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Review paper

A PERSON CENTRED VIEW OF AIMS, GOALS AND TASKS IN CLINICAL SUPERVISION.

PROPOSALS ON EXPERIENTIAL LEARNING SUBJECTS.

ABSTRACT. Person centred clinical supervision trusts the supervisee's internal power and resources and has the role to create a helpful climate for their personal and professional development. The supervisor is not 'wise' expert, but works with trust, empathy, warmth, safety and genuineness from a collaborative perspective to facilitate reflection and conceptualization. This review presents the author's view on the aim, goals and tasks of person centred supervision. Proposals are also made on experiential learning subjects to discuss [49] within the supervisory context.

1. INTRODUCTION

Although many professional healthcare groups now have, or want, to participate in clinical supervision (not management supervision) of our practice, it is not always clear exactly what should be done and how the work may be achieved. Indeed, learners have many and varied experiences in terms of how they have been supervised. Some of their varied experiences, and thus the varied practice, may arise from ideas such as the following. Bernard and Goodyear [1], argue that there are similarities between supervision, teaching, counseling, and mental health consultation. There may be similarities, but each one has very distinctive qualities.

According to a group of 50 Maori psychologists, social workers and counsellors, supervision is 'gathering the treasures of the past into the competencies of the present into the well being of the future' [2]. In addition, Loganbill, Hardy, and Delworth [3] state that supervision is a 'relationship in which one person is designated to facilitate the development of therapeutic competence in the other person'. This may be undertaken from a range of perspectives. But, from a person centred perspective, Carl Rogers suggested that 'my major goal is to help the therapist to grow in self confidence and to grow in understanding of the therapeutic process' [4].

One effective way of to consider the need for clinical supervision *per se* is to consider this personal experience. Michael remembers a strong memory from his first steps in therapy, when he was having sessions, in a psychiatric ward, with people who had been diagnosed with severe depression. Patients' despair, long intervals of silence and deep anger were frequent companions in those sessions. He remembers a woman with three suicide attempts. She had lost her husband and was living alone without friendly relatives. One day she told him: ' As you know , I am decided to suicide. But I want you to answer me one question, is this unsupportable (psychic) burden that I carry in life, going to follow me after death, or am I going to get rid of it?'

This work had a huge burden for him. After the end of each thirty minutes session he needed one hour of supervision. He was miserable himself, felt useless and realized he was identifying with his clients. The work and the effects upon him had a wide ranging impact upon his life and own relationships. Without supervision he may have stopped working with the very clients who perhaps most needed to work. However, he was participating in clinical supervision.
There were two fundamental approaches his supervisor could have taken in their work. She could have given him advice and ideas about how to work with people who are suicidal. She could have shaped the work into a learning experience of her making and direction. Or, she could have been how she was. Michael remembers her as being like a best mother to him, using empathy and acceptance (of him) to help him find his own strength and courage to continue. She trusted his internal power and resources and also she helped him to differentiate - being an ex-depressive – his attitude towards depression. She helped him to discover his potential to overcome the psychic burden and he was able to be useful to his clients.

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Thus, clinical supervision is an essential element for the development of both neophyte and experienced therapists and healthcare workers. It should commence on the basic level courses and continue as long as professional practice continues. It will be suggested that the supervisory process provides support, continued personal growth professional competence and a 'protection' for the clients. Lack of continued satisfactory supervisory relationship can sometimes open the doors to the stairway of inadequacy, helplessness and burnout for the therapist. This article will outline the aims, goals of a person centred supervision. It will examine the relationship and tasks and will un-tangle the person centred view of these tasks. It will untangle several important and complex issues and areas, explore supervision within other main modalities, and will argue that the key aspects of the approach render it valuable as a multi-approach model.

2. AIM AND GOALS OF PERSON CENTRED SUPERVISION

Firstly, it is probably useful to understand that clinical supervision is not therapy. Doehrman [5] suggested that: 'The aim of supervision is the teaching of psychotherapeutic skills, whereas the goal of therapy is to alter the patient's characteristic modes of reacting in order to function m ore effectively in all areas of his life'. However, this differentiation is not unproblematic, not least because, Patterson [6] argues that the aim of person centred supervision, while not being a therapy in itself, becomes so through the supervisory relationship therapeutic.

Within this view every human being is born with its own internal power. Humans are resourceful and resilient to losses and frustrations, provided that they have grown with secure bonds in childhood. Humans are born with an inalienable equality and have a birthright to freedom, creativity and actualisation of their own good goals. Furthermore, every adult human has the right to seek for secure, therapeutic relationships offering warmth and respect in order to heal traumas of the chidhood. So developing secure bonds s(he) will live more authentically, 'discern more clearly' and 'choose more significantly ' thus becoming a fully functioning person [7,8], Purton states [9] that ' … Rogers fundamental belief (is) that the therapist's aim should be to help the client articulate their experience *in the client's terms'* [9]. Accordingly the aim of person centred supervision is to promote the personal and professional development of the supervisee *in her/his terms* and help her/him to unleash her/his internal power and resources. The supervisee's development will subsequently help the relationship with her/his client.

As far as the goals are concerned the person centred therapist has as goals only the ones the defined by the client [10] . Bozarth [11] adds: 'the only therapist goal is to be a certain way and by being that way a natural growth process is promoted in the client'. Consequently, the goal of a person centred supervisor is to create the appropriate climate for the supervisee, using themselves and embodying empathy respect and genuiness [7,8], in order to elaborate the 'hot spots' of her/his therapeutic session and gradually focus in her/his conditions of worth, being probably projected in her/his therapeutic session. This empathic and accepting climate will help the personal and professional development of the supervisee also contributing thoroughly on her/his further theoretical advance.

Inskipp and Proktor [12] argue " that the relationship is not the purpose of supervision**.** It is a means to the end of being able to work creatively together for the benefit of the client". However, Patton, Kivlighan and Multon [13] argue that the purpose is the development of the supervisee-supervisor relationship, which is believed to have a positive influence on the creation of the client-therapist bond, and also on the positive therapeutic outcome. This then secures both, the development of the supervisee and also the development of the client.

In accordance with these two above mentioned trends, Villas-Boas Bowen [14] states that two kinds of person centred supervision are known. The first follows the structure and the application of the principles of a therapeutic approach, where the supervisor has more or less a role of mentor and educator, focusing mainly to the client's needs. The second is a "philosophy of life oriented supervision" focusing on the supervisee's internal locus of evaluation by trusting her/his inner resources and intuition. As previously mentioned (Introduction) Rogers showed in a personal interview his preference for the second supervisory alternative [4].

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According to the philosophy oriented supervision model the supervisor: respects the autonomy and the unique personality of both the supervisee and his client; considers the supervisee as being 'the one who knows'; and, creates a helping climate in order to facilitate their personal and professional development, which will improve the supervisee's relationship with their client and the therapeutic outcome. So, the goal in supervision – like in therapy - is to:

- trust the supervisee's inner resources
- be a trustful companion, in difficult professional moments
- create the appropriate climate,

This is so the supervisee can find and develop their personality strengths and traits [7]. Even more emphatically we suggest, with Lambers [15] that the supervisor "has no other concern, no other agenda than to facilitate the therapist's ability to be open to her experience so that she can become fully present and engaged in a relationship with the client. The person-centered supervisor accepts the supervisee as a person *in process* and trust the supervisee's potential for growth".

3. RELATIONSHIP AND BOND

In order to facilitate what we have described above, there must exist a relationship and a bond between the supervisee and supervisor. In their attempt to revise Bordin's [16] definition concerning the 'working alliance', Horvath and Greenberg [17] argued that the supervisory bond portrays 'issues of mutual trust, acceptance and confidence'. In addition, the supervisory goal represents mutual agreement of objectives and the supervisory tasks illustrate mutual acceptance of responsibility for jobs and practices. In practice, we think that bond is the tender gut feeling which motivates collaboration so as to determine goals and plan tasks. The creation of a secure bond is a safe haven necessary for mutual determination of the supervisory goals and planning of the agreed tasks.

A secure bond creates a closer relationship and vice versa. In addition, as Holloway [18] states 'as the relationship evolves to an interpersonal one, there is a process of reduced uncertainty', and continues: ' With decreased uncertainty , they (the persons) are better able to use control strategies and communicative modes that will reduce the level of conflict in the relationship'. This appears to have impact beyond the immediate. The gains of a closer supervisory relationship and working alliance have been identified in transcripts of the client-therapist relationship, resulting in a positive therapeutic outcome [19, 20, 13] .

Other impacts appear to be that a secure supervisory bond has a positive influence on the supervisee's personal development and self awareness. [21]. In addition, a secure bond improves also communication and as Miller [22] states 'communication influences the relational development and in turn relational development influences the nature of communication'. Finally, it is so important, that supervisors working with supervisees who have weaker attachment ability and development levels [23] should respond and act as a caregiver with empathic attunement and acceptance [24].

4. SUPERVISORY TASKS AND CONTRACTING

The supervisory pair may create the conditions within which they can work well together and also a suitable relationship and bond. Nevertheless, the supervisor still has important tasks to attend to. An initial task is to establish a close relationship, a 'working alliance' [16] which means to work on the relationship with the supervisee and create a good climate for collaboration on the tasks comprised in the initial contract in order to have the desirable outcomes. Caroll [25] lists a series of eight supervisory tasks:

1. To have self-knowledge to pay attention to your interior conditions and to know the origins of your motivation.
2. To be present emotionally, mentally, psychologically and motivationally.
3. To provide a 'safe container' to the supervisee's strong emotions in order to ensure safety in the relationship.
4. To create and maintain the caring relationship realising that each supervisee is unique.

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5. To focus on the supervisee's emotional process and elaborate strong emotions
6. To facilitate with flexibility and openness in order to learn from experience
7. To give feedback on the supervisee's work
8. To generate hope, being as supervisor restorative, resilient and optimistic.

Hawkins and Shohet [26], Inskipp and Proctor [12] and Bond [27] propose three main supervisory task areas, the normative, which monitors the quality of the procedure, the formative, which concerns learning and skills development and the restorative or supportive, which concerns taking care of and support the supervisee.

In order to achieve the accomplishment of the tasks Hawkins and Shohet [26] propose six procedural subcategories:

1. Reflective discussion of the sessions content with her/his client
2. Discussion of the approach methods used by the therapist regarding her/his client
3. The exploration of the therapeutic process
4. The therapist's countertranference in the therapeutic session
5. Reflective discussion of the influence of the 'then and there' in the 'here and now' and in the therapeutic session with the client.
6. The supervisor's experience on the supervisory and the therapeutic session

Since the supervisory tasks, areas and categories are complex, Whitman and Jacobs [28] and Wosket and Page [29] prefer this task agenda to be rendered explicit and negotiated in the first meetings to narrow the supervisee's tension (and then periodically revised). According to Caroll [30] and Van Ooijen [31] supervisory roles and tasks combine in order to have the desirable outcome. Some of the tasks can be rendered more explicit in a Contract. According to Proctor [29], one of the first tasks is the establishment of the supervision contract is important in order to determine explicit needs, fields of interest and commitment and provide a clear, safe and honest agreement.

Caroll [25] lists a series of statements for the supervisor and the supervisee that could be included in their contract. Scaife [33] proposes to include in the contract 'what has to be learned and how'. Caroll [25], reports that sometimes he usually uses an oral contract but has also a flexible form of written contract. He has also published some contract lists for the supervisor and the supervisee, as well as his proper list of supervisory tasks. In some professions and organisations a written contract is mandate. However, we think that a discussion with a new supervisee, in which we both become aware of their needs starts to create the working alliance.

5. A PERSON CENTRED SUPERVISION VIEW ON IMPORTANT ISSUES AND AREAS

The above discussion should not be taken to be suggesting that the person centred supervisor is just a passive actor within the relationship. We will differentiate the role of supervisor from the one of therapist, although sometimes we may have a 'restorative' function [12] and work like a therapist.

Bozarth [11] argues that the therapeutic task is to create a climate for effective operation of the actualising tendency. Indeed, Rogers often showed a 'therapeutic' behaviour when supervising. He once shared that "often when I see a tape of an interview, or even hear a tape of an interview, somehow my feeling very strongly is ' Move out of that chair; let me take over' because I really have a love of doing therapy" [4] Being explicit on this subject Doehrman [5] stated that 'the student's problems in the supervisory and therapeutic situations are dealt with, but only to the extent that they affect his relationship with his supervisor or his relationships with his patients'. Some important issues and areas are considered in this section below.

5.1 From anxiety to safety - using empathy

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235 According to the developmental stages proposed by Stoltenberg, McNeill, and Delworth [34] the
236 neophyte supervisee is generally motivated with high levels of anxiety and, dependent on the
237 supervisor, has concern about specific interventions. They want to know the correct approach to
238 working with their client. Alongside this they may have limited self-awareness and difficulties
239 conceptualizing. It is likely, and according to Porges [35], that in the case of insecure attachment,
240 where fear plays an important role, the social engagement system is inactivated. Anxiety can hinder
241 personal development. Emotional burden reduces significantly the accurate symbolisation level, thus
242 inhibiting reflection, conceptualisation and active experimentation.
243
244 The person centred supervisor will focus with respect and empathic understanding on the supervisee's
245 worries, anxieties and uncertainties. Accurate empathy modulates fear and reduces the amygdala
246 activation, thus involving activation of the median orbitofrontal cortex and other prefrontal areas
247 [36,37]. In its turn the prefrontal cortex controls through GABAergic activity **hippocampus** and
248 amygdala and activates through the tenth brain nerve the autonomic parasympathetic system, which
249 brings soothing and relaxation.
250
251 When the supervisee feels safe, only then is it possible to start discussing their client, slowly
252 approaching their view and 'truths' on the sessions. This process promotes reflective learning,
253 enriches meanings and motivation and deepens the practitioners knowledge. Thus, in this work
254 there is no set agenda, but there may be an agreement for the repartition of the supervision session.
255 But, then we go on to discuss session notes, acknowledging and descriptively praising the therapeutic
256 shifts observed. We listen to selected session recordings in order to understand, symbolise the
257 emotional context of difficult moments and discuss congruence issues, when the client's worries
258 increase the supervisee's anxiety. Reflection and conceptualisation of meanings [38] take place at
259 that moment, and they contribute to 'a more sensitive and mindful approach to practice' [39].
260
261
262 **5.2 Using reflection and conceptualisation to surf in supervision together**
263
264 Reflection is mentioned as an important part of the process above and Skovholt and Ronnestadt [40]
265 define professional it as a three aspects process: 'ongoing professional and personal experiences, a
266 searching process with others within an open and supportive envinronment, and active reflection
267 about one's experiences'. Johns [39] proposes a Model for Structured Reflection (MSR), consisting of
268 specific questions which can be useful for the supervisee in order to trace therapy obstacles and
269 personal 'hot spots'.
270
271 In person centred supervision, where the main process is facilitative of the supervisee's experiences
272 and thoughts, some items of this model can be used. For example, the supervisor can use open and
273 tentative (non rhetorical) questions, like the following. These questions are process directives, but not
274 content directive [39] and they generally facilitate reflection during the supervision session (and
275 probably afterwards too).
276
277
278 • 'What would you like to discuss in today's supervision session?'
279 • 'I wonder what is the meaning of this experience for you'
280 • 'What was your dominant feeling as you worked with…?'
281 • 'What was really important to you in your session with this client?'
282 • 'Did this experience somehow change your sense of how you may work in the future?'
283
284
285 So reflection may be useful as suggested above, but abstract conceptualisation 'relates to relevant
286 concepts, theories and readings to the experience and formulate tentative conclusions, hypotheses or
287 generalizations' [42]. Allstetter-Neufeldt [43] proposes that a supervisee should be encouraged 'to
288 develop hypotheses about the client' in order to conceptualize the case. Encouragement is not often
289 utilized within a person centred supervision process, but it permits to the supervisee 'to be the one
290 who knows'. When a supervisee reflects and conceptualizes they create an environment in which to
291 undertake new therapeutic initiatives and actions. Ornstein [44] argues that the right brain is
292 responsible for concrete experiencing, while the left brain function concerns the abstract
293 conceptualisation.
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The supervisees learning style is important too [45]. They learn their client, and bring them in an embodied form into supervision in their empathic responses. This may be seen and felt in different ways. Rogers [46] states that 'The therapist's tone of voice conveys the complete ability to share the patient's feelings' , thus referring to the prosody of the therapist's response which comprises, mainly, the timbre, the speed, the rhythm and loudness of the therapist's voice. These factors, together with the supervisee's body language are significant in order to 'surf on the same wave', and work at relational depth [47]. The appropriate moments in the therapeutic session for evocative and maintaining empathic reactions as well as the process directive and content directive interventions can be also discussed 'ad hoc' [48, 41]. The supervisor can show through 'modelling' these differences.

5.3 Other learnings in supervision

It is likely that new supervisors would be concerned if the above were to be considered the only tasks in person centred supervision. They are not. But we are concerned with the means by which, or the way, in which other (experiential) learning may take place. Caroll [25] refers to the difference between learning and teaching by stating that :"All learning begins from the learners frame of reference, while teaching invites the learner into the world of the teacher". He further explains: 'experiential learning is the engagement between the outer world of the environment and inner world of the person'. Likewise, we may remember that Galileo Galilei (1564-1642) stated: 'We cannot teach people anything; we can only help them discover it within themselves'.

According to Rogers [49] learning can be efficiently facilitated through the learner's experiences. Aspy and Roebuck [50] working with a sample of 10,000 students have shown very significant results on academic measures, intelligence quotient (I.Q), disciplinary problems and creativity through facilitated experiential learning. So, depending on the contract and on the supervisee and client, the person centred supervisor may promote experiential learning through facilitative process in the following areas. These are 'other' and supplemental within the supervision. They are not core.

- Work on the embodiment of experiences and their inner meanings through process directive focusing methods [51]
- Some basic elements of mechanisms concerning psychotherapy and relating to psychobiology, neuroendocrinology and epigenetics, which are essential to understand the reactions of the body in psychotherapy.
- Discussion of common ethical issues and dilemmas through papers and articles reading [52,53] .
- Group centred discussion on theoretical subjects through a 'journal club' where each member can bring a summary of a paper s(he) is interested in.
- Specific subjects like client outcome and developments in anger management [54], stress management, parental skills etc.

5.5 Supervision in groups

Despite the obviously essential inter-personal and relational aspects of this work, this type of supervision is not antithetical to group working and learning. For example, counselling students who participate in supervision groups can write a report for each session in which they can include their experience of empathic understanding. They can refer perhaps to the Carkhuff scale [6]. The trainees can also report their level of anxiety and their congruence degree for the difficult moments of the session, thus helping to facilitate them with their difficulties. The supervisor can acknowledge with descriptive praise their efforts to bypass their obstacles. This seems to give them confidence and help them develop their skills. Group centred learning can be very efficient.

5.6 Some ethical concerns and issues

Obviously, all modern healthcare must pay due regard to ethical issues and concerns. Indeed, Tudor and Worall [38] state that 'it's important that supervisors work within legal and ethical responsibilities'.

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355 The UK based British Association for Counselling and Psychotherapy (BACP) recently reviewed its
356 ethical framework and now has an extract designated specifically towards supervision [55]. They
357 recommend that clinical supervision should be provided for anyone offering services that are
358 therapeutic. They state supervisors must model high levels of good practice with reference to areas
359 such as competence, professionalism, professional boundaries and relationship building.
360 Furthermore, the ethical framework must be reviewed annually (with supervisees) and areas such as
361 communications regarding clients must be consistent with the confidentiality agreements made with
362 the client.
363
364 With reference specifically to person centred supervision, Davenport [56] is critical and asserts that it
365 'fails to meet the rigorous ethical and legal guidelines now required of counsellor supervisors'. She
366 argues that person centred supervision puts the needs of the supervisee before the client's needs.
367 She is concerned that if the supervisor does not evaluate the supervisee's work, then it is likely the
368 client is not receiving a proper therapy. This is particularly important when working with trainees, and
369 Bernard and Goodyear [57] believe that 'supervisors are ultimately responsible for the ethical
370 behaviour of the trainees'. However, it is likely that use of empathy, honesty and warmth in the
371 attention to the developing supervisee (therapist) will result in the supervisees development and
372 hence that therapist will be able to provide the best possible conditions for the clients growth.
373
374 What is indisputable is that Caroll [25] argues that 'supporting supervisees to develop ethical
375 antennae, is one of the most important supervisor tasks. From within a person centred framework,
376 Lambers [15] says that, 'when there are concerns about the supervisee's practice, the challenge to
377 the supervisor is to offer a consistent, accepting relationship through which the supervisee can
378 achieve a greater degree of congruence in relation to the client'. It is through this relationship that the
379 supervisee will come to be aware of the growth of those ethical antennae as part of their professional
380 self concept.
381
382 Carl Rogers [8] stated that counselors have an ethical choice of values [58]. But what are the
383 principles by which we can judge whether a behaviour lays outside ethical boundaries or not? This is
384 obviously by no means clear or incontraversial. The duty of the physician to his patient, as
385 Hippocrates (400 BC*)* states in his book on Epidemics, is: "ὠφελεῖν ἢ μὴ βλάπτειν" which means "to
386 help, or at least, to do no harm" [59]. In our terms, beneficence and non maleficence need to rule the
387 relationship, which in supervisory terms is three dimensional: client, therapist and supervisor. Page
388 and Wosket [60], acknowledge these two principles and also add autonomy, fidelity and justice as
389 principles to guide us with ethical dilemmas.
390
391 In the recent consultation on their new Code of Ethics the United Kingdom Council for Psychotherapy
392 (UKCP) [61] outlined a notion of a virtuous psychotherapist as one who is (for example) reflective and
393 self-critical, having respect for the autonomy and self-determination of individual clients. The above
394 are integral to the theory and practice of the person centered approach, along with the therapist
395 avoiding imposing their thoughts, feelings on clients. Some of these are obviously person centred, but
396 others are more problematic, like the suggestion that the virtuous psychotherapist should engage in
397 supervision (and seek advice and guidance). These latter points (in brackets) are contained within
398 the same bullet point. Almost as if the guidance and knowledge would not emerge from the client or
399 their frame of reference. In addition, the UKCP [61] also suggest that the virtuous psychotherapist
400 should work with various principles, these are: honesty, candour, competence, human rights and
401 social justice, beneficence and personal accountability.
402
403 Obviously, such ethical principles are simply that. Notions we may use upon which we may start to
404 think in order to make decisions. They are often extremely difficult to use.. Using the five principles
405 proposed by Page and Wosket [60] and the notion of a "duty to warn" , it is difficult to gain clarity. If a
406 therapist or a supervisor has a duty to warn others about possible harm, whose autonomy is
407 protected is either party warns. Likewise, beneficence depends , as Scaife [33] proposes, "on who
408 judges what for the good and for whom it is judged to be good … bearing in mind the welfare of the
409 supervisee, the client and involved others". This means that if the final decision of the client is not
410 harmful, then there no beneficence for all parts, since even the involved others will have a false alarm.
411 But if the client has decided to harm and the supervisee had succeeded in warning after
412 the supervisor's suggestion, then her relationship with the supervisor will be reinforced although
413 having a 'touch' of directiveness.
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Perhaps working tangentially to the above, Michael has developed what he thinks of as his intuition and a sense of an ‘internal smell’. These may make him aware if empathic understanding and acceptance are so strong that they can alleviate the client’s anger and hate towards himself and others. However, he does not know if he has the ability to discriminate whether the supervisee has the ability to ‘smell the real intentions’ of her client. Moreover, we would question if he should rely on his feeling and become responsible of her client’s acts. However, if he does advise his supervisee to inform the police, he is aware of the fact that he might be putting her relationship with the client in danger.

In more depth, one other area within ethical issues that is often controversial is confidentiality. The controversies include whether or not confidentiality should be discussed and the potential consequences ether way. Bernard and O’Laughlin [62] believe that confidentiality exceptions must be discussed with supervisees and clients. Michael remembers his first client. In the very first session, when he started talking about the strictly confidential character of the session he added, that the only exception to confidentiality would arise if she wanted to harm herself or somebody else. The client got angry. It seemed to them both that he may not trust her initiatives and intentions in life.

Although this client continued her therapeutic relationship with him for a long time after this incident it is likely that it had several impacts upon her, their relationship and upon his practice. Several times since then he has worked with clients who declare an intention to harm themselves or another person. He has never chosen to take preventative action outside the session, and nothing has happened. Breaching confidentiality (in relationships with clients and supervisees) is a major dilemma which has to be examined ‘ad hoc’, since such an act can or will disrupt the fidelity within the therapeutic and supervisory relationship. One approach is to draw on the framework offered in the UKCP Ethics consultation document where they suggest that a practitioner and supervisor could move through: acknowledging /recognizing, to understanding the impact, to taking responsibility for what is known, to demonstrating outcomes, to implementing new learning. This framework would be used taking into account the notion of the virtuous psychotherapist and the principles mentioned previously.

Another ethical problem arises through the different (ethical) codes which are applied in medicine and psychotherapy. In the medical model confidentiality is 'horizontal' since all clinical staff in a department, can have access to the medical record of every patient. Whereas, in psychotherapy the confidentiality is very strict, it is more 'vertical', since very few individuals (dependant upon the laws of a country) can ever have access to the client’s data. Even the supervisor usually does not know the name of the supervisee's client. Connected to this one other dilemma often arises when the referring person is a physician, since it becomes very difficult for the supervisee to work out what to what to write and what to hide when reporting back to the referring doctor. In these cases the supervisee may consult with the client when drafting the letter. Obviously, the main ethical principles [54] , and the notion of the virtuous psychotherapist are of crucial importance and need to be examined by the supervisory pair on an ‘ad hoc’ basis.

6. CONCLUSION

This article has reviewed several important aspects of clinical supervision, particularly from a person centred perspective. It has un-tangled several complex issues and areas. It is apparent that clinical supervision is desirable for a range of healthcare workers and we have argued that use of a person centred approach may be of considerable benefit for both supervisees and clients alike. In addition, use of a person centred approach to supervision can be trustworthy, therapeutic, developmental and useful within a significant number of non content directive psychotherapeutic approaches, as well as in education and medicine.

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