ACSA

AUSTRALIAN CLINICAL SUPERVISION ASSOCIATION 2015

Definitions of Clinical Supervision

for clinical supervisees and supervisors

Acknowledgments

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Definition of Clinical Supervision

There is little question that the term, 'clinical supervision' is problematic. Although there is an extensive international body of literature spanning nearly a century that overwhelmingly supports the defining characteristics presented in this document, the terminology has consistently caused problems and continues to do so. Various scholars and organisations have either failed to understand the original meaning of the term, or misappropriated the practice to suit their own or organisational and political needs. From time to time, the suggestion arises that we simply replace 'clinical supervision' with a more descriptive term in order to understand it better. Experience teaches us, however, that this well-meaning tactic simply serves to complicate the picture further. As the Australian Clinical Supervision Association (ASCA) intends to remain with the term, and the subsequent confusion, it is incumbent upon us to do our best to define our position.

ACSA has adopted the following rather terse and simple definition deliberately to ensure that the practice of clinical supervision does not become overly prescriptive. This allows room for the exercise of various styles and theoretical orientations within the practice of clinical supervision while safeguarding a common core understanding.

> *Clinical supervision is a formal professional relationship between two or more people in designated roles, which facilitates reflective practice, explores ethical issues, and develops skills.*

The purpose of this document will enable people to determine whether our organisation is the appropriate resource for information, support, and services that we may eventually offer.

To clarify our position, it is unavoidable initially to define clinical supervision by what it is not. That is not to say that any territory omitted is less relevant, but rather, we highlight the major areas of confusion and misdirection. These include the domains of operational supervision and professional supervision juxtaposed against clinical supervision as we uphold it.

Clinical Supervision is not Operational Supervision

At heart, we are all very familiar with this kind of supervision. In every practice situation, professionals have a reporting relationship to a superior or oversighting body, even when that reporting relationship is to a board of credentialing or registration.

The operational supervision relationship, however benign, is based on hierarchical principles with the power placed in the hands of management and not with subordinate staff members. The organisational body delegates the authority of making operational decisions to the line manager who, in turn, delegates specific tasks to each staff member. The line manager is responsible to the organisation for ensuring that staff undertake the tasks delegated to them in a satisfactory manner. Information that the staff member shares with a line manager can stay confidential in relatively few situations. This is because the line manager's responsibility is primarily to the organisation and not to a particular staff member.

Clinical Supervision is not Professional or Gatekeeping Supervision

This relationship is also based on hierarchical power. Here, it is the professional board, accrediting university, collegial professional authority (for example appointed professional senior) or some similar body that holds the authority, sets the standards and decides matters for the student or staff member to achieve. The student or staff member who wishes to belong to this profession, either complies with this authority's decisions or is not admitted into membership of that particular body of professionals or may even suffer consequences within the workplace.

Whereas some professional disciplines and individual professional supervisors may utilise the techniques and styles of clinical supervision within the context of professional supervision, there are predetermined and largely unnegotiable power differences and limitations on what may be confidential in any professional or gate-keeping relationship.

Clinical Supervision

In line with our definition, clinical supervision is not based on hierarchical principles within a pass or fail culture. Rather, in clinical supervision, the power primarily, but not exclusively, belongs to the practitioner being supervised. This distinct understanding of power and authority is a career long developmental process. Initially, given the dominance of the other two paradigms in most institutional contexts, a novice supervisee is uncertain whether to trust this inverted use of power or even how to make use of the time offered.

Confidentiality is an important component of effective clinical supervision and the few exceptions to confidentiality are articulated by both parties, and agreed to in writing as a central motif of a formalised working agreement.

Clinical supervision is characterised by choice of supervisor exercised by the supervisee, and a clear written agreement with particular emphasis on the parameters of confidentiality, the agreed developmental goals, and evaluation of the supervision within the relationship.

Training is essential for the clinical supervisor who, consequently can articulate at least one evidence-based model of clinical supervision and engaged in supervision for themselves. Training in the supervisee role is also highly desirable.

An avoidance of dual relationships is important in clinical supervision, especially where they involve power hierarchies inherent to either operational or professional supervision. Friendships and close collegial relationships should also be avoided in the choice of supervisor, where possible. Again, issues of power and confidentiality may interfere with the reflective process as well as place an emotional burden on either party.

Operational VS. Clinical Supervision

The following diagram represents the key differences between operational and clinical supervision.

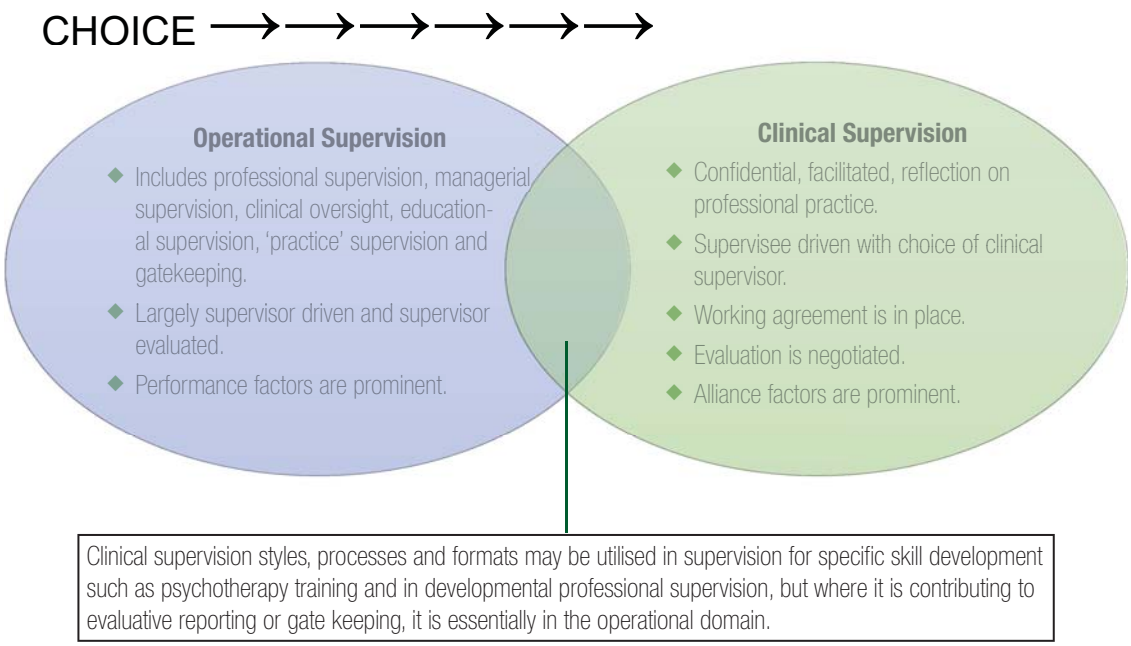

Figure 1: Operational VS. Clinical Supervision

Developmental Phases

The following steps are a brief description of the phases that the practice of clinical supervision encompasses in its three roles of supervisee, supervisor and supervising supervisor. There will be overlaps at some points of course; for instance, the supervisor will remain a supervisee, both for their own clinical work and for the supervision they provide. In general, the developmental phases apply to both individual and group supervision practice arrangements; however, group supervision requires specific skills and preparation. Training in individual supervision, alone, is not adequate preparation for supervising a group.

Step 1: Beginning clinical supervisee

All practitioners begin as supervisees. The role continues to develop throughout a practitioner's professional life. All practitioners continue to be supervisees even if, at some later stage, they train to become clinical supervisors. Formal learning supports this role, like all other roles in clinical supervision practice. Beginning supervisees need to use their time effectively, and ensure that the relationship is confidential and is a safe and respectful opportunity to reflect on what they want to reflect on regarding their work as practitioners. Eventually, supervisees will move through a number of developmental phases as they begin to make use of the opportunity for professional reflection that a safe clinical supervision relationship offers.

Step 2: Intermediate clinical supervisee

Practitioners will often move from a professional supervision arrangement to clinical supervision, which is non-hierarchical and, thus, distinct from the explicitly professional. This may include or be accompanied by choosing a clinical supervisor outside their own discipline, although this is certainly not a requirement. The supervisee at this stage has tested their supervisor for 'fit', often in terms of establishing trustworthiness in the supervisor. Paradoxically, disagreements and ruptures may emerge in the supervisory alliance as part of the testing process. This process of rupture and repair is not only expectable, but also optimal for good supervision to proceed. A robust alliance and a clear written agreement goes a long way to successfully address such ruptures.

Step 3: Senior clinical supervisee

The supervisee is firmly the driver of their supervision, setting goals and agendas and exercising choice in supervisors. At this stage, the supervisee may have more than one supervisor as may be required for varying roles. They will have an agenda of using the supervision itself and their own reflective process to develop their capacity to use the supervision more effectively.

Step 4: Beginning clinical supervisor

Becoming a clinical supervisor should be marked with a recommendation from their own clinical supervisor, undertaking formal training in the clinical supervisor role and the commencement of supervision of supervision. Although paradoxical, ideally, the beginning clinical supervisor should initially work with experienced clinical supervisees. Nevertheless, remaining within discipline is comfortable for novice clinical supervisors.

The beginning supervisor requires three to five years of clinical experience in their field and should be able to articulate some descriptive theory of human behaviour relevant to interpersonal relations.

Step 5: Intermediate clinical supervisor

The intermediate clinical supervisor further develops the role of consultation with their supervising supervisor and develops their capacity to challenge and tolerate the process of rupture and repair. They will engage more robustly with the supervisee in the evaluation process, particularly the evaluation of the supervisory alliance and of themselves as supervisors. The developing supervisor may engage with a wider range of supervisees in terms of experience and disciplinary background.

Step 6: Senior clinical supervisor

With the progression of supervisory skills, the senior clinical supervisor is able to take on a broader range of supervisees in terms of numbers, professional background, and experience, within organisational parameters, as applicable. Becoming sophisticated in reflecting on and evaluating their supervisory practice, they are able to tolerate robust feedback on their practice, and may begin to work with groups, following additional training and specific supervision.

Step 7: Beginning supervising supervisor

A recommendation from their supervising supervisor, along with further formal training, marks the process of becoming a supervising supervisor. The supervisor at this level is consciously joining a "community of elders" in the practice of clinical supervision, where they should be prepared to demonstrate their capacity and preparation. As with the beginning supervisor, it is desirable that the beginning supervising supervisor works initially with more experienced supervisors, although discipline consistency at this level is much less important. Their practice should be open to examination and evaluation by their peers.

Step 8: Intermediate supervising supervisor

The developing supervising supervisor may work with a wider range of supervised supervisors and possibly, in groups, although it should be noted again that, group supervision is a particular skill. They should be able to articulate complex theoretical constructs around clinical supervision practice and evaluation and to demonstrate application to their own practice. They may also begin to facilitate supervision training.

Step 9: Senior supervising supervisor

The practitioner at this level is a recognised expert in clinical supervision practice and, likely, is contributing to practice, research, evaluation, and theory development, as well as facilitating training. They will be prepared to demonstrate high quality supervision at all levels, encourage robust feedback from supervisees and peers, and continue to develop their role as both a supervisee and a supervisor.

Closing Thoughts

Importantly, collectively, we constitute at all of these levels, a community of clinical supervision practice which is continuously reflecting on, refining and developing the discipline of clinical supervision. As an interdisciplinary body entirely devoted to developing clinical supervision within Australia, it is our hope that the ACSA becomes an important part of that discourse.