"The Sorcerer and the Apprentice"

A study of clinical supervision of psychotherapy and counselling occurring in a district wide general adult psychiatric service

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Clinical supervision of counselling and psychotherapeutic work performed in a district general adult psychiatric service is examined. Most staff received regular supervision, usually having more than one source of supervision. Paired peer supervision, within a discipline, was the commonest structure. Supervision was mainly focused in two areas, on interventions made by the therapist, and examining the therapeutic relationship. Most staff had confidence in their supervision, but those who had not discussed a supervision contract were significantly less likely to be satisfied with their supervision.

Clinical supervision is of increasing importance but little is written on it outside specialist texts. We looked at a general psychiatric service, where psychotherapy and counselling is offered on a multidisciplinary basis, gaining information about staff receiving supervision and details of the supervision itself.

The study

We identified all disciplines, working with outpatients or day-patients, who offered psychotherapy or counselling as a distinct treatment to their patients. The questionnaire sought information on their professional status, experience in the National Health Service, caseload, training in psychotherapy, number of sources of supervision, if they acted as supervisors themselves, and their attitudes to supervision.

We then examined in more detail the nature of clinical supervision that they received, asking the following questions:

(a) If it was individual or group supervision
(b) If it was within their own profession or inter-disciplinary
(c) The nature of the supervisory relationship as defined in the following four ways: peer supervision, i.e. that occurring between staff of equal status for support; consultancy supervision, i.e. where a senior colleague provides supervision; teaching and training supervision, i.e. primarily educative relationship; and managerial supervision, i.e. supervision by the line manager looking at organisational aspects of work
(d) If a contract for supervision had been discussed, such as negotiation of any of the following: frequency and length of sessions; the purpose of supervision; the content of material brought; the process of supervision itself; how feedback is offered and received; and training and developmental issues
(e) To identify, from the following, the main processes analysed in their supervision: the verbatim account; interventions made; nature of the therapeutic relationship; supervisory activity as a parallel to the therapeutic activity (parallel process); countertransference issues for the therapist; countertransference issues for the supervisor.

Findings

The respondents

Forty-seven multidisciplinary workers were identified. We had a 100% return rate of questionnaires. Forty-four (94%) received regular supervision. This included 16 doctors, nine psychologists, eight CPNs, eight staff nurses, three occupational therapists and three art therapists. Interestingly, none of the five social workers based in the service saw themselves as offering counselling to their clients.

Post-qualification NHS experience

Twenty staff had up to five years, 15 staff between 5–10 years and 11 over 10 years post-qualification experience in the NHS. Those with least experience tended to be the training grade doctors.

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The psychotherapy caseload

Those with caseloads of over 20 patients weekly were either art therapists (who work with groups) or clinical psychologists. The staff with smallest caseloads were junior doctors, or occupational therapists.

Psychotherapy experience

Psychotherapy training was mostly a reflection of the professional background. Two doctors were registered with the United Kingdom Council for Psychotherapy (UKCP) and three people were in training with member organisations of the UKCP. Seven had certificates in counselling from local university courses. Only seven staff (15%) had any training in clinical supervision.

Sources of supervision

Three senior staff had no supervision (6%). The mode was one source of supervision (n=18, 38%), but many staff had several sources of supervision; eight having two sources (17%), 13 having three sources (28%), four having four sources (9%), and one person having five sources (2%).

Thirty-two staff (68%) also acted as supervisors. Doctors were less likely than psychologists to act as supervisors, possibly due to their lower use of peer supervision.

Attitudes

Forty-four (94%) staff regarded supervision as essential to good clinical practice and only five (11%) did not have confidence in their supervision; this latter group were less likely to have discussed a contract for supervision.

The supervision

Group supervision was less common than one to one supervision (44% versus 56%). Most supervision occurred within professional groups (n=58, 73%), and was most likely to be either peer (n=36, 45%) or consultancy (n=27, 34%). Peer supervision was common in all groups except doctors. Teaching-training and managerial supervision were both uncommon. In 47 supervisions (60%) a contract for the supervision had been discussed, staff least likely to have done this were either doctors or clinical psychologists. The emphasis of work in the supervision is shown in Table 1.

Table 1. The focus of processes examined within the supervision session

Process	As the main focus
Verbatim account therapy	1 (1%)
Interventions made	26 (33%)
Therapeutic relationship	30 (38%)
Parallel process	10 (13%)
Therapist c-transference	8 (10%)
Supervisors c-transference	4 (5%)

Comment

There is increasing recognition of the role of psychotherapeutic approaches in general psychiatric practice (Holmes, 1991) and that this work can occur at varying levels of sophistication (Cawley, 1977). Little is written, however, about clinical supervision of such work in general psychiatric settings. Hess (1980) defined supervision as "a quintessential interpersonal interaction with a general goal that one person, the supervisor, meets with another, the supervisee, in an effort to make the latter more effective in helping people in psychotherapy". We have used this broad definition and applied it to the less specialised supervision of clinical work of a general psychiatric service.

In our service nearly all staff receive supervision of clinical work. They regard supervision as essential to good clinical practice. Most supervision occurred within professional groups. Group and peer supervision were both popular. Peer supervision can promote mutuality rather than a more traditional hierarchical supervisor–supervisee relationship. Group supervision is a time and resource efficient way of working and can promote a sense of belonging to the organisation. Satisfaction with clinical supervision was greater for those who negotiated a supervision contract. This underlines the importance of planning and discussion in setting up clinical supervision. The supervisees' perceptions of the contents of clinical supervision has been described using the generic model of Hawkins & Shohat (1989). This model has particular relevance to the multidisciplinary team, using different theoretical approaches, who need a common framework for defining what goes on in sessions. Our respondents appear to focus primarily on the therapeutic relationships, and the interventions used, when they discussed their cases.

While a broad definition of clinical supervision has allowed our survey to be inclusive, its use has bypassed the issue of the theoretical model used. Being aware of this, respondents were also asked to specify the training they had received and to which models they adhered. Psychotherapy orientation reflected general professional training, which only appeared to influence the pattern of supervision in one area, i.e. the doctors' low use of peer support. Some members of staff were in training for UKCP accreditation (e.g. Cognitive Analytic and Gestalt therapies). Thus a broad

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range of theoretical approaches was used, probably with differing levels of sophistication across different disciplines. Most staff had more than one source of supervision which together with the frequent use of group and peer supervision implies a network of support inherent in this service. The logistics of organising clinical supervision are complex and it is interesting that the government is already promoting this area of practice (Department of Health, 1994).

Our survey reveals a service which offers a range of psychotherapeutic approaches, based primarily on each professional group supervising its own members. Holmes & Mitchison (1995) outline such a model for an integrated service. As the pressure mounts for effective integration of general psychiatric and psychotherapeutic approaches we believe that the definition and implementation of clinical supervision will form a cornerstone of a modern general psychiatric service.

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