

SUPERVISION as CRITICAL CLINICAL REFLECTION¹

Module iv in Section VII, *Professional Development and Contributions to the Field*.

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INTRODUCTION

My first experience of supervision took place in a clinical pastoral education program in a hospital. I remember that I started in a state of awe inspired by the stature of the chaplain supervisor. He seemed comfortable in the context of the hospital, a place that intimidated me each time when I as a young parish pastor had to make a pastoral call. The chaplain moved with apparent ease and confidence in a world of human frailty and suffering, surrounded by busy nurses and authoritative doctors in the midst of a complex administrative system.

In the course of the CPE unit, the program's focus seemed to shift from developing practical competencies to relational issues, specifically to me as the student. Increasingly I became aware of my own idiosyncrasies and growing edges as I critically reflected on my clinical experience. Years later, when I prepared my "model" of supervision, I conceptualized these early experiences:

*The genius of Supervised Pastoral Education (SPE) is in its complexity as a multidimensional process of education. SPE takes place within an intricate network of interrelationships which focuses on the self, others, and encounters between the self and others in a variety of helping contexts. When SPE ceases to be such a complex process, it can become abusive. A simplistic view and practice of SPE tends to absolutize one or another aspect of the SPE learning process. Two extreme examples can be cited. A preoccupation with the supervisor as "guru" reduces SPE to a quasi-religious enterprise in which disciples are cultivated, while a preoccupation with the student as "patient" reduces SPE to a quasi-therapeutic enterprise in which the student's actual or potential pathology is diagnosed and, hopefully, treated.*²

This module on supervision needs to be read in conjunction with the previous module in this section, VII, iii *Adult Learning Theory and Teaching*, a module that provides a full range of professional literature resources. This present module on supervision focuses on a process that can be applied as an ongoing guide in critical clinical self-reflection beyond the CPE supervisory context. This includes the utilization of the *helping style inventory* and extends supervision to the use of professional and personal consultation.

A Systems Model of Supervision

The module will explore the complexity of the supervisory process through a systems conceptualization. Systems supervision is not the supervision of a systems approach to therapy such as family therapy. Rather it means that supervision itself is a multidimensional process composed of diverse parts - parts that in theory can be examined independently but in actual practice merge in a dynamic and intricate systemic interaction.

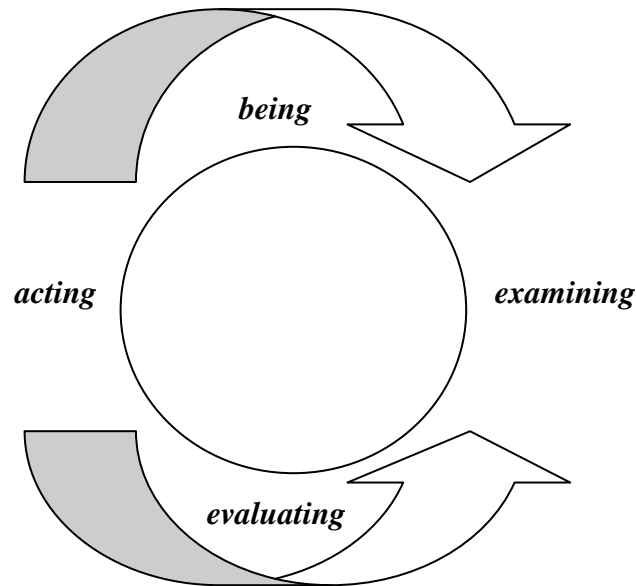
The core of supervision has traditionally been defined in the *experiential learning* model followed in clinical education. Supervision is at the center of this learning approach in facilitating students in the process of making meanings, developing skills and expanding their use of self. The experiential learning process has been conceptualized as a cyclical process where four crucial phases stand out. Using active verbs appropriate to experiential learning, these four phases are: *being with* others in a clinical experience that is connected with the practice of *examining*, *evaluating*, and *acting upon* this experience.

This cyclical process constantly generates new clinical experiences to examine, to evaluate, and to act upon, *ad infinitum*. There is no rigid order to this experiential learning process – the learner can start at any point in the cycle and pass through each phase from different directions and in different frequencies in the course of completing a cycle or round of learning. Students bring their own unique learning styles which organize these “four seasons” into personalized climates in which optimum professional and personal growth can take place.³

While there is no clockwork precision and sequence to pacing the four phases in experiential learning, there is inner harmony. A balance arises from movement back and forth between concrete experience (being with) and abstract conceptualizing (evaluating), and between reflective observation (examining) and active experimentation (acting).⁴ The various tools of clinical education, including audio/video tape recordings, supervisory feedback, written reflection reports, peer group interaction, role play, learning contracts and evaluations, are designed to engage the student in the various stages of the experiential learning cycle.

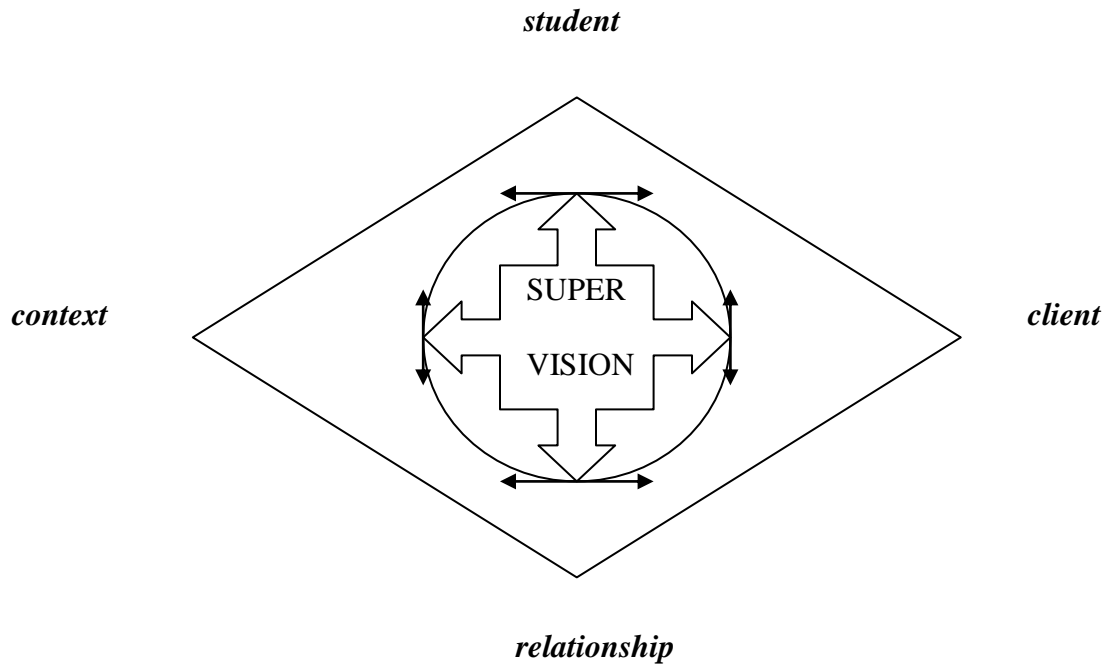
Figure 1

The Experiential Learning Cycle



The experiential *learning cycle* is at the center of a fourfold *learning focus* consisting of the student, the client, the relationship, and the larger context or environment in which that relationship takes place and is assigned a specific meaning. Shifts in learning focus are illustrated in the history of the Clinical Pastoral Education (CPE) in America. This movement started with an emphasis not on the supervisor, nor on the student, but on the patient as the *living human document*.⁵ Starting in the early 1920's, Anton Boisen emphasized the significance of *case records* and *case analyses* as primary tools in understanding the patient and, in the context of the psychiatric hospital, learn about the religious meanings of mental illness. Beginning in the 1930's, the focus shifted from the patient to the student, specifically under the influence of the Russell L. Dicks with the emergence of the *conversation process record*, later refined to the *verbatim*. The one-time Boisen student Seward Hiltner became instrumental in establishing Carl Roger's client-centered approach in pastoral care and counselling. This client-centered focus, however, was not a return to Boisen's patient-centered focus toward insight, but, rather, embraces the more complicated relational context of student, client, and the encounter between the two. By the 1960's the focus in CPE had shifted from *intra*-personal dynamics (whether the patient or student) to the *inter*-personal dynamics of *being with* others. Thus the helping relationship came into prominence as the main focus for spiritual care.

Figure 2
The CPE Experiential Learning Focus



The *experiential learning focus* diagram sketches an overview of the major dimensions of supervision. While we can distinguish the four learning focus areas, in practice they interact and define themselves as one integrated system. The value of looking at each focus separately is that each learning focus highlights the various types of supervisory issues and processes operative in the four focus areas:

1. The Student/Self

The student brings his or her cultural identity, including gender, ethnic, socioeconomic and religious background, values and beliefs, sexual orientation and social history. There is a person shaped by a family history, with a particular theoretical and theological orientation, level of personal awareness and clinical readiness. These are all critical components of supervision; factors the supervisor needs to know and incorporate in the supervision. However, a singular focus on the student can shift supervision into therapy. Since the use of self is a primary therapeutic tool in most counselling models, it is often impossible to maintain a clear boundary between supervision and therapy. Rather than simply excluding the person of the student, supervision can best include the student by focusing on the relationship roles in which the student represents himself or herself in the spiritual care and supervisory context. That approach will be further discussed in the section on helping styles

2. The Patient/Client

The client brings the supervisor and the student together, while the client's *presenting problem* often organizes the supervisory agenda and frames the case conceptualization. The client can be one person or a relationship that presents itself in the caring encounter. The supervisor normally hears about the patient's or client's presenting problem as presented by the student. The *presenting problem* thus presents both client and student. The supervisor can choose where to place himself or herself on the continuum between the client and the student. As a representative of the client's best interests, the supervisor uses supervision to direct the practice of care through the student. As a representative of the student's best interests, the supervisor uses supervision to educate the student through the client. Rather than a linear continuum of polar opposites, in reality supervision may resemble more of a triangle where the supervisor constantly balances the interests of both client and student.

3. The Relationship

The relationship focuses on how the self/student presents himself or herself in the various contexts as caregiver, student, staff member, peer and colleague. Such social roles indicate how the person participates in the various systems. Following the historical migration of the point of focus in the CPE movement - from patient to student to their relationship - this module centers on the relationship. The next section on *Helping Styles* explores the various helping postures between caregiver and client, and, in parallel fashion, between supervisor and student.

4. The Context

The supervisor functions in the larger context of a health care organization and professional, educational and religious communities with their respective ethical structures and organizational guides. Sometimes the primary context of supervision is administrative and managerial in nature. In clinical supervision the focus is primarily educational. The educational context includes the learning contract with the evaluation process reflecting goals and expectations, theological reflection on the clinical experience, theoretical exploration and innovative practice experimentation. The professional and religious context includes standards of practice, professional codes of ethics, and religious practices and beliefs from an inclusive, cross-cultural perspective.

Styles of Caring

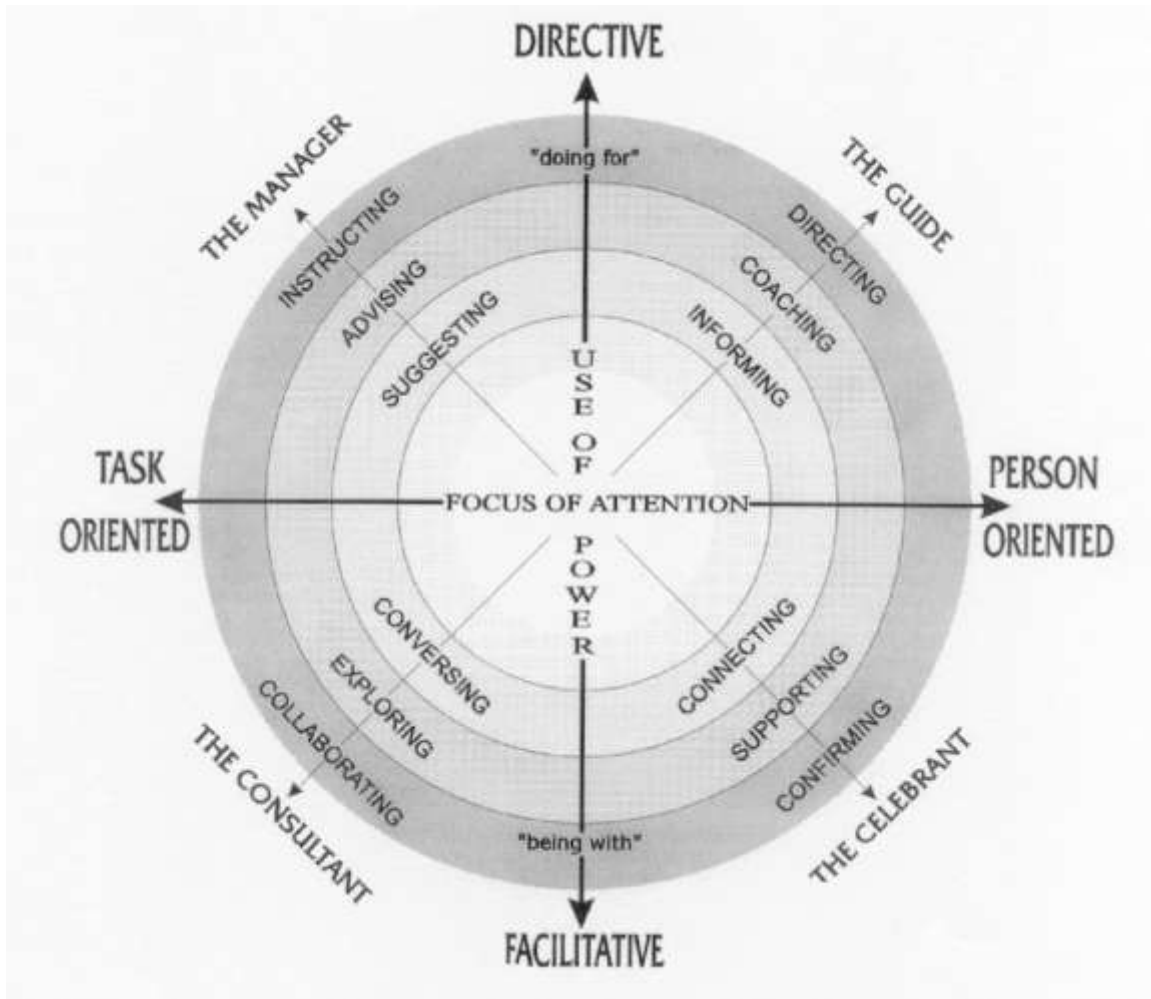
Supervision is vitalized and directed by the supervisor's vision and understanding of the goal of supervision. The goal of supervision is found in the triad of *what to know*, *what to do*, and *what to be*.⁶ The goal of supervision is to connect *what to know* (theory) and *what to do* (practice) in *what to be* (the helping relationship). The crucial bridge between theory and practice is the therapist's use of self in the act of caring. It seems ironical that what is most at the core of supervision often is least accessible. My supervision experience has shown that students, at least initially, prefer supervision to focus on the client. There is a reluctance to move from the client and the presenting problem to the immediacy of the helping relationship and of what is going on in the therapy room. Simple supervisory questions like "what do you like/dislike most about this client?" or "how do you imagine the client sees you?" can be disorienting on account of the shift of focus from the client to the student and the helping relationship.

As therapist Salvador Minuchin asks the critical supervisory question, "What kind of therapist do I aim to co-create in supervision?" (1997, 278). His answer brings together the therapist's maps of knowledge and techniques in the therapist's use of self: "This therapist has an hypothesis about the best way to help this family. She knows that any hypothesis is only tentative, a map to be changed whenever new information makes a better fit possible. That means a therapist who can take possession of many partial truths and use them as probes, until the family responds and a better fit can be calibrated. She needs to know herself sufficiently well to access the parts of herself that are useful for the therapeutic goal. She needs to have a map of final goals, along with the ability to zigzag in whatever way the process requires, while keeping the goals in mind" (278).

From this perspective, supervision begins with the student's habitual and routine ways of being helpful or doing therapy. Minuchin uses the term "the therapist's style" to describe this focus of supervision: "To reach the goal of a therapist who is both strategic and self-aware, I have learned in my supervision to focus on the therapist's style – that is, on his or her use of a preferred, narrow set of predictable responses under a variety of diverse circumstances." The goal of supervision is first to ascertain the students' therapeutic style and then go beyond it: "What are the responses in their repertory that they utilize most frequently? We accept them. They are okay. Then we declare them wanting. The therapist's style is all right as far as it goes, but it can be enlarged" (278).

The *Helping Style Inventory* (HSI), the core conceptualization in the module *Styles of Caring* (I, iv), maps the major helping styles and helping images. This diagram is designed to span the scope and classify the diversity of helping styles. As a tool of supervision, the HSI becomes the instrument that draws the profile of the student's distinctive or dominant helping style. The purpose is not to invalidate this helping style profile, even though it may have only limited therapeutic applications, but to encourage students to extend themselves beyond their natural modes of self-expression into new territory.

Figure 3
The Helping Style Inventory



The HSI approach fits the experiential learning cycle: students get specific feedback with which to examine, evaluate, expand and modify their caring responses. The feedback is not primarily confrontational or evaluative but part of an adult learning process activated by tape-recorded, verbatim-reported caring/counselling excerpts, or actual clinical experiences or role-plays that are shared and examined in a collaborative context. As a descriptive device, the HSI avoids the defensive preoccupation of students with questions of right and wrong. The supervision hypothesis is that the two factors of regular and primarily descriptive feedback work well together in the experiential learning cycle.

The Supervisory Relationship

In supervision, the supervisory relationship presents itself as the theatre staging a differential use of *helping styles*. As depicted in Figure 2, the supervisory relationship is at the center of students' experiential learning process. The supervisor brings his or her own personal history, values, cultural identity and theoretical orientation into a professionally defined working relationship with students. The quality of the supervisory relationship hinges on how the supervisory roles and tasks are integrated with a personal, interactive involvement between supervisor and student.

Related Models in Systems Supervision

Holloway (1995) distinguishes between the functions and tasks of supervision:

- The *tasks* are content areas of basic competencies expected from the student, such as counselling skills, case conceptualization and professional identity.
- In distinction the supervision *functions* are process oriented: monitoring/evaluating, advising/instructing, modeling, consulting, and supporting/sharing. These process functions are represented in the HSI as helping behaviors that define particular helping stances: manager, guide, consultant, and celebrant.

Williams' (1995) integrates four supervisory roles with six supervision focus areas into a *role-focus matrix*:

- The supervisory roles (teacher, facilitator, consultant, evaluator) parallel the respective HSI helping images of guide, celebrant, consultant, and manager.
- Williams' *six-focus approach* correlates the therapy system with the supervisory system, resembling the *experiential learning focus* framework in Figure 2 in this module.

The respective frameworks of Holloway and Williams are examples of a systems approach to supervision emphasizing its multidimensional nature based in the relational core of supervision.

Interpersonal patterns connect the therapy system and the supervisory system. In doing supervision, I often became aware how the supervisory system and the therapy system mirror each other. When the supervisor focuses on the joining between therapist and client (the therapy system), the joining between supervisor and student (the supervisory system) becomes the mirror. When the student presents a client who "talks too much and will not listen," the "talk and listen" interaction between student and supervisor becomes the mirror. In teaching diversity in helping, the supervisor's own flexible and playful use of different parts of the self becomes the mirror.

Of special significance – and concern - is the *use of power* dimension in supervision. In view of the nature of supervisory tasks and roles, the relationship is unequal due to the power differential between the supervisor and the student. In the context of the HSI model, the vertical “use of power” continuum stretches from the *directive* end (power localized in the supervisor) to the *facilitative* end (power localized in the student). The model’s ideal is not to polarize but to balance these two ends on the power continuum. In a balanced supervisory relationship both power and empowerment are present, each including the other. Directiveness and facilitation are not mutually exclusive helping styles but function in codependence. In supervision, power does not reside exclusively in either the supervisor or the student, but comes to play in their mutual involvement in the supervisory relationship.

The same applies to the horizontal *focus of attention* HSI continuum stretching from the *task-* to the *person-*orientation. In the history of therapy, this continuum has been frequently subject to polarization where one end is favored over the other.⁷ A more flexible supervisory style is evident when the tasks of supervision are balanced with the needs of the care receiver. At times most of the attention can focus on the task, balanced by other times when the attention shifts to the person as effected by the task.

Often the polarization of the two HSI continuums is presented as gender specific: male helping/supervising as typically task-focused and directive in contrast with a female approach that is typically affiliative, self-disclosing, and non-directive. While encouraging differences in individual supervision styles, the HSI resists gender or any other polarization in favor of the ideal of an inclusive, contextual approach that claims the whole map. Yet it is evident that power and gender are not disconnected but bound in cultural, historical and systemic ties.⁸ In view of the inherent potential for the abuse of power and insensitivity to diversity, I support the suggestion to use dyadic supervision where students have more of a presence and can more readily opt the role of consultants and contributors in the supervisory process.

The developmental nature of supervision is another significant feature of supervisory relationships. These relationships are not static but in constant flux as they evolve over time. A developmental perspective tracks the stages through which supervision moves: from the initial stage of establishing a working relationship, to a real relationship that is less role bound and more interpersonal, to the terminating stage when the goals of supervision have been realized and, hopefully, when the supervisory relationship is being replaced with a peer relationship. Holloway highlights the “mature phase” when the supervisory relationship becomes more interpersonal: “After initial interactions, participants come to know one another better and are thus more accurate in their messages. With decreased uncertainty, they are better able to use control strategies and communicative modes that will reduce the level of conflict in the relationship. Participants also become increasingly more vulnerable and more willing to risk self-disclosure, whereas in the initial stages, genuine self-disclosure is seldom observed” (1995, 49). This description sees the development of the supervisory relationship as

analogous to the therapy relationship in its focus on building a secure interpersonal climate with a more open and less defensive style of communication.

Another developmental perspective (Stoltenberg & Delworth, 1987) focuses not so much on the supervisory relationship as on the student's learning level. Here the emphasis is on matching the style of supervision with the level of the student's development as a counsellor. The HSI map can be used to track such shifts in supervisory style. The developmental approach assumes is that at a basic level, students are best served by supervisors who provide both guidance and structure. Following the HSI map, the appropriate supervision style for this level of training is predominantly "directively person-oriented," combining direction and support. However, a next phase in supervision may well be a shift to a "facilitatively person-directed" style, allowing the supervisor to become less directive and more supportive, hopefully confirming and celebrating the student's budding efforts in counselling. When students reach a more advanced level, however, the assumption is that there is less need for personal support and encouragement – although who can do without it? – but more of a need and interest in a practice-focus in supervision. This developmental process is expressed in a shift to a "facilitatively task-oriented" style that defines supervision as primarily a collaborative and consultative process.

A Supervision Case Illustration

The following is a composite picture taken from my supervision experience in an interdisciplinary setting. David is a student in a combined Masters Degree Program in theology and social work and has his first clinical placement in a Pastoral Counselling Centre. The supervisor has done the assessment interview of a client, Mrs. Clare, who is assigned to David. David has read the following information from the assessment report before the interview:

Mrs. Clare became a widow with the sudden death of her husband three months ago. Her daughter separated from her husband about the same time. She and her two young children came to live with Mrs. Clare, and soon conflict erupted between the two women. Mrs. Clare has come to the pastoral counselling centre to present the mounting tension with her daughter, but has refused the recommendation of the assessment counsellor for joint therapy with her daughter to address the relational conflict.

David came to supervision with an audio tape of the first session and had selected the following short excerpt for supervision:

(C=Client, Mrs. Clare, D=Counsellor, David)

C.1 I have already told the other counsellor [during the assessment] about my daughter. I am glad that you will be the counsellor because you seem more open-minded and are closer to her age, you might be better able to talk with her.

D.1 You have concerns about your daughter. And I understand she lives with you now.

C.2 Yes, she came to live with me the month after my husband died. She has the two children too. She separated from her husband who is abusive. His personality changed the day after the marriage. All of this has changed her personality too. She used to be so easy to get along with, but now she is impossible.

D.2 There have been a lot of changes for you – your husband’s death and then within a few weeks your daughter’s separation...

C.3 (a long silence followed by the sound of crying)

D.3 No time for yourself. So busy having to think of others...

C.4 (long silence with more sobbing)

D.4 Can you tell me a bit more about your daughter, Mrs. Clare?

C.5 ...(After a pause)... She really wanted her husband to come back but he refused. He is already with somebody else. I don’t understand why she has to be so miserable. She is better without him.

D.5 It sounds to me that she is grieving for her husband and the loss of her marriage.

C.6 I think she needs psychiatric help. But she doesn’t want help. She doesn’t think she needs it. She refuses when I mention it to her. I can’t take more. (deep sigh)

D.6 You have already taken a lot. I can understand it feels like getting too much.

C.7 I was thinking that I can ask my daughter to take me for the next appointment and that you invite her in and talk to her.

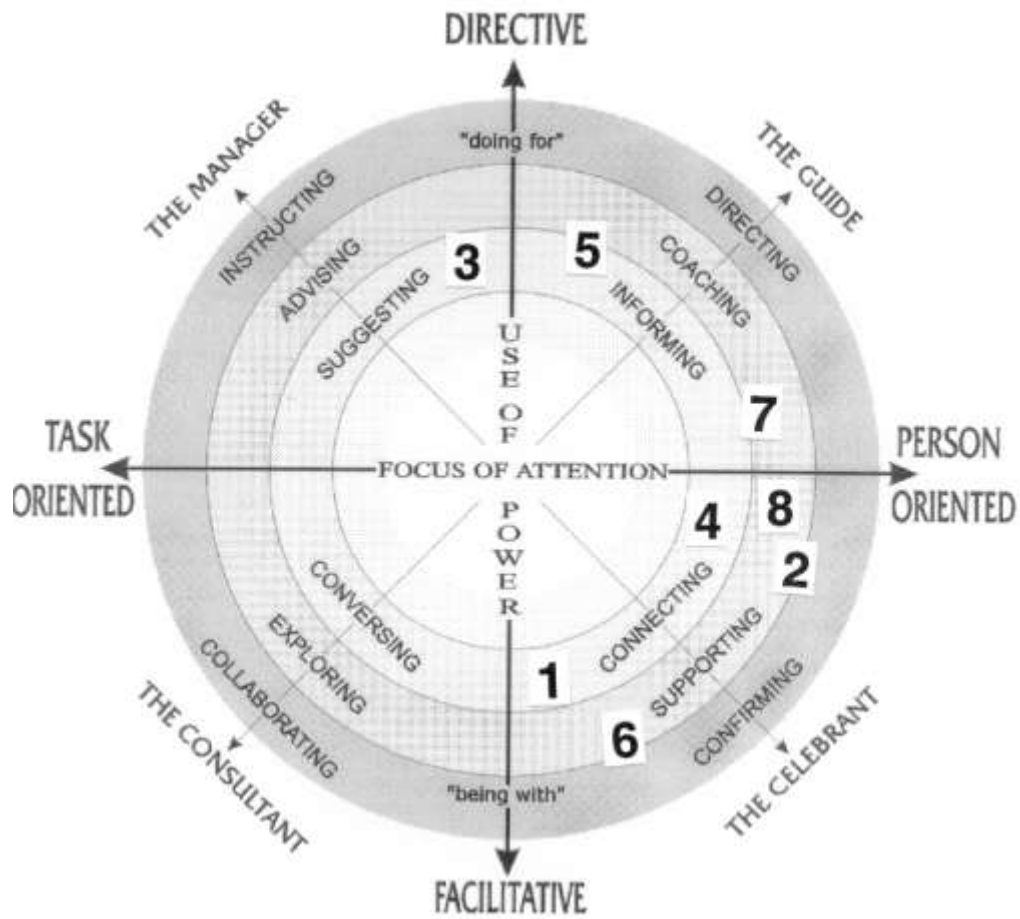
D.7 I can do that but I would appreciate if you tell her that I like to talk to both of you.

C.8 If I do, she will not come with me. I know it.

D.8 Well... okay... let’s see what happens.

Tracking David's responses on the HSI diagram, presents the following profile:

Figure 2
Student Helping Style Profile



Your Personal Notes

Some Questions:

- How would you have scored the interview on the HSI map?
- What accounts for different scoring assessments?
- How can a group analysis benefit from a diversity of scoring perspectives?

Some Assessment Exercises:

- In a provisional assessment based on the above HSI profile, what significant features of David's therapeutic style could you note at this point?
- In a provisional examination of the four focus areas in the case, using your creative and narrative imagination, what could you say on the following:

1. ***The student David***

What is your mental picture of David, his personal history and character style?
What can you like/dislike about him?

2. ***The client***

How would you answer the question of "who is the client" in this case?
What makes this situation a challenge for you?

3. ***The relationship***

What relational change(s) can you think of?
What shifts over time could make the relationship more caring or helpful?

4. ***The context***

What are some of the contextual issues raised by Mrs. Clare?

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END NOTES

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- ¹ This module adapts Chapter 12 "Supervision in Learning and Teaching Spiritual Care" in Peter L. VanKatwyk, *Spiritual Care and Therapy*, 2003, WLU Press.
- ² This paper was later published in *The Journal of Pastoral Care*, Winter 1988, Vol. XLII, No. 4, 319-327.
- ³ See D. Kolb and B. McCarthy, *The Learning Style Inventory* (Oak Brook, IL: Excell, 1980). For a description of adult education theory in the practice of pastoral supervision see Thomas St. James O'Connor, "Take What You Can and Dance: Adult Education Theory and the Practice of Pastoral Supervision," *Journal of Supervision and Training in Ministry*, Volume 15, 1994, 50-62
- ⁴ See Maclean Batts & Mandsley, 1981
- ⁵ Anton Boisen's term. See Robert C. Powell, 1975; Peter L. VanKatwyk, "Seeing the Same Different: The 'living human document' in a Postmodern Context of Clinical Pastoral Education" in *The Spiritual Care Giver's Guide* (2008).
- ⁶ See the Introduction of the Curriculum.
- ⁷ In section I of the curriculum, I differentiate *person-centered caring* (module v) from *task-focused caring* (module vi).
- ⁸ Elizabeth Meakes and Tom O'Connor (1993) in a study of women's experience of pastoral supervision in the *Canadian Association of Pastoral Practice and Education*, report that: "Generally, the data showed that female supervisees were empowered by a supervision approach which respected the uniqueness of females' experiences in ministry, built on the learning style of the supervisee, and used a learning contract and a more collaborative supervision style."