
Defining moments in practice. Clinical supervision as a method of promoting critical reflection in fieldwork: A qualitative inquiry

Margaret Pack

Dr Margaret Pack is Associate Professor and Theme Leader of the Social Work, Community and Humanitarian Studies School of Charles Darwin University, Darwin, Australia. The social work team at Charles Darwin University specialise in rural and remote fieldwork practice education in social work and community and humanitarian studies. Due to Darwin's proximity to Indonesia and the Pacific, international students are able to study in their home locations by distance. Charles Darwin University's campus in Alice Springs provides opportunities for rural and remote fieldwork placement experiences. Dr Margaret Pack can be contacted at margaret.pack@cdu.edu.au.

Abstract

In 2008, as coordinator and lecturer of a postgraduate allied mental health programme, I asked clinical supervisors and their supervisees who were completing the programme what their 'most difficult' practice scenario taken to supervision had been as part of a research project approved for ethics by Victoria University.

Secondly, I asked clinical supervisees and clinical supervisors about how they had resolved or dealt with this practice issue. The aim of the research was to determine if the self reflective and reflexive process described by Napier and Fook (2001) and Gardner (2009) was experienced by the social workers and occupational therapists completing their post-graduate studies. The results indicate that for students, through discussing complex and difficult cases in clinical supervision, they came to view their practice both more positively and more self reflectively and reflexively through engagement in clinical supervision. For supervisors, the most difficult scenarios for those who were the students' line managers involved navigating a mixed role that balanced providing performance feedback in addition to clinical supervision. The implications for clinical supervision as the method of learning in fieldwork education are discussed.

Introduction

Clinical supervision is an activity that is conducted on an individual or group basis in social work (Harre-Hindmarsh, 1992). In social work, clinical supervision may have assessment, managerial or monitoring functions (Wepa, 2007). Those styles of clinical supervision termed 'managerial supervision' have been connected with overseeing, accountability for assessing performance and the level of functioning of the supervisee. Managerial models of clinical supervision may involve reporting to the professional associations, training agency or

employer if practice is unsafe (McBride, 2007). In the managerial or administrative models of clinical supervision, risk to the organisational structure and smooth operation seem to underlie the intent of clinical supervision. Key activities include confronting unrecognised feelings or attitudes in the supervisee that are likely to impact on the relationship with clients. Clinical supervision may be conducted by one's line manager. Definitions of the purpose of clinical supervision include support, encouragement and teaching to integrate training and theoretical knowledge with practice (Wepa, 2007). How exactly these functions or roles relate to one another, however, seems less clear. The intention of this paper is to report on how postgraduate social work students and their supervisors define clinical supervision in order to navigate the meanings of clinical supervision mentioned in the literature.

Literature review

The focus of clinical supervision in practicum placement is to support the student in advancing their clinical practice. Students in the allied health programme for social workers and occupational therapists (offered at Victoria University during 2003-2009) were 'scaffolded' (Ramsden, 2003) through clinical supervision to develop their practice knowledge and skills by considering self reflectively what they do in the agencies in which they are employed. Ramsden (2003) uses the term 'scaffolding' to refer to the process of experiential learning by which students incrementally move to increasing expertise through engagement with appropriate learning activities and assessment feedback. In this process of reflecting on their practice with a clinical supervisor in an established relationship, in an organisational context, the aim of the programme was to develop critical thinking and to integrate theory with practice.

In New Zealand, social work is grounded in social justice concerns, biculturalism and adult education principles (ANZASW, 2008) yet these themes seem lacking or absent from the literature on clinical supervision. The predominant discourse in the clinical supervision literature reflects the psychoanalytic or psychodynamic framework underlying clinical supervision, with an emphasis on supervision as a developmental process in which the supervisee is depicted as being in a perpetual state of adolescence and who gradually learns the necessary skills and confidence to gain increasing independence from an experienced, knowledgeable clinical supervisor (MacDonald, 2002). The focus on the quality of relationship between the supervisor and supervisee, prevalent in the clinical supervision literature (Yontef, 1996) does not easily fit the reality of many workplaces in the third millennium where, increasingly, time and managerialism do not allow for an experienced clinical supervisor to provide the continuity of a clinical supervisory relationship offering sustained on-the-job reflection and insights to grow and flourish over a number of years (Gardner, 2009; Napier and Fook, 2001). Neither do the inherent power dynamics of the supervisory relationship allow clinical supervisees to voice their experiences of clinical supervision openly and honestly in evaluations, without fear of influencing promotional opportunities (Baum, 2007; McBride, 2007). The need to undertake research on the experiences of clinical supervision by triangulating supervisee and supervisor views is, therefore, needed to address this identified gap in the existing research undertaken internationally on clinical supervision (Pack, 2009 and Pack, forthcoming).

Programme overview

The overall goal of the allied health programme was to assist students to advance their mental health practice within the student's scope of practice. As the programme had a largely

clinical focus, students engaged in written reflective exploration of their own practice and practice contexts. This process was supported through consideration of relevant literature and theory to produce work that was academically rigorous, created new and workable possibilities for clinical practice as well as advancement of the student's practice competencies to align with their professional practice standards.

As much of the course content for this programme revolved around clinical practice it was important for students to maintain clear and appropriate professional boundaries while undertaking study for these courses. In particular, one assignment within the certificate raised specific ethical issues as they involved a case study and analysis of practice interventions. Therefore, ethical clearance from Victoria University of Wellington Ethics Committee was obtained to enable students to speak about their experiences in their practicum in relation to clinical supervision.

The programme comprised two integrated Masters level courses: HEAL 512: Practicum 1 and HEAL 521: Allied Mental Health Practice. The programme was clinically based and the theoretical content and assessments were designed to be complementary and relevant to the varied mental health clinical settings in which students practise as social workers or occupational therapists.

HEAL 521 was the theoretical component of the programme. Problem-based learning (PBL) principles underpinned this course. A series of context-based learning packages were developed in collaboration with senior occupational therapists and senior social workers who were working in mental health practice (Pack, 2010). Each package focused on a specific scenario of a major diagnostic classification, for example, schizophrenia. Key learning areas covered in the case scenarios included: relevant legislation; cultural safety; professional and practice contexts; assessment; diagnostic classification of mental health disorders; case management; intervention; medication and side-effects, and more (Victoria University Allied Health, 2009).

Role of clinical supervisor

There are a number of responsibilities that govern a clinical supervision relationship that were discussed with students at the start of the academic year before clinical supervision commenced. These are outlined below:

Responsibilities of the student

- Identify practice issues to take to supervision
- Share openly with the supervisor
- Develop awareness of organisational issues impinging on supervisor / student relationship
- Be open to feedback
- Evaluate feedback given.

Correspondingly the responsibilities for supervisors were also discussed as follows:

- Provide space for student to reflect on and receive feedback about the content and process of their practice
- Facilitate development of understanding between theory and practice

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- Facilitate development of skills
 - Provide information and different perspectives
 - Validate and support the student
 - Challenge and respond appropriately to practice that is unwise, unsafe or incompetent
 - Help the student explore and clarify thoughts and feelings about practice
 - Be clear about boundaries and confidentiality issues
 - Share experience, information and skills
 - Facilitate critical evaluation of practice
 - Support the student's exploration of issues of self care (Hawkins & Shohet, 1989).

The core requirements were specified at the outset of the relationship in the following way:

- Supervision is to involve regular face-to-face meetings throughout the academic year – at least fortnightly
- A suitable, safe environment with no interruptions and, where possible, one that is removed from the daily work place is required
- Clinical supervision for the programme is in addition to the student's existing workplace supervision. Consideration should be given to linking both together
- A supervisor may supervise more than one student on the programme
- The clinical supervisor may be internal or external to the student's employing organisation
- In some circumstances the clinical supervisor may also be an appropriate cultural supervisor

(Victoria University Allied Health, 2009)

Methodology

Gardner (2009) and Napier and Fook (2001) recommend critical-reflective theorising to enable social work practitioners to draw out their theories of action directly from accounts of their own practice. This process occurs through reflection on practice. However, critical-reflective approaches are not widely acknowledged as 'knowledge' due to the challenges these approaches make to more traditional paradigms of theory development (Napier and Fook, 2001). Therefore, these authors use extended case narratives with reflection from the participant on their experience of practice dilemmas to inform our understanding of the process of clinical reasoning. Reflection on this process often leads to 'breakthroughs in practice' (Napier and Fook, 2001) where the social worker who discusses practice reflectively comes to view his or her practice more positively in difficult situations (Napier and Fook, 2001).

Based in this reflective theorising about practice, I wanted also to know how supervisees entering a new field of practice make sense of the complex situations they routinely encounter in their practice. In this regard, asking about the experience of clinical supervision highlights the gap between theory and practice that new graduates in social work experience routinely (Harre-Hindmarsh, 1992). Thus I aimed within the interviews to engage reflection on the situations each group defines as 'challenging' or what they see as 'obstacles' that were related to practice and the supervisory relationship to inquire whether or how they resolved these situations. With this focus, I aimed to explore the narratives that supervisees and supervisors say they develop about what they do, drawing from examples that represent applications of their use of practice wisdom.

To interview clinical supervisees and their clinical supervisors about their ‘most difficult’ scenarios encountered in clinical supervision, a research assistant helped with these interviews with the 2008 cohort of students to avoid the blurring of boundaries between research, teaching and/assessment activities.

It was made clear that participation was voluntary and would not affect course grades, in an introductory letter with the interview schedule attached. In this letter it was confirmed that the content of interviews would remain confidential in the sense that individual contributions would remain unidentified in the final research report and any specific issues raised in one interview would not be discussed in another except as general themes to verify the validity of emerging findings.

Characteristics of participants

Out of the letters sent to 25 clinical supervisors and 25 clinical supervisees who were currently or had been involved in the allied mental health programme in 2007-8, 10 supervisors and 12 supervisees agreed to participate in the research project. Participants were currently engaged in clinical supervision as ‘pairs’ of supervisors and supervisees.

Other participant characteristics are summarised in the following table:

Table one. Characteristics of supervisors/supervisees (Pack, Forthcoming).

	Age Range (years)	Occupational Background and Training	Area of Work	Ethnicity - Self Identified	Length of Time as a Clinical Supervisor/Supervisee
<i>Supervisors</i>	25-64	Social work (6)	Community mental health (4)	Pākehā (8)	5-30 years
		Occupational therapy (4)	Inpatient mental health (2)	English (1)	
			Professional advisor (3)	South African (1)	
			Service manager(1)		
<i>Supervisees</i>	21-55	Social work (8)	Community mental health (8)	Māori (2)	7 months-3 years
		Occupational therapy (4)	Inpatient mental health (2)	Pakeha (7)	
			NGO mental health (1)	South African (1)	
				Fijian Indian (1) Rwandan (1)	

* Māori is a term which refers to a New Zealander who is indigenous to New Zealand.

* Pākehā is a term that refers to a New Zealander of European descent.

Data analysis

Once the interviews were completed and transcribed, the responses under each of the questions were compared across the groupings – supervisors as a group, supervisees as a group, and then compared within the couples who were supervisor and supervisee. Key words and responses were identified and highlighted from each of the interview transcripts and these were considered together as forming themes. The emerging themes were then clustered to form categories and checked with participants to confirm the validity of these key themes and to glean ideas about the relevance of the categories chosen. Pseudonyms were assigned to each participant that were not their real names but were used to identify their individual contributions.

Findings and discussion

The clinical supervisees discussed their ‘most difficult’ practice situations involving clients at risk of self-harm, deprivation, death or suicide in their descriptions of their most difficult case scenarios taken to clinical supervision. This theme mirrors Napier and Fook’s (2001) research into the kinds of situations explored by social workers in their clinical supervision. Napier and Fook (2001) discovered that clinical supervisees came to view their practice more positively when they had an opportunity to discuss the incident and the surrounding thoughts and emotions in clinical supervision. The organisational context in which the incident occurred often compounds the complexity and the issues for the supervisees (Gardner, 2009).

One of the clinical supervisees I interviewed concurred with this view. Her narrative involving a client’s death was complicated by the attitudes of her team members and the system around her as the following quotation from her interview illustrates:

That was when a client died; that was really difficult for me because of the way it was handled. We’re in a helping profession but there didn’t seem to be a lot of care amongst colleagues. It wasn’t my client, it was someone else’s but I felt the sorrow more for the client. I felt the client wasn’t shown enough respect although they had died. It was like the client was just a commodity.

She [clinical supervisor] had thought with me in depth about my own cultural understanding and how we view death. So we explored how the [name of employing organisation] handles death and the mistakes that have happened in the past. And the good thing that came out of the whole supervision was that there needs to be some consistency when clients die across the organisation and not just in different parts of the services. She [supervisor] told me about other experiences of staff not actually knowing that their clients had passed on and then hearing about that two years down the line. And how we actually traumatise staff. It was helpful to my practice and for the organisation as well because there didn’t seem to be any constructive policy on how to react to staff when clients die. And so that is something my supervisor is drafting at the moment.

Another supervisee discussed the logistics of connecting with her supervisor soon after she had a crisis on the job to deal with. Due to the time constraints she decided to see her workplace mentor to have her intuitive assessment of the client’s safety affirmed. Having clinical supervision at a structured time fortnightly did not meet the immediate needs of the supervisee in this instance:

I took it to my preceptor [workplace mentor] first because it was immediate. And I didn't get the chance to take it to formal clinical supervision – it happened just before I left and the supervision timing was out. I knew that something was awry, unusual in the person's presentation. I didn't quite know what it was but intuitively it didn't sit quite right with me. And I knew I had to leave in 10 minutes because I had another appointment and I'd be out for the rest of the afternoon. There was a resolution because she [preceptor] was going to do something about it. She heard me and understood what I was saying.

'Unsticking the stuckness' is how another supervisee discussed his experience of clinical supervision. His clinical supervisor reflected on his narrative of 'stuckness' as the supervisee's expectation of needing to have all the answers for a client with high and complex needs. The transference between the social worker and client was explored, illuminating an important learning for the clinical supervisee:

It [supervision] changed my whole view of the situation, really. When I was speaking, I remember using the words: 'I'm stuck'. And it really changed by the end, talking about it, who exactly was 'stuck'. And I went away feeling like it wasn't me that was stuck, which gave me a whole different perspective.

Offering a 'different perspective' was a common theme across the supervisees' group. The relationship established in clinical supervision enabled supervisees to trust and feel safe enough to explore areas of ambiguity and complexity without fearing, shaming or personal humiliation for not knowing what to do. This avoidance of shaming through a quality of trust and respect with clear boundaries in the relationship with clinical supervisors are considered important pre-requisites of effective clinical supervision (Baum, 2007; Pack, 2009 and 2009a; Wepa, 2007).

Supervisor perspectives of 'most difficult scenarios' raised in clinical supervision

The clinical supervisors discussed their 'most difficult situations' they had encountered as clinical supervisors as dealing with performance issues with their clinical supervisees. In two instances the most difficult situation discussed involved meetings about the supervisees' performance in which the supervisee subsequently withdrew from employment at the employing agency. The supervisees had either misinterpreted the social work role and had acted outside of policy and/or had become psychologically unwell on the job as one supervisor elaborates:

The one I want to talk about is probably no good because I was the line manager so it got into performance issues. The situation was that the person didn't really understand what the social work role was. At all. And didn't understand the nuances of the practice field at all. So it was working out what my role was in that situation. It was my making a movement between two roles, clinical supervisor to manager, transparent to the supervisee.

Another clinical supervisor found that she needed to break her supervisee's confidentiality when the welfare of the supervisee's client sounded to be threatened:

You break confidentiality but it has to be as my focus is on the client outcomes a lot of the time. I guess you have to be open to deal with that situation.

In the case of external supervisors who were contracted outside the supervisee's organisation, conflict between the supervisee and the employing organisation was seen as most difficult. As one clinical supervisor explains:

I think amongst the most difficult situations are those where there is an internal agency conflict between the agency and his or her line supervisor or manager in the service, but it is the service that pays me to do the clinical supervision. So having to be very careful also around employment law things, that can be tricky.

Multidisciplinary relationships within the team were another 'most difficult situation' raised by clinical supervisors. For one clinical supervisor nursing colleagues did not share the same definitions of clinical supervision to social workers within the team so it was difficult to get the message across about the process of clinical supervision. When the social worker clinically supervised other professional groupings who were involved in mentoring social work students, there was the difficulty of how to educate and role model appropriate use of clinical supervision, as this clinical supervisor explains:

She [nurse colleague] didn't seem to know how to reflect on her practice and didn't know what reflecting on practice meant. So she would come in and say: 'I did this and this, this week and I'd done that last week'. And I'd say: 'No, I just want to see how it goes for you and how you think about it and what your feelings are!' [Gasp of exasperation]. It was like pushing water uphill.

Teaching the supervisee about navigating ethical and boundary issues was seen as 'difficult' for a clinical supervisor who saw her supervisee falling into an inappropriate but highly valued therapeutic relationship with his woman client who had an idealised transference towards the supervisee:

The new grad didn't know what to do with all of that. It's about how to maintain boundaries, how to keep yourself safe in their practice and not putting themselves in that situation and learning from that experience so that it doesn't happen again. It is very easy to chat with people and think that you are just being friendly when people think it is really big and not realise it was just work unfortunately. And it's about making sure pretty quickly that they can't do things like that, to avoid getting into trouble.

What is normal developmental learning for supervisees and what are more serious practice errors necessitating performance management, however, is a matter for professional judgment by the supervisor and work supervisors. How far these critical decisions are made on the basis of an informed opinion that transcends mere conjecture, however, remains unclear.

The managerial discourse of clinical supervision as being primarily a tool of quality assurance for employing organisations exists alongside the psychodynamic framework which sees clinical supervision as a developmental process in which the supervisee gradually learns from a more experienced supervisor to act more independently and competently over time (MacDonald, 2002). The ambiguity of these mixed meanings is one reason for the persisting lack of uptake of clinical supervision despite measures to facilitate access to it (McBride, 2007).

These two discourses – the managerial, and the psychodynamic, coexist in the narratives of the clinical supervisees and supervisors who were interviewed. Clinical supervisees saw

supervision as a safe learning environment in which they felt cared for. Clinical supervision was seen for the supervisee group as a way of gaining a more accurate and accepting sense of self as a worker and as a person. Through the vehicle of the supervisory process and the interaction with the clinical supervisor this personal and professional development was facilitated. When this was not the case the climate was not deemed 'safe' enough to allow the supervisee to be completely honest and to freely disclose core issues with the clinical supervisor.

For the clinical supervisor there was a greater awareness of their responsibilities to the employing organisation for the supervisee's conduct on the job. When the supervisee was not meeting standards of practice, the establishment of the 'safe environment' above, was difficult if not impossible to provide. The hierarchical nature of the clinical supervisory relationship can be conducive to invoking shame or a sense of unworthiness (Yontef, 1996 p.96). This is particularly noticeable when clinical supervisors are involved in breaking confidentiality or taking disciplinary action which was the experience of two of the supervisors in the study. Time and work pressures were the greatest constraint as being a clinical supervisor was one among many varied roles undertaken in the agency.

Conclusion

This research with pairs of clinical supervisors and their clinical supervisees highlights the differences in supervisee and supervisor roles and perspectives of clinical supervision. It also highlights cross-disciplinary themes as to what constitutes clinical supervision from the 'most difficult' practice scenario taken to clinical supervision. There are a number of recommendations that can be made on the basis of the themes emerging from the supervisor and supervisee narratives of most difficult practice scenario. Interestingly, but not unexpectedly, these themes are different for clinical supervisors and clinical supervisees respectively. For clinical supervisees, information on the process of clinical supervision needs to be demonstrated more dynamically than is possible on paper. In fieldwork education modeling the process of clinical supervision could be exemplified in role play and using other audio-visual means (For example, see Pack, 2010). Greater attention to discussing the power differences in the clinical supervisory relationship explicitly, allowing choice of clinical supervisor, and fostering a high quality of relating in the supervisory relationship are suggested in the supervisee definitions of clinical supervision.

Providing adequate time and resource in terms of the training of clinical supervisors for the role and then the organisation following through with an infrastructure of support, is one of the imperatives from the clinical supervisors' perspectives. Training for new clinical supervisors who have a 'dual role' as the clinical supervisee's line manager and clinical supervisor is also highlighted as a neglected area.

In summary, this research project has illuminated the 'talking past each other' that occurs between clinical supervisors, and their clinical supervisees who are relatively new to clinical supervision. This process mirrors the experience of social workers learning to work in diverse and differing cultural contexts with their clients and with their multi-disciplinary teams. Meaning-making for clinical supervision is a process that new graduate social workers engage in alongside their clinical supervisors. Clinical supervisors often have different priorities to their clinical supervisees due to their seniority, role and responsibilities within

the employing institution. In this way, the most difficult practice scenarios encountered by clinical supervisors and supervisees in this research capture both the central issues and politics of clinical supervision with which social work continues to grapple.

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