

# A Common Approach for Clinical Supervision in Psychotherapy and Medicine: The Person Centred and Experiential Model

Callifronas MD<sup>1\*</sup>, Montaiuti C<sup>2,3</sup> and Nina E<sup>4</sup>

<sup>1</sup>Hellenic Institute for Psychotherapy, Psychiko, Greece

<sup>2</sup>The University of Liverpool, Liverpool, UK

<sup>3</sup>The University of Derby, UK

<sup>4</sup>Clinical Psychologist, Private practitioner, Greece

\*Corresponding author: Michael D. Callifronas, MD, ECP, The Hellenic Institute for Psychotherapy, 17, Kalvou St., 15452, Psychiko, Athens, Greece, Tel: +30 2106823451; E-mail: michael@callifronas.com

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## Abstract

For over 50 years common supervisory models are being proposed that can be used for different therapeutic approaches. Amongst them two categories are of major interests in order to build a common supervisory approach: structured and developmental models.

In the present article we propose a unified model based in person-centred and experiential principles, also integrating principles from structured and developmental models. It can be used for supervision with practitioners originating from a number of modalities, who have completed their studies in psychotherapy and have (at least) some professional experience.

The different supervisory details for each therapeutic approach are discussed. Special attention is given to the implementation of the person-centred and experiential model in medical and health settings, where the risk for compassion, fatigue, stress and burnout is important. In the present review we propose the person centred and experiential model as an appropriate common model for efficient supervision with psychotherapy and medicine professionals.

**Keywords:** Common supervision models; Person-centred supervision; Experiential supervision; Focusing; Narrative supervision; Humanistic supervision; Medical supervision; Compassion fatigue; Professional stress; Professional burnout; Empathy, Reflection; Conceptualisation

## Introduction

The industrial revolution and capitalism saw people slowly turn away from religion and communities for emotional support, and in the 19th century Western culture focused more on the individual rather than the community (p. 10) [1]. Until WWI, mental health and antisocial behaviours were perceived to be issues of class and therefore inherited [2] beliefs that were challenged when soldiers from all walks of life were affected by what was then called shell shock [3]. A shift occurred, and as psychology developed, emotional problems started to be seen as medical issues throughout Europe and the United States [1]. Western society has since developed into a reductionist society that sees individuals as elements of a 'productive' resource [4].

The increasingly reductionist view of the mental health in society and the categorisation of mental health has become necessary. In other words, to explain a complex phenomenon (like human behavior) we have reduced it to its constituent elements. Whereas the increasing reliance upon the DSM [5] and the ICD classification [6] of mental disorders, has emphasised the reduction of mental health to a set of classifiable behaviours, where to explain a complex phenomenon such as human behavior, it is reduced it to its essential components. This is

reflected in the supervision models' development, where supervisors have become accustomed to prescriptive models of supervision and its focus on the normative aspect of supervision.

As psychotherapy evolved, so did supervision, being now recognised as closely related to effective delivery psychotherapeutic services. Casement [7] developed the idea that an 'internal supervisor' guides the supervisee to reflect upon the meaning of their communication and therapeutic progress. Yet, in an increasingly reductionist society, that sees individuals as elements of a greater 'machine' [8], the development of an internal supervisor [7] remains under-developed. But as experience grows, the supervisee's internal locus of evaluation [9] grows with her/him, and the supervisee develops his own internal supervisor [10].

We welcome the current shift in psychotherapy, which steps away from a reductionist to include a more encompassing biopsychosocial model of mental health encompassing brain, mind and social environment [11]. While this shift may be evident in emerging supervision models, existing models of supervision may need evolving into a more-encompassing internal supervisor model [10].

This is because supervision develops and extends the relationship of the supervisee with her/his client or patient and also/the supervisee-supervisor bond in order to have a deeper insight and reveal blind spots or repeated patterns in professional practice. The supervisory sessions can help to increase the practitioner's awareness and engagement in difficult clinical situations, thus maximizing the safety of clients/patients and improving the quality of care [9] (p. 2,15), [12].

This process facilitates the supervisee's professional and personal development [12] (pp, 2, 15), [13]. As Launer [14] states 'If reflective practice is considered an intelligent conversation with oneself, then clinical supervision, on the other hand, is an intelligent conversation with another about a case or issue'. This means that the nature of the conversation has to be confidential with respect and empathic understanding on the practitioner's point of view. So, the supervisory process relies significantly on the relationship and agreement between supervisee and supervisor. A secure bond between them, as described below, creates a significant potential for problem resolution.

Clinical Supervision provides place and space to self-reflection which aids cope with professional insecurities, uncertainties, challenges, frustrations and complicated or denied grief. Reflection also helps to resolve puzzles about what to do and how to do it in complex situations [12] (pp. 4,10), [15].

Person centred and experiential supervision is an appropriate environment to discuss and deepen insight on challenging professional issues, to unleash the internal resources of the supervisee-practitioner through reflective elaboration, and to integrate new skills into professional practice.

## Aims and goals

Callifronas and Brock [16] presented their thoughts on supervisory aim, goals and tasks from a person centred view. They argued that the aim of a person centred supervisor is to work for the personal and professional development of the supervisee and unleash her/his internal resources, thus helping the relationship with her/his client.

The supervisor's goal would be to create the appropriate climate offering empathy, respect, genuineness, offering mutual acceptance of responsibility for practices and tasks planning. Furthermore, the creation of a secure bond with the supervisee confiding her/his internal power will have a positive influence on the supervisee's personal development and self-awareness. According to Horvath and Greenberg [17] the supervisory bond is of fundamental importance, since it portrays 'issues of mutual trust, acceptance and confidence'.

Supervision can contribute to bring psychic stability, vision and flexibility in the supervisee's daily medical practice and reveal to her/him some invisible points of view for her/his patient which can drive to new insights [18] (pp.24,31).

Hunt [19] suggests that there is a need for a degree of warmth, trust and genuineness and respect between them (supervisor and supervisee) in order to create a safe enough environment for supervision to take place.

The quality of the supervisory relationship plays a fundamental role in the process since it needs to be accepting enough and open for the supervisee to unfold the relationship and its specific aspects with the client or patient, explore the uncertainties and help to reestablish the supervisee's equilibrium [10]. Such a climate is favorable to promote satisfactory management of the situation. The person-centred supervisory model can play an important role here.

## The supervisory tasks and roles

Hawkins and Shohet [20], Inskipp and Proctor [21] and Bond [22] propose three main supervisory task areas and roles.

Clinical supervision plays [21]:

- A formative role which is exercised through experiential learning and effort on personal development,
- A normative role with discussions on ethics and framework issues, and
- A restorative role supporting the supervisee in vulnerable, challenging and uncertain moments and working on his/her resilience.

Fundamental skills of the clinical supervisor include the ability to create a climate of safety, respect and trust, with empathy, genuineness and focus on the 'here and now' of the physician's professional and personal relationships with good tracking of the discussed issues.

In order to achieve the accomplishment of the tasks, Hawkins and Shohet [20] propose a seven mode process and will be discussed in paragraph 2. According to Carroll [23] and Van Ooijen [24] supervisory roles and tasks combine in order to have the desirable outcome.

## Experiential learning

Supervision is also a process of experiential learning [23]. Therefore, it is frequent to discuss during the session specific subjects, depending on the supervisee's interests on the issue. Such learning could be initiated upon the supervisee's request or on supervisor's proposal according to the developmental level, the learning style [25-27] and the needs of each supervisee [16]. They comprise:

- Fundamentals of couple and family therapy according to the principles of Gaylin [28] and O'Leary [29] or according to Johnson's EFT frame of work comprising three stages [30].
- Focusing methods to facilitate the embodiment of explicit meanings which emerge during the supervisory session. These methods include a six step procedure [31] as well as elements of focusing oriented therapy which is a specific way of facilitating the way to embody the feelings.
- Methods and approaches used in pretherapy [32] that are particularly helpful when used with silent clients during the session.
- Working with parts of self in focusing [33] and the two chair gestalt technique [34].
- Neurobiological mechanisms that are implicated in the psychotherapy process and in the therapeutic changes [35,36].
- A frame discussion on ethics and some common issues [37].
- Mindfulness methods and techniques [38] which are very useful especially for young colleagues - in order to control the eventually increased anxiety of early developmental stages (paragraph 2).

## Parallel process

A common behavior in supervision is called parallel process and refers to the mirroring, observed as a sequence between the patient or client, the supervisee and the supervisor [39-42].

This means that the supervisee-practitioner can have the same behaviour 'here and now' in supervision as his/her client had 'then and there' when s(he) visited the practitioner. For instance, a resistant patient or client can often be reproduced by the resistance of the supervisee practitioner in the supervisory session [43,44].

But parallel process, in our opinion, can also happen in the opposite direction. So, a practitioner advancing in her/his personal and professional development through the supervisory process transmits

this beneficence at the therapeutic session, thus helping the patient-client to better advance in her/his therapy.

## Common Supervision Models

Goodyear and Bradley [45] examined five supervision models and as they stated 'they were struck with the extent to which supervision techniques must be similar across supervisors, regardless of theory'. So the fact that supervision models seem to have more similarities than differences can encourage the effort of person centred supervisors to work with colleagues who follow different therapeutic approaches. We discuss below some important common models.

Kagan [46] developed the 'interpersonal process recall' (IPR) model, which includes concepts coming from the humanistic, psychodynamic and cognitive-behavioural approaches in order to supervise counselling students and beginners. IPR is based on the dyad of needing people as well as fearing them, which leads to an "approach-avoidance syndrome". Namely, the implicit and often distorted memories of our earlier years of life drive our adult lives and provoke 'unexplained' fears [47].

The model includes questions pointing to the past and to the gut feeling of the therapist thus facilitating the symbolisation of old unexperienced and unlabeled memories. This procedure results in bringing the "then and there" episode next to the 'here and now' experience and reduce the distress provoked by the fearful memory of the past.

This approach could be a useful tool to be used together with the person centred theory of supervision in working with supervisees from other modalities. It can also be used with experienced therapists and in supervising other professionals like staff in health settings, teachers or managers [48].

## Structured models and supervisory practice

Developmental models offer precious information about the personal development level of each supervisee [49].

The Integrated developmental model developed by Stoltenberg et al. [50] which is one of the most referred to and cited, mentions specific areas of the supervisee's development, like self-other awareness, motivation and autonomy. But in our opinion the model of Rønnestad and Skovholt [10] with six stages and more detailed description of the supervisee's characteristics seem to be preferable.

There is some criticism concerning the real progress offered by developmental models, their complexity and the evidence of their effectiveness [51]. Moreover, as Scaiffe [27] notes, every supervisee can be more developed in one area, while less advanced in another domain (p. 93). Furthermore, we believe that human mental and emotional development is not linear and has forward and backward steps.

Neufeldt [52] proposed a model which can be adapted in the supervision of the major therapeutic orientations and consists of two main terms: The first term aims to help trainees build collaborative relationships, identify resistance and interferences, establish focus on change, work with emotions and handle ethical issues. The second term focuses mainly on client change through case conceptualisation. Furthermore, Morgan and Sprengle [53] proposed a common supervision model in marital and family therapy focusing on the supervisee's competence and specific needs as well as on the supervisory relationship.

The detailed work of Hawkins and Shohet [20,54] on a seven modes process enlightens the different aspects and views of the supervisory practice. The "first matrix" focuses on reflective discussion concerning the content of therapy, on the therapeutic methods and strategies and on the therapeutic process and relationship [55]. This "matrix" can be a helpful frame, especially for elaborating the therapeutic session with a less experienced trainee therapist.

The "second matrix" of the model consists of the fourth, fifth and sixth modes and focuses on both the therapist's and the supervisor's implicit feelings and on the supervisory relationship. However, the probability of discussing such issues depends on the supervisee's "here and now" feelings, since everything starts from this point. For example, in the case of a supervisee who starts talking about a "burning" problem concerning ethics, it is a "sine qua non" condition, before every other task, to focus on the supervisee's emotional incongruence and anxious thoughts. A good supervisory practice would - first of all - listen empathically to her/his issue, support her/him and restore her/his clear view. So, as Scaiffe [27] proposes, one can always keep in mind a structured supervisory model, but this is not the only and inevitable way to make supervision.

Furthermore, seen from a person-centred perspective, this model somehow places the supervisor at the top of the hierarchy [56] and is more structured and directive than the life-philosophy oriented model [9] which - in our view - is preferable when working with experienced supervisees and was also preferred by Carl Rogers [57].

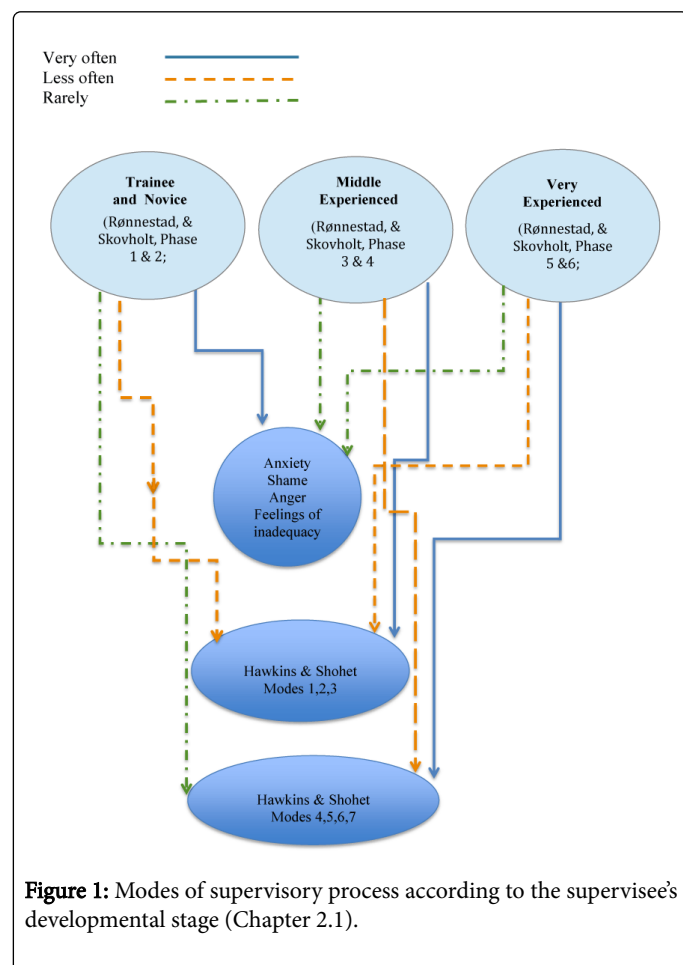
Hawkins and Shohet [54] state that the supervisee's personal issues should not be discussed in the supervision unless they directly concern the therapeutic relationship (p. 69). Nevertheless, very often, in mode IV of their model, there is a need for the supervisee to work on personal issues which seem to be irrelevant to therapy, but in reality they can block her/his empathic understanding with the client.

The supervisor can then propose to deepen the reflection and the conceptualization on the discussed subject [58] through Focusing [59]. This process offers deep work and embodiment of the session's feeling, thus elucidating the therapist's process and countertransference.

Concerning a potential relationship of the developmental stage [10,50] with the process model [53], it is obvious that higher modes belonging to the second matrix would be more appropriate to be discussed with more developed and less defensive supervisees, e.g. level III therapists. Hawkins and Shohet [54] agree to this perspective by noting that later stages of their model become central with competent and sophisticated supervisees (p. 73). This statement gives a satisfactory explanation on how the model can be implemented in the supervisory work, as shown in Figure 1.

On the other hand, Page and Wosket [60] proposes a cyclical model comprising of a contract, a focusing, a space, a bridge, and a review stage. Scaiffe [27] notes that it can be in mind but not in an orderly way (p. 93). In our view, it has a rather mentoring and directive air and concerns an ideal supervisory session moving "magically" from one stage to the other. In our experience things rarely function in a so structured way like the cyclical model. There might be sessions without review and mutual feedback if the supervisee has plenty of questions but time runs out. Moreover, a space stage with discussion of ideas and the supervisor's opinion and a bridge stage, where theory could be linked with practice and explore ways for action [52] (p. 91), can easily occur within the focusing stage, right after having talked about the discussed issue. Additionally, a contract and a review phase can

periodically take place (every five or more sessions) while discussing a summary of the previous sessions.



## A humanistic view : The person centred and experiential supervision

Somewhat expedient reductionist approaches to supervision tend to address ambiguity through prescriptive expedient normative processes [61], link strict normative procedures to successful measurable outcomes, and perhaps underplay diversity [62]. Alternatively, we seek to present a humanistic of supervision model which retains the fundamental character of science- practitioner model [63], while balancing two different worlds: where supervisors rely on rigorous research, while remaining actively involved in their reflective selfregulated supervision journey, free of prescriptive reductionism.

Although Goodyear [64] argued that self-regulated learning found in reflective practice is not an exclusive of the most experienced practitioners, as long as external feedback continues to trigger reflection, we are promoting herein a non-structured humanistic form of supervision for more experienced therapists and supervisors. In our model, self-regulated learning [64,65], conceptualisation and active experimentation evolve to support the development of the supervisee's internal locus of evaluation as a basis for her/his internal supervisor [7] By triggering internal feedback, the person can balance their perception and expectations with existing internalised canons. The trigger for further exploration is found within the supervisee's

behaviour, which in turn triggers additional self-feedback, inevitably evolving into a reflective process [64].

It is clear that the supervisory process with a novice therapist has, amongst others, an educative function. In this case the good theoretical knowledge of each approach is the only way forward, since it represents a compass in the everyday practice and also in the professional and personal development of every therapist. In this phase, every deviation from the basic principles of the learned approach would not bring into term the final target. Therefore, the modes 1,2 and 3 of the process model or the stages of the cyclical model [60] are very important and necessary to students and new practitioners.

However, after the first years of the supervisee's therapeutic experience, it seems that the supervisors are less insisting in the theoretical principles in a close sense and prefer a larger supervisory context, or even an open supervisory framework. This kind of "open" relationship is very often observed in peer supervision with experienced therapists. The recitation of a supervisee when describing an emotionally deep case, cannot be interrupted by supervisory "steps" as it hinders internal reflection and further conceptualisation. Process directiveness and interruption often loose the relational depth and the internal processing. The person centred and experiential supervision model can offer the needed relational depth and become the cornerstone to deepen the meanings and develop the freedom of choice in therapy and in private life of the more experienced supervisee.

## Supervision in Psychotherapy

### Supervision in humanistic approaches

**Focusing:** Focusing, also named 'experiential psychotherapy' was developed on the theoretical frame of the person centred approach [59]. The method concerns a six step process-directive procedure, which focuses on the bodily feelings and perceptions in order to discover deeper meanings, thus making a therapeutic shift and symbolising the 'felt sense' [31].

Focusing usually works with the clients who can experience their 'gut feelings' and bring them to awareness. Gendlin stated about Focusing that '...these focusing steps I described come in client-centered therapy'.

Therefore, an experienced person centred practitioner would not have a serious difficulty in supervising focusing therapists. Specific attention needs to be given to a process-centred character of the supervisory form, which means to concentrate on the experiential process rather than on the content, which concerns the client's story or theory [66]. Furthermore, a person centred supervisor experienced in Focusing can efficiently use this approach with a large number of supervisees with different orientations.

**Gestalt:** Gestalt theory states that 'Humans are a unit of parts which operate independently' and respects the humanistic approach by focusing to the needs and feelings of each person [67]. This gives us the impression of a human mosaic and seems similar to the person centred theory of configurations [68] with a supervisee of this approach; the supervisor can focus into the coherence between these configurations and the eventual discomfort that might exist among them.

**Existential approach:** The Existential psychotherapy belongs also to the humanistic spectrum having also psychodynamic principles



concerning the basic human conflict [69,70]. Supervision of an existential therapist would focus on the relationship with the supervisee and on the four pillars of the approach, which are considered as the basic worries of our existence: freedom, meaning of life, isolation and death.

### **Integrative approach**

The integrative approach refers to the integration of the person-client and according to Norcross and Goldfried [71] its theoretical frame is based on four different pillars: common factors theory, technical eclecticism, theoretical integration and assimilative integration. It incorporates humanistic, psychodynamic cognitive and behavioural principles integrating them into one sole approach.

Empathic understanding and acceptance very often constitute the basis of integrative therapy with humanistic orientation and can focus on the relationship and on the 'here and now' to supervise integrative therapists. Possibly, the person centred supervision combined with the Interpersonal Process Recall [46] would be useful in the supervision of the integrative approach, since this supervision model is based in humanistic, psychodynamic and cognitive-behavioural principles, too.

### **Psychodynamic approach**

According to Frawley-O'Dea and Sarnat [72] there are three approaches in psychodynamic supervision: patient-centered, supervisee-centered and supervisory-matrix-centered. Freud's supervisory model was didactic and patient-centred while the supervisor had considerable authority [72].

Supervisee-centered psychodynamic supervision, also called Competency-based Approach, is focusing on the content and process of the therapeutic session with the client, and Supervision is more experiential than didactic [72,73]. Emphasis is given in the supervisee's resistances and 'the ability to apply knowledge and skills' while the supervisor remains an uninvolved expert.

The supervisory-matrix-centered approach is a relational model where the supervisor is no longer an uninvolved expert, but participates in the experiential process [72,73]. This relational model is based on neuroscientific data and introduces examination of the relationship of the therapeutic and supervisory dyads. Sarnat [73] argues that 'Viewing the supervisory relationship as a tool for developing emotional and relational capacities, and, as a means of facilitating learning-through-experience, seems to me to open up one of psychoanalytic supervision's most exciting potentials'.

So, it is clear that a person centred supervisor can work with a psychodynamic supervisee focusing mainly on the client-therapist relationship, working on her/his personal and professional development from the 'here and now' view as well as on the dynamics produced from the supervisee-supervisor 'working alliance' to the therapeutic alliance with her/his client [52].

There is criticism about the fact that the person centred approach is not working with the unconscious dimension of the client and does not give much attention to the transference-countertransference relationship [74,75].

However, the person centred therapist works very often with distorted experiences, the so called 'conditions of worth' [76,77] between the unconscious and the conscious, at the 'edge of awareness' as Gendlin [78] states. These memories are then fully experienced and

comprised in the client's perceptual field, enlarging and deepening through this procedure.

Therefore, a person centred supervisor can focus on the awareness of the relationship with the supervisee and how her/his distorted beliefs and intense emotions could hinder and delay her/his client's development. Some supervising issues could emerge with the analytical terminology and the provocation of anxiety often used in the analytical practice [79].

### **Reichian body psychotherapy**

This model of psycho-analytical orientation, which is created by Reich [80,81] focuses mainly on the analysis of the character and the embodiment of the emotions, comprising also elements from neuroscience and psychobiology. Object relations, stages of brain evolution, character traits and the bodily imprints of relationships are the areas of interest in Reichian therapy.

The Reichian Character-Analytical Vegetotherapy (CAV) proposes bodily therapeutic work in order to couple the unconscious experiences which represent the 'then and there' with the metacognitive level of the prefrontal cortex. Through this process, therapy helps the old and often painful memories to elaborate and 'strip' these memories of their emotional complications and join the awareness, thus becoming a part of the 'here and now' and being present in interpersonal relationships [80,82].

Ferri [82] has created a supervisory model comprising 18 steps including diagnosis, data analysis, examination of the therapeutic relationship and therapeutic embodied activation and introduced the term 'trait- mind'. In this supervisory model the therapeutic and supervisory relationships as well as the client's early and present relationships are thoroughly and in depth examined [80]. Special attention is given in the interaction between the characterological traits of the therapist and the traits of the client.

Person-centred and experiential supervision process can work with the therapist's level of empathic understanding and trace eventual obstacles of emotional identification with her/his client. The supervisor can deeply focus into the supervisee's countertransference and bodily experience as described in mode four of the Hawkins and Shohet [54] supervisory model, thus helping to conceptualize the meaning of the examined issue which is brought in the session.

A person centred supervisor could focus on the experiential view of the brought issue by stressing on the 'here and now' and on the acceptance (or unconditional positive regard) for both the supervisory and therapeutic relationship.

Of course, specific knowledge is needed for the implementation of the 18 steps, and the neuroscientific data concerning this approach, in order for the supervisor to work according to the CAV-supervisory model and propose the appropriate bodily exercises. However, experimented body therapists would need more to focus into reflection and conceptualization of the specific issue, than to discuss the first supervisory steps proposed by Ferri [82], e.g. the case history, the diagnosis and the aetiopathogenesis of the examined case.

### **Systemic family therapy**

The systemic approach considers the family as a totality, and part of larger systems. Each family member is considered as having different roles, i.e., as mother, daughter, wife, aunt, etc. So this model

approaches the client as a part of her/his family and the wider social system.

The 2nd order cybernetics emphasizes on the relationship and feedback between the observing systems, while the 1st order cybernetics is the cybernetics of observed systems [83-88]. In accordance to this second order, systemic supervision emphasizes on the relationship between the observer-supervisor and the observed-supervisee. So in systemic supervision two systems are present in the 'here and now': The first refers to the thoughts, feelings and associations of the observer-supervisor concerning the supervisee and the discussed case. The second refers respectively to the thoughts, feelings and associations of the observed supervisee concerning the supervisor and the discussed issue.

For example, if the supervisor, while listening to the case, acknowledges that s(he) feels anger, fuss, and rejection, s(he) needs to check if the supervisee feels the same way. What is the relationship of the supervisee with rejection concerning the therapeutic case and concerning her/his life? Moreover, what is the meaning, the use, the function and the role of rejection in this specific case? While discussing this matter a common space is created between the supervisor, the supervisee and the client's case. The meaning of rejection is the bridge for resonance of the supervisor's and supervisee's systems and is of major importance for systemic supervision.

The cornerstone of resonance created between the supervisee's and supervisor's systems is empathic understanding. Namely, the supervisor needs to make a fine attunement to the 'here and now' of the supervisee and facilitate the supervisee to reflect and conceptualise the discussed issue in order to (permit both of them) to make an active movement towards the understanding of the case, and choose a further therapeutic step with the client.

Johnson [89] created a model for couple therapy the Emotionally Focused Therapy (EFT) which was also extended to family therapy (EFFT) [90]. This approach is 'borrowing' principles from the person centred, the family systems approach and the attachment theory [91,92]. It focuses mainly on the creation of a relationship between therapist and clients and consequently on the recreation of the bond between couple members.

Furthermore, Anderson [93] has created the Postmodern Collaborative Approach which, as she argues, has many similarities with the person centred approach and some distinct differences. Holloway [94] adds that in the systems approach to supervision, the relationship is the most important constituent: '...relationship is the container of dynamic process in which the supervisor and supervisee negotiate a personal way of using a structure of power and involvement that accommodates the trainee's progression of learning'

These examples show that a person centred supervisor can work with a systemic supervisee, focusing on the relationship and working from a collaborative perspective on the therapeutic process to promote thinking, reframing and conceptualization of the client's case. The content of the therapeutic session can be left intact. The supervisee-supervisor relationship will be an important factor to surpass any difficulties of the procedure.

Attention will also be paid to the genogram and to the isomorphism of the client's family. Finally –when needed - live supervision is also a possible alternative, witnessing the process and acknowledging the blind (for the therapist) patterns.

## Cognitive-behavioural approach

Cognitive therapy or Rational emotive Therapy (RET) according to of Ellis [95,96] has a philosophical basis and includes therapeutic techniques focusing on irrational beliefs, also called automatic negative thoughts (ANT). Ellis uses the model ABC, where A is the event, B is our belief and explanation on the event and C are our feelings and reaction. This approach uses also techniques of progressive muscle relaxation [97].

On the other hand, B.F. Skinner promoted the cognitive-behavioural therapy by advocating that human behaviour depends on two factors: social conditioning and free will. Skinner believes that the external factors act as reinforcing contingencies and control on the person's behaviour [98-100].

Both approaches also use in vivo gradual desensitisation with homework exercises [82]. This technique has many things in common with the medical desensitisation proposed by Besredka [101], which is commonly used in medicine through vaccination procedures.

The CBT supervisor acts mostly as an educator [102] with goal definition, establishment of assessment criteria and homework. Liese, and Beck [103] proposed a structured method of nine steps for the cognitive behavioural supervision which comprises listening of the supervisee's feelings, agenda setting with determination of priorities, reflection on the case and feedback from supervisee on the supervision session.

The person centred therapist usually works with distorted beliefs as presented by the client, but in a nondirective manner which is somehow different. Nevertheless, the person centred supervisor can approach the case with the supervisee by focusing on what happens 'here and now' when an automatic negative thought appears. The supervisor will have to focus both in the process and the content of the therapeutic process which will be a directive procedure approximating somehow the biomedical approach. Also paying attention on empathy and reflective answers would improve listening of a less experienced CBT trainee.

Moreover, Socratic questioning [104] which are fundamental for RET and CBT therapy could be transformed by the supervisor to Focusing oriented (FOT) questions [78] in order to include the body feeling of the supervisee and help the development of her/his therapeutic awareness. Furthermore less directive questions create less defensive answers and reduce the function of amygdala, thus promoting neocortex functioning, reflection and conceptualisation [105,106]. For instance instead of asking "Has something happened to lead you to this conclusion (of being a complete failure)" [104] the supervisor can gently ask "what makes you feel like a complete failure" or "How does it feel in your body (being a complete failure)?" [78]. Less directive verbalisations lead to the expression of the "gut feeling" [76] and promote personal development.

## Teachers

Gebhard [107] mentions that many teachers state "I think that when my supervisor repeats back to me my own ideas, things become clearer. I think this makes me more aware of the way I teach—at least I am aware of my feelings about what I do with students..."

However, mentioning that some inexperienced teachers might feel anxious with this approach, Gebhard [107] proposes a combination of models starting from a directive approach and moving on later to the

non-directive and creative type. In our supervisory experience with larger groups of teachers of 10-15 members, they show an immediate need for solution to their problems and become difficult to move into the reflection process. In these cases some experiential learning sessions focused on listening skills development are needed.

## Supervision in Medical and Health Settings

### Models for medical supervision

Supervision, as a general term, refers to a process of objectivity and overview of projects and of everyday work. In medical and health settings – as well as other therapeutic environments - three main types of supervision exist - managerial, educational and clinical. Other types of supervision like mentoring and coaching also exist [12,108,109]. They all need to be clearly differentiated in supervisory practice.

Managerial supervision emphasizes on organizational goals as well as efficiency and quality control issues. It also pays attention to team work, to tensions between members and to individual needs of each supervisee with emphasis to performance and medical outcome (p. 8) [12].

Educational supervision has a long history in medical schools and hospitals with pre- and post-graduate trainees, where the traditional lecture has a rather poor learning outcome dropping to 3-5% learned key points after a week [110]. This supervisory model considers a more formal type of learning and has two primary goals: a) to deliver the appropriate medical service on time in order to ensure the best therapeutic outcome for the patient with safety and quality of care [111-114] and b) to couple theoretical knowledge with medical practice in order to help trainees advance in their professional development (p. 8) [12].

Young physicians acquire faster primary care skills and clinical experience through close supervision, coaching, modeling, support and collaboration with clinical teachers. The communication and facilitative skills of the teachers, as well as their effort to adapt to the learning level of each trainee play an important role in the outcome [115-118].

Educational supervision is proposed for one to one or for groups with a skilled and qualified professional supervisor and has as target both the acquirement of cognitive knowledge and the implementation of the knowledge into clinical practice [108,110,118,119].

Clinical supervision in medical settings concerns formative, normative and restorative work focusing on the supervisee's professional and personal development with special attention on his/her ability to take care of and treat patients [120] (p.275), [12] (p. 8).

In medical settings of most countries, clinical supervision is not a frequent method of support yet. However, in Finland a quest responded by 10552 physicians showed that 29-42% (depending on the specialty) had attended clinical supervision, while another 25% of family physicians expressed the need for clinical supervision, which remained unsatisfied, since it was not possible to find a supervisory framework [120]. Additionally, Danish GPs prefer supervision than other continuing medical education [121] and about 33% of Danish GPs are joining a supervision group [108].

Sometimes educational, managerial and clinical supervision, including monitoring, guidance and feedback, can be combined in the

same process. The supervisory process is a valuable tool for most medical specialties which is specially needed in medical settings while working with chronic diseases.

### The treatment of chronic diseases

The biomedical model seems more like a reductionistic approach which derived from the mind-body dualism, separating the mental from the somatic [122] and advocating that “mental illness is a myth” [123] since it is not compatible with the concept of disease. Therefore, the biomedical ‘directive’ model can work in the treatment of acute diseases but it hardly works in the treatment of chronic diseases like diabetes mellitus since “Diabetes educators...need to cultivate relationships with patients that are characterized by trust, respect, and acceptance”. In this case the “patient centred” approach, represented by the psychosocial model, is preferable and supervision is a ‘sine qua non’ for this approach of medical intervention, because the psychological exposure of the involved staff is non negligible and sometimes very important.

Medical studies and also general practitioners are mostly concentrated on acute diseases and problems. The management of chronic or terminal diseases needs special skills to be acquired, in order to accept the continuous variation of psychic reactions of each patient, as well as to monitor the therapeutic progress and discuss special issues with the patient, like changing lifestyle and work habits or deciding about the treatment options. The specialized practitioner often faces the patient's inability to follow the medication and to show discipline about the needed lifestyle changes. Despite these (human!) imperfections the physician cannot remain passively compliant and unable to react. S(he) needs to convert each ‘therapeutic crisis’ into an opportunity by reframing its meaning and showing confidence on the patient's freedom of choice and responsibility [124-127]. The acquirement of these counselling skills need a thorough experiential work on the creation of relationships and attachment theory [128,129], as well as frequent clinical supervision, in order to elaborate her/his insight. Reflective and supportive supervisory space will definitely help to ‘cut the edges’ which are emerging from everyday practice with chronic patients [18].

Furthermore, as discussed in paragraph 1.4, the parallel process phenomenon is very commonly seen in chronic diseases, where the physician's presence and authenticity - which can be obtained through the supervisory process - plays a fundamental role to the patient's cure.

Two examples: Using the ‘biopsychosocial’ model of Engel [122], where the expression of grief, worries, and adverse feelings were empathically understood and accepted, our work in diabetes mellitus type 1 groups showed significant results. The patients were making significant steps in their lives and their biological indices were ameliorated [130]. Our supervision experience, in the group of clinicians consisting of medical doctors, psychologists and psychotherapists were running these diabetes psychoeducation groups, was fruitful. Trainee-Endocrinologists show themselves often defensive when facing the patient's worries and anxiety about the future, while psychologists sometimes remain speechless or other times they focus solely in counselling and psychotherapy. So the supervisor needed to couple the rational with the experiential and the logical with the phenomenological by trying to create bridges between the physicians and psychotherapists in order to serve a common goal [131].

We remember the words of a trainee endocrinologist in a supervisory session with the staff participating in diabetes groups. He



expressed his fear for psychiatric entities by saying: “whenever I perceive that a patient is somehow anxious, I directly refer her/him to the psychiatrist!”.

A second example: Some time ago we had a discussion with a colleague, who runs a Hematology clinic, about our supervisory experience in medical settings. He shared with us his belief concerning the need of supervisory sessions by stating “... you know the other day I went to the funeral of a patient. Afterwards, I returned to the clinic to participate at a birthday party of another leukemic inpatient. We really need psychological help and support in order to handle all these adverse feelings and remain calm.”

For the cure of most chronic diseases, the biopsychosocial model, based on a unique relationship between the client and the therapist, offers empathic understanding collaborative work which can promote and emphasize therapeutic change.

### **The balint groups**

There was a previous long experience of clinical supervision groups with initially psychoanalytic orientation created in 1956 from Michael Balint [132,133]: The Balint groups for medical practitioners were pioneered at Tavistock Clinic as an enduring model for supervision. They focused their supervisory practice to general practitioners (GPs) who were considered as needing support for being more exposed in stress and burnout. They were originally created in order to work on clinical cases and their hidden emotional meaning, thus increasing psychological awareness for the everyday practice of the participating clinicians [120,134].

Physicians that participated in Balint groups became more patient-centred, while having a better control and satisfaction for their work [135,136]. Moreover, the groups helped physicians to reduce their stress and improve their behaviour to patients [13,137-140].

### **A ‘post Balint’ era?**

Balint groups are helpful in dealing with workload and stress but they are not psychotherapy [138,141]. Launer [142] proposes to move from Balint groups, since they only work with the psychological side of the practitioners and probably inhibit them to explore solutions to other approaches which can “serve ourselves and the public well” (p. 8). Balint group facilitators seem to prefer a more technocratic and target-focused approach. Tavistock clinic uses a ‘post-Balint’ approach based on systemic therapy, medical training and narrative approach [143]. This model is not limited to the emotional context and includes discussion on the methodological view of the brought issue [142] (p. 7).

We agree that a further move in medical supervision is needed, but our approach is somehow different, based on a closer relationship with the group, characterised by empathy, unconditional positive regard and congruence as described and empirically confirmed by the client centred approach [76]. The therapist should be capable to go deeper and work on beliefs and solutions in medical issues which can also be proposed through discussion with colleagues. As far as skills development and exploration of problem based alternatives are concerned, we prefer to follow an experiential learning model [144,145] (See paragraph “Experiential learning”).

### **Evaluative or philosophical supervision?**

Clinical supervision is described by some authors as a process which mainly focuses on the improvement of practice, on the therapeutic outcome as well as on promotion of professional development [146,147]. Nevertheless, professional development passes through support, reflection and personal development. According to NHS, staff needs to feel sustained and secure [148] without blaming, in order to report errors and learn from them. When evaluation is present, practitioners need to show their best parts and not their weak stuff [149]. Therefore, supportive clinical supervision needs not to be confused with managerial supervision which is an assessment tool in organizational contexts and has to be a separate function [150-152].

Supportive clinical supervision often raises the need for deeper work and passes the border between clinical supervision and practice of psychotherapy. Patterson [153] argues that the aim of supervision in the person-centred model, although is not a therapy by definition, it becomes therapeutic through the supervisee-supervisor relationship. Launer [154] goes ahead by asking rhetorically “Why shouldn’t we conceptualise supervision in medicine as primarily therapeutic in its purpose?” When the story narrated by the patient is recreated by the practitioner in supervision, the difficulties are reviewed, mistakes that make feel guilty are reexamined and underlying interpretations are clarified, thus creating a safe context for conceptualization of the case [148,155,156]. Narrative supervision [157,158] is appropriate for reflective practice, ethics discussion and personal development, which will also produce a better medical outcome for the patient [159-161]. In this context the Person Centred and Focusing Experiential Model can create the appropriate climate so that the supervisee can develop his own internal objectivity.

Today’s programmes are mostly focused on supervising GPs and do not include specialised doctors and physicians serving in hospitals. Their nature is educative or focused to the patient doctor relationships. This fits well with younger physicians and trainees. But in our opinion, a different kind of supervision is appropriate for more experienced and senior colleagues.

### **A supervisory model for medical settings**

The model we propose has its focus on the doctor and the relationship between the doctor and the supervisor. The supervisor takes care of the relationship which nurtures the professional and personal development of the supervisee. Moreover, it is through parallel process that the therapeutic relationship with the patient and the health outcome can change.

Owen and Shohet [12] argue that “while recognizing that there is a legitimate fear of ‘supervision for supervision’s sake’, we must also recognize that there is a reluctance to look at things closely in case we do not like what we see’.

Henderson [162] (p.87) reports that “approximately 70% of consultations with GPs entail symptoms without a primarily biomedical explanation and a very small percentage of them is referred for counselling”. Within this percentage there are very often ‘heart sink’ patients with ‘heavy’ medical files and obvious psychic distress which is somatised by creating physical symptoms. A lot of them are convinced to be seriously ill and even have unrealistic expectations of the physician. Patients have often neurotic illness with repressed desires and fears [134] and their requests often provoke negative feelings in practitioners [120,163]. Some of them provoke an automatic reaction



in the practitioner's body and mind, as if they have pushed a secret button [8], which can lead clinicians to stress, to change of professional behaviour and to burnout [164-167]. Balint [133] used to say that such patients need a dose of 'the doctor as a drug'.

Such issues can cause us problems; they can generate greater perceived workload, lower job satisfaction, anhedonia and boredom, thus influencing the quality of our work. Health practitioners have sometimes a hard time and feel insecurity to acknowledge their limits and lack of knowledge [168]. Our view concerning the needs for a more reflective and philosophical approach in clinical, is described below.

## Resistance

Often, what is said by the patient touches a vulnerable side, a hidden aspect of the practitioner and provokes painful reaction and resistance in order to accept it. In nature, action brings reaction and force produces reverse force [169,170], so resistance is a natural phenomenon.

Resistance can be expressed as boredom, sudden fatigue, anger or flight and 'hits' the physician's core beliefs. In fact it creates vulnerability, ie. a denial to have a deeper reflection on the discussed issue and face our deeper fears and sorrow. Vulnerability is often, considered as a sign of weakness.

Psychological resistance can be a serious obstacle to the clear view of the physician into the patient's aspects. Moreover, it can hinder from new experiences.

As Shohet [44] (p. 281) argues "resistance", like the immune system, is there for a purpose and we need to understand it. "If a skilled supervisor can listen and honour the practitioner's resistance, then change will happen" (p. 213). Then, discomfort and ambivalence about a patient and about the decision to take on his/her problem can easily lead to reinforcement and relief.

## Blind spots

In medicine we often remain unclear about the cause of the symptoms reported by the patient. In other cases we cannot define the problem like having a 'blind spot', a hidden aspect, an area we struggle to see inside us. Patient and doctor can have similar blind spots [171].

We need to perceive ourselves accurately in order to have a clear view on others. We have often denied peculiarities in our personality, i.e., some unrecognized traits which constitute the so called 'blind spots' [12] (p. 6). These are hidden personal beliefs that regulate the manner of processing some specific information. They can generate unexpected and unexplained behaviour 'against' our significant ones.

Some patients – often called 'heart sink patients' in the medical jargon - can have similar and overlapping blind spots with us [12,171] (p.21,25) and show an aggressive dependence [76] toward us with an obvious wish to unload their burden by 'dumping' it on us [12] (p. 6) and repetitively assert for solutions. They can even recall some difficulties in communication with our own relatives, especially with the 'significant ones'.

Blind spots and difficult situations with 'heart sink patients' can be identified through effective supervision. The physician can get help in a protected supervisory environment in order to discover and perceive these issues lucidly and clearly, to deeply reflect on them and to

overcome her his difficulties by creating a 'menu' of alternative solutions for the specific issues [18] (p. 21).

Physicians are often reluctant to work face to face with their difficulties in supervision which can be a major cause of job dissatisfaction and well-being erosion [12]. However, sometimes, when challenged by the difficulty of the situation and having their 'buttons' emotionally pushed, physicians are protecting themselves by transferring the problem to the patient and labeling him/her as 'heart sink'. The 'heart sink patient' attitude is often a way of protecting a doctor's difficulty on to the patient and then labeling the patient.

## 'Nuclear' beliefs

Physicians are often facing improbable expectations from the patient side, which generate pressure in their effort and leads to the creation of distorted beliefs.

Some examples of issues are [44]:

- 'I am fully responsible for this patient and his cure'
- 'I must find ways to give her/him back the quality of life s(he) merits to have'
- 'I must fulfill the patient's expectations'
- 'Errors are not allowed'
- 'I feel guilty about the side effects of this treatment'
- 'I feel guilty when the outcome of my treatment is death of my patient'
- 'I feel guilty towards the relatives of a patient who died'

These statements and feelings declare unrealistic medical responsibility over a patient's life. The truth is that doctors are expected to do the best they can, to know what they know and to know what they do not know. To do their best to avoid errors always having in mind that the real responsible, the real 'guilty' for what will happen and for the outcome is the illness, not the physician!

But the patient is another component of the final outcome, and a very important one! In chronic diseases the mental dominance and resilience of the patient is very important for the outcome of the treatment, much more important than the medical factor. Moreover, if errors that occurred have not been acknowledged and discussed with colleagues in a reflective manner, then the probability to see them happen again is increased [172].

This is something that doctors often hardly acknowledge and feel totally responsible and guilty about the outcome of their intervention. In these cases clinical supervision and reflective work can elicit the details of the case and clear the physician's mind.

## Resilience, compassion fatigue, stress and burnout

Resilience is described as the faculty to overcome the stressful situations created by professional and life's challenges and maintain successful selfregulation with a good level of functionality [173].

On the other hand, work overload as well as emotional exhaustion – which are described as 'compassion fatigue' [174] - produces a highly stressful environment and reduces resilience, also diminishing working memory and selective attention [175]. Working memory and selective attention are critical brain functions for the practice of the medical and health professions and their functional impairment can often lead to errors [176].

Moreover, the prolongation of such highly stressful and emotionally exhausting conditions for long periods of time creates professional burnout conditions. Therefore, it can be easily understood that stress and burnout reduce the quality of care and the medical outcome [177]. It is also notable that programs for medical specialization and professional development do not focus on resilience to stress and trauma [178].

An Australian survey [179] argues that especially GPs, being the first door to knock at, are often exposed to exhausting emotional situations that are at risk of burnout and compassion fatigue. Furthermore, European studies confirm that an important number of GPs – that goes up to 33% of physicians in Switzerland- shows signs of burnout [165,180]. Apart from GPs, practitioners taking care of traumatised people with chronic or terminal illnesses might have a secondary trauma [13,174]. They might have insomnia, nightmares, tiredness, anger, aggressiveness, unhappiness and frequent accidents. They might hardly be as compassionate to themselves, their family, their friends and colleagues, as they show compassion for their patients.

Clinical supervision of physicians is related to a clear decline of rates in stress, burnout and compassion fatigue, while increasing engagement in medical practitioners. The decrease of burnout rate of clinically supervised physicians could even be as high as 50% in comparison to the rate of non-supervised clinicians [181]. Nielsen and Tulinius [13] state that according to Danish regional reports Communication skills, personal and professional development and job satisfaction were also improved in supervised physicians.

Similar data are shown in Norway with counselling-type intervention where emotional exhaustion was significantly reduced one year after the intervention. Additionally, the researchers of this study observed an increase of the practitioners undergoing psychotherapy from 20% to 53% after their intervention [182].

Physicians need to have a peaceful and reflective space using the filter of their past experience, gaining experience and feedback from colleagues, brainstorming solutions, identifying and conceptualizing the details of the ‘burning’ issue, connecting with their vulnerability, expressing their frustrations, organizing daily practice and exploring their creativity and ways to improve in their professional and personal life [12,183] (p. 4). Moreover, meaning has been found as a mediator for stress and burnout [184] It follows that the meaning found in the supervision process can increase resistance against compassion fatigue. This is what good clinical supervision can successfully offer as well as preventing stress, compassion fatigue and burnout in health profession [185,186].

### Reflective practice

Clinical supervision in medical contexts is something nonhierarchical, nonjudgmental and focused on the practitioner rather than on the organisation [142].

In order to examine and face the above mentioned psychic issues, deeper psychological work and elaboration is needed. Reflective practice creates the necessary and sufficient environment to make a flash back and examine frame by frame the experience, staying in touch with feelings of grief, irritation, anxiety or sadness for being frustrated, blamed or severely criticized in order to trace deeply hidden beliefs. Questions can also be put to work on the content of a case like “What are the good elements of this experience? Or “how would I manage this feeling of ‘stackness’ if I would make this consultation

again?” or even “what made me react so anxiously when I described the risks and benefits of this specific therapy to the patient?” This kind of mirroring and elaboration can lead to changes to professional but also to personal level.

As Fowler [187] argues, many health practitioners are not ready to explore self-awareness and support reflective supervisory work. However, there is no need to try to deepen the supervisory level and insight right from the first moment in a new supervisory group. The group process is usually getting more reflective by itself after a certain period of time.

Furthermore, reflective practice can be taught starting with mindfulness exercises [188] which are efficient in stress reduction [178] and then proceed to the Focusing method as a taught procedure [31] (described in the next paragraph). Moreover, as mentioned before and according to the model of Hawkins and Shohet [54], the supervisor works mostly with the first three modes when the supervisee(s) have a lower developmental level [10,50] while the upper four modes concern an advanced level of professional and personal development. The clinical supervisor can have the flexibility to accept physicians either trained or non-trained in reflective practice. They can even work in the same group, thus contributing to a more fruitful supervisory experience.

### The role of focusing oriented therapy (FOT) in the supervisory process

Clinical supervision helps physicians to clear the space, to slow down, to think about the details of the case and to ‘see’ these blind spots clearly.

The body language and somatic feelings of the physician-supervisee are also very useful in supervision. They can lead to the inner meaning of the issues by removing external distractions and bringing into mind images of the discussed issue [18,189]. A very useful action to resolve the problem would be to close her/his eyes to clear the space of her/his conscience and attention and focus into the felt sense about the discussed issue. We can also add reflective questions like: “How would it be for you to see this patient’s biological indices and quality of life deteriorates?” or “Can we stay for a moment and concentrate to your body to let it feel the loss of this patient” [31,59,190,191].

This procedure is called focusing and can be taught as a procedure. It concerns to find images or words for the examined situation, then get a “handle” and check it against the gut feeling of the issue, ask it what really creates these difficulties and finally welcome it and accept it. This procedure can be proved very helpful. It very often leads to what Gendlin and Owen call the ‘aha’ moment [192].

### Dual Roles

When the supervisor has also a managerial and evaluative role that gives her/him important power, s(he) needs to focus on the power differential with the supervisee. In this way a functional relationship can be obtained and sustained [193].

### Epilogue

Clinical supervision can support uncertainty [194] and contribute to break the negative spiral of stress and burnout [13]. This helps to make the doctor’s dilemmas and core beliefs explicit, to build insight and resilience, thus restoring emotional equilibrium and reflective view

to manage difficult situations. Thus, clinicians can better collaborate and be attentive and caring towards the patient's needs. They become able to see the patient's reality through her/his eyes, while maintaining an objective perception.

Practitioners need to have their moments of deep reflection to see things with the 'mind's eye' and make the shift to the 'aha' moment, as mentioned before [169], in other words to focus on their 'felt sense' and understand the inner meanings of their experiences [195]. Such a reflective process allows to also acknowledging the positive side of the process. Over time, the issues brought by the supervisees deepen and broaden and include general aspects of their medical work and approach for the patients care.

Last but not least, clinical supervision helps physicians who are interested in their 'duty' and professional development leaving apart their relationships with collaborators and their own quality of life. Supervision gives significant help for change in personal level nurturing the relationships with our significant ones.

In our experience the person centred supervision is appropriate for supervision of clinicians working with chronic diseases and palliative care as well as with GP's facing everyday patients with major emotional load, offering a supportive space for reflection. It is also important to include all the suppliers of health services in a similar process in order to promote collaboration, professional efficiency and their own emotional quality of life.

## Conclusion

Clinical supervision provides an occasion for deeper insight of dilemmas, experiential learning and integrates a range of professional skills, beliefs and comportments. Also, the supervisory process supports practitioners, psychotherapists and physicians, so they can be resilient and even survive cases where the patient or client blames them face to face for real or fictional therapy errors [18] (p.25) [13] (p. 357). So clinical supervision helps to improve reflective practice and professional awareness for the clients and patients benefit, while also preventing compassion fatigue, stress and burnout [12,13,24] (p. 354,15).

Concerning the nature of the supervisory model, Goodyear and Robyak [196] found that - in a later phase of supervision with each supervisee - supervisors are moving more and more into common supervisory practices, which are being used by many modalities.

Humanistic supervision with its three models, Developmental, Integrated, and Orientation-Specific, in its purest form, non-directive, is focused on expressing empathy by integrates as primary the reflection of feelings, and is focused on what the client brings to the session, avoiding introduction of new issues by the therapist [197]. Likewise, the person-centred and focusing - experiential clinical supervision model is non-directive and focused on the primary tenets of humanistic psychotherapy. In this model of supervision, the more the supervisee is experienced the more supervision becomes narrative and has relational depth [198].

This model is particularly apt at acknowledging the needs of the more experienced supervisee, irrespectively of therapeutic approach and aims at encouraging a more focused development of the internal locus of evaluation which represents the basis of her/his internal supervisor [7]. Therefore, it represents an efficient common (cross-theoretical) model for supervision [199]. This supervisory approach can satisfy the need - as Kilminster et al. [200] argue - for "an effective

system to address poor performance and inadequate supervision" and to support 'out of hours of work' failure (p.17).

Experienced practitioners often need much more than a suggestion for a solution. They need to be deeply listened and understood, to nurture and cultivate their freedom of choice. The proposed person centred and experiential model is appropriate for this purpose. Empathic understanding and acceptance can emphasize the focus on the supervisee's internal locus of evaluation [9] (p. 294) and develop her/his professional and personal self-esteem.

The more the supervisee -supervisor relationship gets trustful and deeper, the more it actualizes an "I-Thou" relationship as described and discussed by Martin Buber in his dialogue with Carl Rogers [201].

## Authors

Michael Callifronas MD, ECP is Physician, Registered Psychotherapist, Clinical Supervisor, Editor, Author and Reviewer in scientific Journals, President of the Hellenic Institute for Psychotherapy.

Christina Montaiuti PhD is British Psychological Society Associate Fellow and HCPC registered counselling and occupational psychologist. Christina is an honorary faculty and dissertation advisor at Liverpool University. Christina occasionally works as an academic tutor in the University of Derby.

Eleni Nina MSc, ECP is Clinical Psychologist, Registered Psychotherapist, Trainer, Supervisor, Private practitioner and General Secretary of the Hellenic Association of Systemic Therapy.

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