), Kohner (1994) and Rodenhauser *et al.* (1989) point out that it is important in staying open and committed to learning. However, Ekstein and Wallenstein (1972) and Rogers (1957) suggest that it is important in maintaining self-awareness. Therefore, supervisors have to be teachers and innovators (Goldhammer *et al.*, 1980; Sergiovanni and Starratt, 1973; Van Ooijen, 2000).

On the other hand, Ekstein and Wallenstein (1972) also identify different styles of approach within the supervisor's role, including: openness to feelings, anxieties and experiences and reward, which give encouragement and recognition. With experience, the supervisor's role should develop and they should become more skilled at helping and supporting other practitioners (Berger and Bushholz, 1993; Butterworth and Faugier, 1992; Page and Wosket, 1994). Carroll (1996) states that the generic tasks of counselling supervision should include consulting, evaluating (Pierce, 2004; Van Ooijen, 2000) and monitoring professional or ethical issues and highlights the fact that emotional awareness and self-evaluation are also among the tasks that are necessary for all counsellors as they work with clients. Holloway (1995) agrees with

Carroll (1996), but suggests other tasks such as instructing, advising and sharing. While, Van Ooijen (2000) refers to modelling. However, Holloway (1995) mentions that a supervisor should understand the client's psychosocial history and present problems. A supervisor should also learn the tasks of record-keeping (Kohner, 1994; Neufeldt, 2004), procedures and appropriate inter-professional relationships and participate fully in the supervisory relationship (Carroll, 1996).

Information will now be given regarding the qualities and skills that it is necessary to acquire in order to be an effective supervisor. As Butterworth and Faugier (1992) mention, supervisors require training in supervision as an integral part of their professional development. Many authors have advocated more structured training for supervisors (Alien *et al.*, 1986; Alonso, 1985; Harrar *et al.*, 1990; Loganbill and Hardy, 1983; Styczynski, 1980). Meanwhile, Rogers (1957) proposes that clinical supervisor should: (1) be a role model; (2) establish a safe confidential environment (Page and Wosket, 1994); (3) give clear feedback (Alien *et al.*, 1986; Fowler, 1999; Freeman, 1985; Harrar *et al.*, 1990; Keith-Spiegel and Koocher, 1985; Nelson, 1978); and (4) be aware of organisational and personal constraints.

Wilkin *et al.* (1997) identify the following skills as required by the supervisor: (1) communication skills (Butterworth and Faugier, 1992; Holloway, 1995; Simms, 1993), which involve being attentive and actively listening (Rogers, 1957) and being able to comment openly, objectively and constructively; (2) supportive skills which involve being able to identify when support is needed and offer supportive responses (Fowler, 1999; Holloway, 1995; Rogers, 1957); (3) general skills; and (4) specialist skills which means that those who specialise in particular fields of work should have access to supervision by someone who is similarly orientated. Effective supervisors are also characterised by respect (Berger and Bushholz, 1993; Butterworth and Faugier, 1992; Carroll, 1996; Kohner, 1994; Page and Wosket 1994), empathy (Berger and Bushholz, 1993; Carroll, 1996; Holloway, 1995), genuineness (Carroll 1996; Page and Wosket, 1994), honesty (Butterworth and Faugier, 1992; Carroll, 1996), non-sexist and non-authoritarian attitudes (Butterworth and Faugier, 1992; Carroll, 1996; Holloway, 1995). An effective supervisor should also pay attention to client welfare (Fowler, 1999; Page and Wosket, 1994).

Carroll (1996) identifies a good supervisor as being a good teacher, who has access to a range of teaching and learning methods and can adapt to individual supervisees. In a similar vein, Berger and Bushholz (1993) mention that, teachers should be flexible in their relationship with supervisees, moving easily between the roles of teacher, monitor, evaluator, model, mentor and counsellor. Good teachers understand individual differences and adapt accordingly. They maintain flexible roles and are capable of moving, when needed, between roles. They are able to share their

own work in a facilitative manner, are open to negotiation and flexible in working and create clear boundaries (Yogev, 1982).

In summary, there are a number of supervisors' tasks and roles in clinical supervision. Some of the tasks relate to mentoring and counselling. This is because, as discussed in section 2.2, mentoring is based on counselling, and counselling and clinical supervision are very close to each other as they share a client-centred approach. On the other hand, effective clinical supervisor should emphasise the professional development of the supervisee. The supervisor and supervisee must also have clear goals and their relationship will reflect what they have as goals. **Table 1** summarises the role of an effective supervisor.

Table 1: Summaries of the Role of an Effective Supervisor in Clinical Supervision

Role of Supervisor	Effective Supervisor
Support and guidance	Structure supervision appropriately
Consultant	Evaluate fairly and according to agreed criteria
To create the learning relationship	Adapt to individual differences in supervisees
Mentor	Give feedback clearly, directly and constructively
Counsellor	Use the counselling role
Teacher	Are good teachers
Evaluator	Have access to a variety of supervisory interventions
Model	Are flexible across roles

The Role of Supervisees and their Relationship with their Supervisor

There is much more literature about the supervisor's role than there is about that of the supervisee. It is clear that the important objective of both to the supervisor and supervisee is the personal and professional development of the latter. Effective supervision is an interpersonal process in which the supervisor is designated to enable the supervisee to become a competent clinician. This process occurs within the context of the supervisory relationship (Loganbill *et al.*, 1982). In fact, a supportive supervisory relationship has been shown to be perhaps, the essential ingredient of effective supervision (Alonso and Rutan, 1988; Berger and Buchholz, 1993; Heppner and Roehlke, 1984; Loganbill *et al.*, 1982). Simm (1993) agrees with this statement:

Overall the quality of the supervision depends on both parties, abilities to communicate clearly and openly. The development of this ability is the foundation of learning and is the stuff of counselling and interpersonal practice.

Before starting out on supervision, it is important for there to be discussion between the supervisor and supervisee of the expectations, as a lack of such discussion may lead to one or both ending up dissatisfied (Carifio and Hess, 1987; Goldberg, 1985; Holloway, 1995; Talen and Schindler, 1993; Van Ooijen, 2000). Van Ooijen (2000) suggests that adequate preparation is essential and, in particular, that the supervisee needs to be clear about what it is he/she wants and needs from supervision. Then the supervisee needs to look around for the kind of person who is likely to be able to meet these needs in order to ensure that the process is as useful as possible. Furthermore, Anderson and Swim (1995) and White (1990) propose that, during the therapy session, supervisees should tell their stories in ways that maximise options for thinking about and dealing with problems as they experience them.

In the relationship, both parties should also discuss a supervision contract (Neufeldt, 2004). Such a contract needs to be fairly detailed so that both parties know exactly where they stand. It is useful to subdivide a contract into a few main areas like logistics or ground rules, limits and boundaries, accountability, aims and goals, responsibilities and the preferred process (Kohner, 1994; UKPPG, 2004). The supervisee should also develop and maintain trust and manage ethical and legal issues (Neufeldt, 2004). He/she should be prepared for all sessions with any documents, audiotapes, videotapes, case or process recordings needed for that session. He/she should also maintain the attitude of an adult learner, willing to read and review material provided by the supervisor. Also, he/she is responsible for learning about

practice settings and also responsible for arriving at all supervision appointments on time (Pierce, 2004).

The content of supervision should be agreed in advance between the supervisor and supervisee. Swain (1995) suggests that there should be agreement about: (1) what should be brought to the session (and what would not be considered appropriate); and (2) whether and how the agenda is set, with the recognition that the supervisee will initiate those matters to be included. According to UKPPG (2004), the allocated time may be used in a number of ways, as agreed by the supervisor and supervisee, and this will vary according to the volume of work, the experience of supervisees and their work setting. The length of the supervisory session again will vary. Ideally it will be fifty minutes for individual supervision. In fact, the UKPPG suggests that a minimum of forty-five minutes or a maximum of one and a half hours should be allocated for supervision. The location, day and time of supervision sessions should be fixed and regular, with work planned around this professional commitment. Clinical supervision should take place in a quiet room free from interruption. The time between each clinical supervision session should be no longer than eight weeks. A brief record of matters discussed during the session should be made and signed by both parties. A record of action agreed should be kept, and reviewed and evaluated at the next session. This policy is the subject of review in the light of new developments in clinical practice at periodic intervals and routinely every twelve months (UKPPG, 2004).

Wright (1992) states that, in clinical supervision the supervisor and supervisee would together think about what was happening and why, and what was done or said, and how it was handled, could it have been handled better or differently, and if so how. The supervisory relationship is the means by which other relationships are reflected upon and analysed, and through which learning takes place (Brown and Bourne, 1996). Swain (1995) suggests that in the systems approach to supervision, the relationship involves dynamic process, while Simms (1993) indicates that in this process, the supervisor and supervisee negotiate a personal way of using a structure of power and involvement that accommodates the trainee's progress in learning.

From the empirical base and knowledge gained from practice, Holloway (1995) identifies three essential elements: (1) the interpersonal structure of the relationship which include the dimensions of power and involvement; (2) phases of the relationship which include relational development specific to the participant; and (3) a supervisory contract which include the establishment of a set of expectations for the tasks and functions of supervision. On the other hand, Furlong and Maynard (1995) propose three other important stages as phases of the relationship, which they call the beginning phase, the mature phase and the terminating phase as stated in **Table 2**.

Table 2: Phases of the Relationship

Beginning Phase	Mature Phase	Terminating Phase
<ul style="list-style-type: none"> • Clarifying relationship with supervisor • Establishing of supervision contract • Supporting teaching interventions • Developing competencies • Developing treatment plans 	<ul style="list-style-type: none"> • Increasing individual nature of relationship, becoming less role bound • Increasing social bonding and influence potential • Developing skills of case conceptualisation • Increasing self-confidence and self-efficacy in counselling • Confronting personal issues as they relate to professional performance 	<ul style="list-style-type: none"> • Understanding connections between theory and practice in relation to particular client. • Decreasing need for direction from supervisor

Source: Furlong, J. and Maynard, T. (1995).

Loganbill *et al.* (1982) point out that the central focus of the beginning phase is the development of trust between the supervisor and supervisee. This is reflected in supervisee behaviour designed to make this unfamiliar experience a familiar one. The identification and definition of salient, conscious expectations regarding supervision often take place during this stage. When other issues become the focus of supervision, the relationship has moved to the mature or developing phase. To guard against maintaining unrealistic expectations in supervisees, Loganbill and Hardy (1983) emphasise the importance of the supervisor appreciation that the supervision relationship progresses over time. This implies that insufficient time and effort in establishing trust within the supervision relationship is likely to be reflected in trainee resistance to addressing client or therapist issues because they have differential needs

for support depending on the level of training. For example, Heppner and Roehkle (1984) conclude that supervisory interaction may become more complex and confrontative depending on the experience of the trainee. In this sense, the person of the supervisee is increasingly likely to become the focus of supervision as the trainee becomes more skilled.

The Clinical Supervision Model

Clinical supervision involves the construction of individualised learning plans for supervisees working with clients. The systematic manner in which supervision is applied is called a model. Training in theory and models of supervision increases supervisor knowledge, and provides guidance for how to direct student learning, as well as how to understand the supervisees' experiences and development. Both the Standards for Supervision (Association for Counsellor Education and Supervision 1990) and the Curriculum Guide for Counselling Supervision (Borders *et al.*, 1991) identify knowledge of models as fundamental to ethical practice. A range of models has been developed or refined to meet the needs of the many diverse groups, such as Faugier and Butterworth (1994), Hawkins and Shohet (1989), Page and Wosket (1994), Proctor (1988) and the reflective models of Van Manen (1995). While models vary, they tend to encompass aspects of personal and professional support, and the educational and quality assurance function. This follows Proctor's (1988) model of supervision, which comprises of what she terms restorative, formative and normative elements, which itself mirrored earlier work by Kadushin (1976) who termed these elements supportive, educational and managerial.

Faugier and Butterworth (1994) see models of supervision falling into three major categories. Firstly there are those which describe supervision in relation to the main functions of the supervisory relationship and its constituents. Secondly there are those which describe the main functions of the role, and thirdly there are those developmental models which emphasise the process of the supervisory relationship. However, Yegdich (1999) argues that in categorising the literature on supervision into these three forms, the authors have sidestepped debate on the essential differences between a supervisory approach and a therapeutic one. She asserts that supervision is concerned primarily with the client and the professional development of the supervisee. She sees little role for restorative or supportive supervision, citing Adelson (1995) in asserting that any therapeutic benefits from supervision are merely incidental and secondary to the primary teaching goal of learning therapeutic skills (Yegdich 1999).

Hart (1982) took a broad perspective describing three models, the skill

development model, the personal growth model and the integration model. In the skill development model, the goal is to increase the supervisee's skills and conceptual understanding of clients. There is a teaching type relationship with a focus on the client followed by a focus on the supervisee's approach to helping the client. In the personal growth model, the goal is to increase the insight and affective sensitivity of the supervisee. Barnfield (2004) adds that the relationship is more like counselling with a focus on the supervisee's personal feelings and thoughts about interpersonal relations with clients. The integration model has the goal of assisting the supervisee to integrate acquired skills and personal awareness into effective relationships with clients. There is a collaborative relationship with a focus on the supervisee client unit or interaction, followed by a focus on supervisor-supervisee interaction. Leddick and Bernard (1980) agree with Hart (1982) as they state that, as supervision became more purposeful, three types of models emerged: developmental models, integrated/eclectic models and orientation-specific/social role supervision models. However, in giving an example of how the clinical model works, the researcher will only focus on the development and social role model.

The aim of the developmental model is to maximise and identify the growth needed for the future. Thus, it is typical in this model to be continuously identifying new areas of growth in a life-long learning process (Worthington 1987). Developmental models of supervision have dominated supervision thinking and research since the 1980s. Overall developmental models work on premises similar to models of developmental psychology. In the latter, people are seen as moving through distinct stages of life, each stage characterised by its own tasks and demands, which have to be fulfilled before the individual is ready and able to move to the next stage. This model also describes similar movements. The supervisee, the supervisor and the supervisory relationship all move through discernible and somewhat predictable stages, each characterised by its own tasks and issues (Carroll 1996). Hawkins and Shohet (1989) mention a number of developmental models, like: (1) the Littrell, Lee-Borden and Lorenz Model, a four stage model that matches supervisor behaviour to the developmental needs of trainees (Littrell *et al.* 1979); (2) the Stoltenberg Model, which describes trainee as being at four possible levels, with the optimum supervision environment at each level of maturation (Stoltenberg 1981); (3) the Loganbill and Hardy Model, in which the supervisor assesses the trainee on eight professional issues over three stages of development (Loganbill and Hardy 1983); and (4) the Stoltenberg and Delworth Model, which is a revision of the Stoltenberg model, including three structures to trace the progress of trainees through the three levels (Stoltenberg and Delworth 1987). However, for reasons of brevity, the researcher will only discuss the two models as examples of the developmental model.

The Littrell, Lee-Borden and Lorenz Model is a developmental model, which attempts to match supervisor behaviour to the developmental needs of the supervisee (Littrell *et al.* 1979). There are four stages to this model. The first is characterised by relationship building, goal setting and contracting. In the second, the supervisor alternates between the role of counsellor and teacher as the trainee is faced with affective issues and skill deficits. In the third, the supervisor adopts a more collegial role of consultant as the trainee gains confidence and expertise, while, in the fourth, the supervisor's role becomes distant and he/she serves as a consultant. At this stage the supervisor takes responsibility for the supervisee's learning and development as a counsellor.

The second example of the developmental model is the Stoltenberg and Delworth Model. Stoltenberg and Delworth (1987) revised the earlier contribution of Stoltenberg (1981) and included aspects of the Loganbill and Hardy Model (Loganbill and Hardy 1983). They describe three developmental levels and eight growth areas for the supervisee. The three levels of the supervisee are the beginning, intermediate and advanced. Stoltenberg and Delworth (1987) then highlight the content of the eight growth areas for each supervisee. These are intervention skills, assessment techniques, interpersonal differences, client conceptualisation, individual differences, theoretical orientation, treatment goals and plans and professional ethics. The three structures proposed to trace the progress of trainees through the levels on each dimension are: (1) the trainee's awareness of self and others; (2) motivation towards the developmental process; and (3) the amount of dependency or autonomy displayed by the trainee. Helping supervisees identify their own strengths and growth areas enables them to be responsible for their life-long development as both therapists and supervisors.

The social role models have their roots in early understandings of supervision, where supervisor and supervisee adopt certain relationships towards one another. The social role models attempt to tell us what supervisors and supervisees do within supervision, what tasks are performed and by whom. According to Carroll (1996), the generic tasks of counselling supervision has isolated seven. They are: to create the learning relationship, to teach, to counsel, to consult, to evaluate, to monitor professional/ethical issues, to work with the administrative/organisational aspects of client work. Social role model include: (1) the Discrimination Model which focuses on trainees' intervention, conceptualisation and personalisation skills in three different supervisor roles: teacher, counsellor or consultant (Bernard, 1979); and (2) the Hawkins and Shohet Model which includes six focused approaches of the adequate supervisor (Hawkins and Shohet, 1989).

The Discrimination Model highlights three areas of focus for skill building: process or intervention, conceptualisation and personalisation (Bernard, 1979). Process

issues examine how communication is conveyed or what the trainee is doing in the session that is observable by the supervisor. Conceptualisation issues include how well supervisees can explain their application of a specific theory to a particular case. Personalisation issues pertain to counsellors' use of their persons in therapy, in order that all involved are non-defensively present in the relationship. Once a supervisor has made a judgment about the trainee's abilities within each focus area, a role is chosen to accomplish the supervision goals. Within the supervision process or session, three roles may be assumed by the supervisor. Each these roles is task-specific for the purpose of identifying issues in supervision. Supervisors might take on the role of teacher when they directly lecture, instruct and inform the supervisee. The role of counsellor is undertaken when a supervisor addresses the interpersonal or intra-personal reality of the supervisee. In this way, the supervisee reflects on the meaning of an event for him or herself. The role of consultant is undertaken when a supervisor allows the supervisee to share the responsibility for learning. The supervisor becomes a resource for the supervisee but encourages him/her to have trust in his/her own thoughts, insights, and feelings about the work with the client.

In the Hawkins and Shohet Model, the supervisor's role is to offer support and reassurance and also to contain any overwhelming affective responses that a supervisee might have. There are six foci that are addressed in this model. The first is the reflection on the content of the therapy session known as the therapist narrative. The second focus is on exploration of the strategies and interventions used by the therapist known as therapist activity. The third is on exploration of the therapy process and relationship, known as the therapy process. The fourth is on the therapist's counter-transference, known as the supervisee's state. The fifth is on the 'here-and-now' process as a mirror or parallel of the 'there-and-then', which is known as the supervision process. The sixth is on the supervisor's counter-transference, which is known as the supervisor's experience.

Worthington (1987) points out that one of the main strengths of developmental models is that they offer supervisors possible categories in which they can anchor their observations about supervisory interventions. This assumes that supervisors are both able, and willing to change their supervisory interventions. As yet we do not know that they are. Van Ooijen (2000) referring to developmental and social role supervision models, points at that there is a movement away from clinical models of supervision tied to counselling orientations to more educational, psychosocial models, emphasising the roles or tasks of supervisors and the learning stages of supervisees.

SUMMARY AND CONCLUSION

Clinical supervision is related to self-development, professional growth and career development of the supervisees. The supervisor's role is to help learners to achieve their goals by acting as counsellor, facilitator and advisor. Counselling is an important function in relation to the clinical supervision because it can lead to an improved relationship between the supervisor and supervisee. It consists of support, feedback, providing counsel, consultation, teaching, evaluation, motivation and the monitoring of professional issues. One of the important functions of a supervisor is to be a role model for the supervisee. This view is supported by many authors who have mentioned that the supervisor is someone who has greater experience and helps less skilled or less experienced practitioners to achieve professional abilities.

In order to react effectively, a supervisor must: (1) have certain goals and plans; (2) be a good communicator; (3) have the knowledge and relevant skills about the candidate's area of interest; (4) be able to establish a good and professional relationship; and (5) be flexible in supervision strategies depending on the individual requirements. In maintaining a good relationship, the supervisor and supervisee must have certain goals or objectives. The relationship will focus on these and both parties must trust, respect, empathise and be honest with each other. An effective supervisor will have access to a range of teaching and learning methods, and will be able to adapt to individual supervisees and to provide clear and focused feedback to facilitate learning. A good relationship can make both parties comfortable with meeting regularly and sharing ideas or knowledge with a view to supervisee development. As a student, one must be eager to learn, enhance one's self-awareness, learn from mistakes and successes, develop and apply new skills and design action plans or timetables. In addition, he/she must be diligent, conscientious and hardworking, open to criticism, willing to listen to others and to talk openly.

Assigning experienced supervisors to guide and support supervisee provides valuable professional development for both parties. Clinical supervision helps supervisees face their new challenges; through reflective activities and professional conversations. Clinical supervision allowed supervisors to help others, improve themselves, receive respect, develop collegiality from the supervisees' fresh ideas and energy because the benefits of clinical supervision are both career-related and psychosocial.

REFERENCES

- Association for Counsellor Education and Supervision (1990). Standards for Counselling Supervisors. *Journal of Counselling and Development*, 69, 30-32.
- Adelson M. J. (1995). Clinical Supervision of Therapists with Difficult to Treat Patients. *Bulletin of the Menninger Clinic*, 59(1), 32-52.
- Alonso, A. (1985). *The Quiet Profession: Supervisors of Psychotherapy*. New York: Macmillan.
- Alonso, A. and Rutan, J. S. (1988). Shame and Guilt in Psychotherapy Supervision. In Barnfield, K. (2004). *An Introductory Manual for Intern Supervisors*. Available at: <http://www.psc.uc.edu/rs/tm/TM%20Manual%20for%20Intern%20Superv.htm> (Accessed Dec. 12, 2004).
- Anderson, H. and Swim, S. (1995). Supervision as Collaborative Conversation: Connecting the Voices of Supervisor and Supervisee. *Journal of Systemic Therapies*, 14(2), 1-13.
- Armitage, S. and Rees, C. (1988). Project Supervision. *Nurse Education Today*, 8, 99-104.
- Barber, P. and Norman, I. (1987). *Mental Health Nursing: Skills in Supervision*. In Butterworth, T., Faugier, J. and Burnard, P. (1992). *Clinical Supervision and Mentorship in Nursing* (2nd ed.). Cheltenham: Stanley Thornes Publishers Ltd.
- Barnfield, K. (2004). *An Introductory Manual for Intern Supervisors*. Available at: <http://www.psc.uc.edu/rs/tm/TM%20Manual%20for%20Intern%20Superv.htm> (Accessed Dec. 12, 2004).
- Beam, L. (2001). Would You Like Your Own Coach? *Nursing Homes Long Term Care Management*, 50(3), 58-61.
- Berger, S. S. and Bushholz, E. S. (1993). On Becoming A Supervisee: Preparation for Learning in a Supervisory Relationship. *Psychotherapy*, 30(1), 1-9.
- Bernard, J. M. (1979). Supervisor Training: A Discrimination Model. *Counselor Education and Supervision*, 19, 60-68.
- Bernard, J. (1994). The Meeting as a Lever for Organizational Improvement. *Journal of Organizational Excellence*, 13(3), 369-377.
- Bond, S. (1991). Agencies Supportive to Nursing Research. In McQueeney, E. (1996). The Nature of Effective Research Supervision. *A Journal for Further and Higher Education in Scotland*, 20(1), 23-30.

- Burton, W. H. and Brueckner, L. J. (1955). *Supervision- A Social Process*. New York: Appleton-Century-Crofts, Inc.
- Butterworth, T., Faugier, J. and Burnard, P. (1992). *Clinical Supervision and Mentorship in Nursing* (2nd ed.). Cheltenham: Stanley Thorne Publishers Ltd.
- Campbell, D. T. and Fiske, D. W. (1959). Convergent and Discriminant Validation by the Multi-trait-Multi-method Matrix. *Psychological Bulletin*, 56(1), 81-105.
- Carifio, M. S. and Hess, A. K. (1987). Who is the Ideal Supervisor? In Carroll, M. (1996). *Counselling Supervision- Theory, Skills and Practice*. London: Cassell.
- Carroll, M. (1996). *Counselling Supervision- Theory, Skills and Practice*. London: Cassell.
- Clarke, R. D. (2000). Give Good Guidance. *Black Enterprise*, 31(4), 75-77.
- Cogan, M. L. (1973). *Clinical Supervision*. Boston: Houghton Mifflin Company.
- Conway, P. F. (2001). Anticipating Reflection While Learning to Teach: From a Temporally Truncated to a Temporally Distributed Model of Reflection in Teacher Education. *Teaching and Teacher Education*, 17(1), 89-106.
- Croll, P. (1986). *Systematic Classroom Observation*. London: Falmer.
- Darley, M. (1995) Clinical Supervision. In Adelson M. J. (1995). Clinical Supervision of Therapists with Difficult to Treat Patients. *Bulletin of the Menninger Clinic*, 59(1) 32-52.
- Darling, L. A. W. (1984). What do Nurses Want in a Mentors?. *Nurse Educator*, 11(2): 29-30.
- Department of Health (1993). *A Vision for the Future- The Nursing Midwifery and Health Visiting Contribution to Health Care*. London: HMSO.
- Egan, G. (1998). *The Skilled Helper- A Problem-Management Approach to Helping* (6th ed.). Pacific Grove, California: Brooks/Cole.
- Ekstein, R. and Wallenstein, R. (1972). The Teaching and Learning of Psychotherapy. In Carroll, M. (1996). *Counselling Supervision- Theory, Skills and Practice*. London: Cassell.
- Elliot, J. (1991). A Model of Professionalism and its Implications for Teacher Education. *British Educational Research Journal*. 17(4), 309-18.
- Faugier, J. and Butterworth T. (1994). *Clinical Supervision: A Position Paper*. School of Nursing Studies. University of Manchester.

- Ford, K. and Jones, A. (1987). *Student Supervision*. London: Macmillan Education Ltd.
- Fowler, J. (1996). The Organisation of Clinical Supervision Within the Nursing Profession: A Review of the Literature. In Fowler, J. (1999). *The Handbook of Clinical Supervision: Your Questions Answered*. Wiltshire: Mark Allen Publishing Limited.
- Fowler, J. (1999). *The Handbook of Clinical Supervision: Your Questions Answered*. Wiltshire: Mark Allen Publishing Limited.
- Freeman, E. (1985). The Importance of Feedback in Clinical Supervision: Implications for Direct Practice. *The Clinical Supervisor*, 3, 5-26.
- Goldberg, D. (1985). Process Notes, Audio and Video Tape: Modes of Presentation in Psychotherapy Training. *The Clinical Supervisor*, 3, 3-13.
- Goldhammer, R, Anderson, R. H. and Krajewski, R. J. (1980). *Clinical Supervision-Special Methods for the Supervision of Teachers*. USA: Holt, Rinehart and Winston.
- Hamilton, M. S. (1981). Mentorhood, a Key to Nursing Leadership. *Nursing Leadership*, 4(1), 4-13.
- Harrar, W. R., Vandecreek, L. and Knapp. S. (1990). Ethical and Legal Aspects of Clinical Supervision. *Professional Psychology*, 21, 37-41.
- Hart, G. (1982). *The Process of Clinical Supervision*. Baltimore: University Park Press.
- Heppner, P. P. and Roehlke, H. J. (1984). Differences Among Supervisees at Different Levels of Training: Implications for a Developmental Model of Supervision. In Barnfield, K. (2004). *An Introductory Manual for Intern Supervisors*. Available at: <http://www.psc.uc.edu/rs/tm/TM%20Manual%20for%20Intern%20Superv.htm> (Accessed Dec. 12, 2004).
- Holloway, E. L. (1995). *Clinical Supervision-System Approach*. California: SAGE Publications.
- Humphrey, B. and Stokes, J. (2000, May). The 21st Century Supervisor. *HR Magazine*. 185-192.
- Kadushin, A. (1976). Supervision in Social Work. In Fowler, J. (1999). *The Handbook of Clinical Supervision: Your Questions Answered*. Wiltshire: Mark Allen Publishing Limited.

- Keith-Spiegel, P. and Koocher, G. P. (1985). *Ethics in Psychology*. New York: Random House.
- Knapman, J. and Morrison, T. (1994). The Benefits of Supervision. In Swain, G. (1995). *Clinical Supervision- The Principles and Process*. London: College Hill Press Ltd.
- Kohner, N. (1994). Clinical Supervision in Practice. In Swain, G. (1995). *Clinical Supervision- The Principles and Process*. London: College Hill Press Ltd.
- Krebs, H. A. (1967). The Making of a Scientist, *Nature*, 215, 1441-1445.
- Leddick, G. R. and Bernard, J. M. (1980). The History of Supervision: A Critical Review. *Counselor Education and Supervision*, 27, 186-196.
- Levinson, D. J., Darrow, C. N., Klein, D. B., Levinson, M. H. and McKee, B. (1978). *The Seasons of a Man*
- Littrell, J. M., Lee-Borden, N. and Lorenz, J. (1979). A Developmental Framework for Counselling Supervision. *Counsellor Education and Supervision*, 19, 129-36.
- Loganbill, C. and Hardy, E. (1983). Developing Training Programs for Clinical Supervisors. *The Clinical Supervisor*, 1, 15-21.
- Loganbill, C., Hardy, E. and Delworth, U. (1982). Supervision: A Conceptual Model. In Barnfield, K. (2004). *An Introductory Manual for Intern Supervisors*. Available at: <http://www.psc.uc.edu/rs/tm/TM%20Manual%20for%20Intern%20Superv.htm> (Accessed Dec. 12, 2004).
- Nelson, G. L. (1978). Psychotherapy Supervision from the Trainee's Point of View: A Survey of Preferences. *Professional Psychology*, 9, 539-549.
- Neufeldt, S. A. (2004). *Clinical Supervision, Therapist Development and Culturally Sensitive Practice*. Available at: <http://www.psychsem.com/clinicalsup.html> (Accessed April 01, 2004).
- Page, S. and Wosket, V. (1994). *Supervising the Counsellor. A Cyclical Model*. London: Routledge.
- Pierce, E. C. (2004). *Supervision*. Available at: <http://home.san.rr.com/edwardpierce/Supervision%20Contract.htm> (Accessed April 02, 2004).
- Pollard, A. (2001) *Reflective Teaching in the Primary School: A Handbook for the Classroom* (3rd ed.). London: Cassell.

- Proctor, B. (1988). Supervision: A Cooperative Exercise in Accountability. In Fowler, J. (1999). *The Handbook of Clinical Supervision: Your Questions Answered*. Wiltshire: Mark Allen Publishing Limited.
- Richo, D. (1991). *How to be an Adult*. Mahwah, NJ: Paulist Press.
- Robbins, A. (1991). *Awaken the Giant Within*. New York: Simon & Schuster.
- Rodenhauer, P., Rudisill, J. R. and Painter, A. F. (1989). Attributes Conducive to Learning in Psychotherapy Supervision. In Carroll, M. (1996). *Counselling Supervision- Theory, Skills and Practice*. London: Cassell.
- Rogers, C. (1957). More Input Required. In Fowler, J. (1999). *The Handbook of Clinical Supervision: Your Questions Answered*. Wiltshire: Mark Allen Publishing Limited.
- Rowland, T. W. (2000). On the Ethics of Elite-level Sport Participation by Children. *Pediatric Exercise Science*, 12, 1-5.
- Schon, D. A. (1983). The Reflective Practitioner: How Professionals Think in Action. In Hoban, G. (2000). Using a Reflective Framework to Study Teaching-learning Relationship. *Reflective Practice*, 1(2), 165-182.
- Schon, D. A. (1987). *Educating the Reflective Practitioner*. San Francisco: Jossey-Bass.
- Senge, P. M. (1990). *The Fifth Discipline*. New York: Doubleday.
- Sergiovanni, T. J. and Starratt, R. J. (1973). Supervision: Human Perspectives. In Goldhammer, R, Anderson, R. H. and Krajewski, R. J. (1980). *Clinical Supervision- Special Methods for the Supervision of Teachers*. USA: Holt, Rinehart and Winston.
- Simms J. (1993). In Swain, G. (1995). *Clinical Supervision- The Principles and Process*. London: College Hill Press Ltd.
- Stoltenberg, C. (1981). Approaching Supervision From a Developmental Perspective: The Counsellor-Complexity Model. *Journal of Counseling Psychology*, 28.
- Stoltenberg, C. D. and Delworth, U. (1987) Supervising Counselors and Therapists. In Van Ooijen, E. (2000). *Clinical Supervision- A Practical Guide*. London: Churchill Livingstone.
- Styczynski, L. E. (1980). The Transition From Supervisee to Supervisor. In Berger, S. S. and Bushholz, E. S. (1993). On Becoming A Supervisee: Preparation for Learning in a Supervisory Relationship. *Psychotherapy*, 30(1), 1-9.

- Swain, G. (1995). *Clinical Supervision- The Principles and Process*. London: College Hill Press Ltd.
- Talen, M. R. and Schindler, N. (1993). Goal-Directed Supervision Plans: A Model for Trainee Supervision and Evaluation. In Barnfield, K. (2004). *An Introductory Manual for Intern Supervisors*. Available at: <http://www.psc.uc.edu/rs/tm/TM%20Manual%20for%20Intern%20Superv.htm> (Accessed Dec. 12, 2004).
- United Kingdom Centre Council for Nursing, Midwifery and Health Visiting (UKCC) (1996). *Position Statement on Clinical Supervision for Nursing and Health Visiting*, 1st May 1996. London: UKCC.
- United Kingdom Psychiatric Pharmacy Group (UKPPG) (2004). *Clinical Supervision Policy*. Available at: <http://www.ukppg.co.uk/clinical-supervision-policy.html> (Accessed April 01, 2004).
- Van Manen, M. (1995). Epistemology of Reflective Practice. In Conway, P. F. (2001). Anticipatory Reflection While Learning to Teach: From a Temporally to a Temporally Distributed Model of Reflection in Teacher Education. *Teaching and Teacher Education*, 17(1), 89-106.
- Van Ooijen, E. (2000). *Clinical Supervision- A Practical Guide*. London: Churchill Livingstone.
- White, M. (1990). Family Therapy Training and Supervision in a World of Experience and Narrative. *Dulwich Centre Newsletter*, 27-38.
- Whiteside, J. and Lies, J. (2004). *Minnesota Women in Psychology*. Available at: <http://www.womenpsychologists.org/Newsletter%204-03.htm> (Accessed March 14, 2004).
- Wilkin, P., Bowers, L. and Monk, J. (1997). Clinical Supervision: Managing the Resistance. *Nursing Times*, 93(8), 48-49.
- Worthington, E. L. (1987). Changes in Supervision as Counselors and Supervisors Gain Experience: A Review. In Holloway, E. L. (1995). *Clinical Supervision-System Approach*. California: SAGE Publications.
- Wright, S. (1992). In Swain, G. (1995). *Clinical Supervision- The Principles and Process*. London: College Hill Press Ltd.
- Yegdich, T. (1999). Lost in the Crucible of Supportive Clinical Supervision: Supervision is Not Therapy. *Journal of Advanced Nursing*, 29(5), 1265-1275.

- Yogev, S. (1982). An Eclectic Model of Supervision: A Developmental Sequence for Beginning Psychotherapy Students. In Barnfield, K. (2004). *An Introductory Manual for Intern Supervisors*. Available at: <http://www.psc.uc.edu/rs/tm/TM%20Manual%20for%20Intern%20Superv.htm> (Accessed Dec. 12, 2004).