

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

PROPOSALS ON TOPICS FOR EXPERIENTIAL LEARNING.

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ABSTRACT.

Aim: This paper intends to enlight and review the traits of the person centred clinical supervision model. This model is different to 'mentoring' supervision models. Specifically, the person centred model has a minimal degree of directivity when compared to educative, teaching and judgemental supervision models, since the supervisor is not a 'wise' expert. S(he) works with trust, empathy, warmth, safety and genuineness within the supervisee's frame of reference, thus facilitating her/his experiential learning and development.

Discussion: Details of the aim, goals and tasks of person centred supervision are explored and the essential differences with other supervision models are discussed. Areas of ethical concern receive particular exploration. This paper proposes topics of experiential learning which would be helpful if elaborated within the supervisory context.

Conclusion: The Person Centred Supervision Model is focused on the supervisee's personal and professional development. It necessitates a collaborative perspective to facilitate reflection and conceptualization trusting the supervisee's internal power and resources.

Keywords: Person centred therapy; clinical supervision; personal development; professional development; experiential learning; supervisory topics

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 and practitioners have many and varied experiences in terms of how they have been supervised. Their varied experiences, and practice, may become the cornerstones of their therapeutic experience through the clinical supervision process. This means that the person centred supervisor facilitates each supervisee's therapeutic experiences in order to let her/him develop at personal and professional levels.

Bernard and Goodyear [1], argue that there are similarities between clinical supervision, teaching, counseling, and mental health consultation. There may be similarities, but each one has very distinctive qualities. Detailed consideration of each of these is beyond the scope of this paper, but it is important to create a sense of what we mean when we refer to clinical supervision.

Carroll [2] offers an impressive definition created originally by a group of 50 Maori psychologists, social workers and counsellors. They stated that (clinical) supervision is 'gathering the treasures of the past into the competencies of the present into the well being of the future'. 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. From a more 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].

In our view, clinical supervision is an essential element for the development (particularly in confidence and understanding) of both neophyte and experienced therapists and all other healthcare workers. It should commence on basic level courses and **individuals should want to continue it for as long as they remain in professional practice**. It will be suggested that the supervisory process provides support, continued personal growth, professional competence and a 'protection' for clients. Hence, **we also suggest that a** lack of continued satisfactory supervisory relationship can open the doors to the stairway of inadequacy, helplessness and burnout for the therapist.

This article will outline the aims and goals of the supervisory process from a person centred perspective. It will examine the supervisory relationship and will untangle the person centred view of the supervision tasks as well as several important and complex issues and areas. Furthermore, it will explore some major areas of difference to the educative clinical supervision models. **More specifically, using a directivity axis - as will be explained below (5.2) - it will become clear that educative supervision approaches stand on one side of this, and person centred supervision is situated on the other side .**

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 more effectively in all areas of his life'. **Despite being useful**, this differentiation is not unproblematic. **This is** because, Patterson [6] argues that the aim of person centred supervision, while not being a therapy in itself, **it becomes therapeutic** through the supervisory relationship.

Within this view, every human being is born with their 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 childhood.

In developing secure bonds, the person 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 those 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 genuineness [7,8]. They create these conditions and render more explicit the 'hot spots' of the supervisees therapeutic session and gradually focus on her/his conditions of worth, which maybe being projected in her/his therapeutic sessions. This empathic and accepting climate thus assists the personal and professional development of the supervisee.

The above is in contrast to Inskipp and Proktor [12] who state 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". Patto, Kivlighan and Multon [13] argue that the purpose is, indeed, 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.

Moreover, Villas-Boas Bowen [14] clarifies the nature of person centred supervision by contrasting two kinds of supervision. 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 on the client's needs. The second is a "philosophy of life oriented supervision" focusing on the supervisee's internal locus of evaluation and trusting her/his inner resources and intuition. Carl Rogers showed in a personal interview his preference for the second supervisory alternative [4].

According to the life philosophy oriented supervision model [14] the supervisor: respects the autonomy and the unique personality of both the supervisee and the client; considers the supervisee as being 'the one who knows'; and, creates a helping climate in order to facilitate their personal and professional development. It is believed that this will improve the supervisee's relationship with their client and the therapeutic outcome. So, the goal in person centred supervision – like in therapy - is to:

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

In this way, the supervisee can find and develop their personality strengths and traits [7]. Moreover, Lambers [15] suggests, that the supervisor "has no other concern or agenda, than to facilitate the therapist's ability to be open to his/her experience so that (s)he 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

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 of the 'working alliance', Horvath and Greenberg [17] argued that the supervisory bond embodies 'issues of mutual trust, acceptance and confidence'. In addition, the supervisory goal includes mutual agreement of objectives, and the supervisory tasks illustrate mutual acceptance of responsibility for jobs and practices. In practice, we think that the bond is the tender gut feeling which motivates collaboration so as to determine goals and plan tasks. In our view the creation of a secure bond is a safe haven, it is 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'. This is to be expected and he 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 different gains of this type of 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] .

One effective way of to understand the importance of this type of clinical supervision is to consider a personal experience. The first author of this review, remembers (as a supervisee) a strong memory from his first steps as a therapist. 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 **who had made** three suicide attempts. She had lost her husband and was living alone, without **friends or** relatives. One day she spoke powerfully to 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 statement and question from this woman had a huge impact upon him. At the end of each thirty minute session, he needed one hour of supervision. He was miserable himself, felt useless, and realized he was identifying with his clients. The work, and **its** effects upon him, had a wide ranging impact upon his life and own relationships. Without the right type of **clinical** supervision he may have stopped working with the very clients who perhaps most needed to work.

In this case, two fundamental supervisory approaches could have been followed. Either would have had strengths and weaknesses. Firstly, his supervisor could have given him advice and ideas about how to work with people who are suicidal (including who to warn and inform). She could have shaped the work into the cognitive part of the deeply touching experience. Or secondly, she could have been facilitative in order to help her supervisee to acquire experiential knowledge. She chose this latter.

The first author (of this paper) remembers her as being like a best mother to him. **She created** a secure supervisory bond, **with deep** empathy and acceptance (of him). **This facilitated him** to find his own strength and courage to continue. She trusted his internal power and resources and she helped him to differentiate - being an ex-depressive himself – his attitude towards depression. She helped him to discover his potential to overcome **that** psychic burden and he was able to be useful to his clients.

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 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 form 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]. **In order to have desirable outcomes they will** work on the relationship with the supervisee and **also** create a good climate for collaboration on the tasks comprised in the initial contract. **In more detail,** Caroll [25] lists a series of eight supervisory tasks, the supervisor is to:

1. Have self-knowledge to pay attention to your interior conditions and to know the origins of your motivation.
2. Be present emotionally, mentally, psychologically and motivationally.
3. Provide a 'safe container' to the supervisee's strong emotions in order to ensure safety in the relationship.
4. Create and maintain the caring relationship realising that each supervisee is unique.
5. Focus on the supervisee's emotional process and elaborate strong emotions
6. Facilitate with flexibility and openness in order to learn from experience
7. Give feedback on the supervisee's work
8. 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 **session** 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 countertransference 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 **of both** the supervisory and 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. **It should** then periodically **be** 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 to **both** determine explicit needs, **commitment and** fields of interest, and **also to** 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 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 mandated. 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

According to the developmental stages proposed by Stoltenberg, McNeill, and Delworth [34] the neophyte supervisee is generally motivated with high levels of anxiety and, dependent on the supervisor, has concern about specific interventions. They want to know the **correct** approach to working with their client. Alongside this, they may have limited self-awareness

and difficulties **conceptualising**. It is likely, and according to Porges [35], that in the case of insecure attachment, where fear plays an important role, the social engagement system is inactivated. Anxiety can hinder personal development. Such an emotional burden reduces significantly the accurate symbolisation level, thus inhibiting reflection, conceptualisation and active experimentation.

The person centred supervisor will focus with respect and empathic understanding on the supervisee's worries, **anxieties**, and uncertainties. Accurate empathy modulates fear and reduces the amygdala activation, thus involving activation of the median orbitofrontal cortex and other prefrontal areas [36,37]. In its turn, the prefrontal cortex controls takes control through GABAergic **activity, hippocampus** and amygdala. It also activates the 'vagus' (tenth brain nerve), which is part of the autonomic parasympathetic system, thus contributing to soothing and relaxation.

When the supervisee feels safe, and only then, is it possible to start discussing their client. The supervisee may slowly approach their view **on** and 'truths' **from** the sessions. This process promotes reflective learning, enriches meanings and motivation and deepens the **practitioner's** knowledge. Thus, in this work there is no set agenda, but there may be an agreement for **partitioning** the supervision session. But, **in time**, we may go on to discuss session notes, acknowledging and descriptively praising the therapeutic shifts observed.

When the client's worries increase the supervisee's anxiety we listen to selected session recordings. **This is done** in order to: understand, symbolise the emotional context of difficult moments, and also to discuss congruence issues. Reflection and conceptualisation of meanings [38] take place **in those** moments, and they contribute to 'a more sensitive and mindful approach to practice' [39].

5.2 Using reflection and conceptualisation to surf in supervision together

Reflection is mentioned as an important part of the process above and Skovholt and Ronnestadt [40] define it as a three aspects process: 'ongoing professional and personal experiences; a searching process with others within an open and supportive environment; and **also an** active reflection about one's experiences'. Johns [39] proposes a Model for Structured Reflection (MSR), consisting of specific questions which can be useful for the supervisee in order to trace therapy obstacles and personal 'hot spots'. **Some items of this model can be used in a non-directive supervisory approach like this person centred model.**

In person centred supervision, the main process is facilitative of the supervisee's experiences and thoughts, This is the main difference to educative supervisory models which are often content directive [39]. There, the supervisor often intervenes in the supervisee's perception of the experienced therapeutic moments and meaning. They may give directions and guidelines, instead of promoting reflection and conceptualisation. In person centred supervision the supervisor can use open and tentative (non-rhetorical) questions to facilitate reflection. These questions are process directives not content directive [39]. Below are some examples:

- 'What would you like to discuss in today's supervision session?'
- 'I wonder what is the meaning of this experience for you'
- 'What was your dominant feeling as you worked with...?'
- 'What was really important to you in your session with this client?'
- 'Did this experience somehow change your sense of how you may work in the future?'

So, reflection may be useful as suggested above, but abstract conceptualisation 'relates to relevant concepts, theories and readings to the experience and formulate tentative conclusions, hypotheses or generalizations' [42]. Allstetter-Neufeldt [43] proposes that a supervisee should be encouraged 'to develop hypotheses about the client' **in order** to conceptualize the case. Encouragement is not often utilized within a person centred supervision process, but we acknowledge it does permit the supervisee 'to be the one who knows'. When a supervisee reflects and conceptualizes they create an environment

(both in themselves and in the room) in which to undertake new therapeutic initiatives and actions. Ornstein [44] argues that the right brain is responsible for concrete experiencing, while the left brain function concerns the abstract conceptualisation.

It is clear that the supervisee's 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. This 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 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 learner's 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, dependent on the: contract, supervisee, and client; the person centred supervisor may promote experiential learning through facilitative process in some specific areas. These are 'supplemental within the supervision, and they do not belong to the main body of the person centred supervision. Nevertheless, they can help to improve the 'here and now' focus of the supervisee in the therapeutic process. They can also offer better knowledge in the theory and practice of psychotherapy, providing additional therapeutic 'tools'. They include:

- 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.

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'. The UK based British Association for Counselling and Psychotherapy (BACP) recently reviewed its ethical framework and now has an extract designated specifically towards supervision [55]. They recommend that clinical supervision should be provided for anyone offering services that are therapeutic. They state supervisors must model high levels of good practice with reference to areas such as competence, professionalism, professional boundaries and relationship building. Furthermore, the ethical framework must be reviewed annually (with supervisees) and areas such as communications regarding clients must be consistent with the confidentiality agreements made with the client.

With reference specifically to person centred supervision, Davenport [56] is **critical and** asserts that 'it fails to meet the rigorous ethical and legal guidelines now required of counsellor supervisors'. She argues that person centred supervision puts the needs of the supervisee before the client's needs. She is concerned that if the supervisor does not evaluate the supervisee's work, then it is likely the client is not receiving a proper therapy.

This is particularly important when working with trainees, and Bernard and Goodyear [57] believe that 'supervisors are ultimately responsible for the ethical behaviour of the trainees'. However, it is likely that use of empathy, honesty and warmth **when working with** the developing supervisee (therapist) will result in the supervisee's development. **Hence**, that therapist will **then** be able to provide the best possible conditions for the client's growth and change.

This does not mean that the therapy remains un-evaluated. The supervisor can encourage the supervisee to evaluate her/himself and even to proceed in a SWOT (strength, weaknesses, opportunities and threats) analysis. **Likewise, a client can be encouraged to evaluate the therapy and the relationship with their therapist as part of the work.** When ethical dilemmas arise, the supervisor can propose an experiential elaboration of the alternative solutions in order to conform to the ethics code.

What is indisputable, is that Caroll [25] argues, 'supporting supervisees to develop ethical antennae, is one of the most important supervisor tasks'. From within a person centred framework, Lambers [15] says that, 'when there are concerns about the supervisee's practice, the challenge to the supervisor is to offer a consistent, accepting relationship through which the supervisee can achieve a greater degree of congruence in relation to the client'. It is through this relationship that the supervisee will come to be aware of the growth of those ethical antennae as part of their professional self concept.

Carl Rogers [8] stated that counselors have an ethical choice of values [58]. But what are the principles by which we can judge whether a behaviour lays outside ethical boundaries or not? This is obviously by no means clear or **uncontroversial**. The duty of the physician to his patient, as Hippocrates (400 BC) states in his book on Epidemics, is: "ὠφελεῖν ἢ μὴ βλάπτειν" which means "to help, or at least, to do no harm" [59]. In our terms, beneficence and non-maleficence need to rule the relationship, which in supervisory terms is three dimensional: client, therapist and supervisor. Page and Wosket [60], acknowledge these two principles and **they** also add autonomy, fidelity and justice as principles to guide us with ethical dilemmas.

In the recent consultation on their new Code of Ethics the United Kingdom Council for Psychotherapy (UKCP) [61] outlined a notion of a virtuous psychotherapist as one who is (for example) reflective and self-critical, having respect for the autonomy and self-determination of individual clients. The above are integral to the theory and practice of the person centred approach, along with the therapist avoiding imposing their thoughts **and** feelings on clients. Some of these are obviously person centred, but others are more problematic, like the suggestion that the virtuous psychotherapist should engage in supervision (and seek advice and guidance). These latter points (in brackets) are contained within the

same bullet point. Almost as if the guidance and knowledge would not emerge from the client or their frame of reference. In addition, the UKCP [61] also suggest that the virtuous psychotherapist should work with various principles, these are: honesty, candour, competence, human rights and social justice, beneficence and personal accountability.

It may be useful now to think back to the supervision that the first author of this paper received some years ago when working with the woman who was determined to suicide. Using the five principles proposed by Page and Wosket [60] and the notion of a “duty to warn”, it is perhaps important to consider some of the useful thoughts and questions arise. For example, the autonomy of the supervisee will be/ or can be, influenced by the supervisor’s possible proposal (to warn others of possible harm) concerning the client’s continued suicidality. So, whose autonomy is finally protected? Likewise, beneficence depends, as Scaiffe [33] proposes, “on who judges what for the good and for whom it is judged to be good ... bearing in mind the welfare of the supervisee, the client and involved others”. This means that if the final decision of the client is not harmful, then there will be no beneficence for all parts. This is because the involved others will have received a false alarm and the confidence in the relationship therapist-client will be probably in doubt. On the other hand if the client has decided to harm and the supervisee had succeeded in warning after the supervisor’s suggestion, then her/his relationship with the supervisor will be reinforced, although will now be directive in part.

Non maleficence is congruent to the second part of Hippocrates’ statement which states ‘ ... at least to do no harm’, but in our case it concerns many persons. So if the warning is false, no one is helped and the confident relationship between the supervisee and the client is –at least temporarily – harmed. In any case, fidelity will be very probably negatively influenced between client and supervisee, if the client considers the therapist’s act as a breach of confidence and not as a protective act. Justice would be accomplished if the supervisor examines the case with attention and irrespectively of the time spent on the subject thus ensuring that the decision was the fairest, for the greatest good and the least harm. Obviously, such ethical principles are only notions we may use to guide our thinking, decision making and action. Nevertheless, they are often extremely useful but difficult to use in supervision.

Another area within ethical issues that is often controversial is confidentiality. The controversies here include whether or not confidentiality should be discussed, and the potential consequences either way. Bernard and O’Laughlin [62] believe that confidentiality exceptions must be discussed with supervisees and clients. The first author of this review remembers another one of his first clients. In the very first session, when he informed the client 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 and he (the author) realised that he was often reluctant to breach the confidentiality.

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 concerning confidentiality. Namely, in the medical model a number of members of the clinical staff, can have access to the medical record of every patient. On the contrary in psychotherapy, the confidentiality is very strict, since very few individuals (dependent 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, a dilemma often arises when the referring person is a physician, since it becomes very difficult for the psychotherapist (and supervisee) to work out what to write and what to leave unwritten, when reporting back to the referring doctor. In these cases the supervisee may discuss the issue

with the supervisor and may consult with the client when drafting the letter to the **referring** doctor. 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.

7. CONCLUSION

This article has reviewed several important aspects of clinical supervision, particularly from a person centred perspective. The differences between the educative and a 'philosophy of life' oriented supervision have been untangled. Supervision using the latter, is accomplished mainly through a relationship, and an experiential process and served by the person centred model. **This model is characterised by a higher degree of non directivity, when compared to educative models. Moreover, if the supervisee is an experienced therapist the process takes the form of an equal dialogue between colleagues, thus promoting an 'I-Thou' relationship [63].**

The **aim** of person centred supervision is to respect the human internal power and focuses upon the supervisee's personal and professional development. We trust that every therapist has their own resources to develop therapeutic skills. Thus, the supervisee may unleash **their** internal power and resources within the supervisory relationship. The supervisee's development will subsequently help the relationship with her/his client.

The supervisor's major **goal** is 'to help the therapist to grow in self confidence and to grow in understanding /of/ the therapeutic process' [4].

Concerning the **tasks** it is proposed, amongst others:

- to focus on the supervisee's emotional process and elaborate strong emotions with flexibility and openness in order to learn from experience,
- to give supervisory feedback and
- to generate hope, being as supervisor restorative, resilient and optimistic.

Furthermore, reflective discussion is essential, targeting on the approach methods, on the therapeutic process, on the therapist's countertransference as well as on the influence of the 'then and there' on the 'here and now'. Reflection **on** and conceptualisation **of**, the meanings of the therapeutic sessions are considered as cornerstones in the supervisory work and in the experiential learning process.

Learning may comprise **focusing** methods, **psychobiology** and reactions of the body in psychotherapy, **ethical issues** and dilemmas.

We have argued that the use of a person centred **approach to** supervision may be of considerable benefit for both supervisees and clients alike and can be trustworthy, therapeutic, developmental and useful. According to the person centred model **effective clinical supervision** has –among others- two elementary qualities: . **Firstly, it** examines in the very first range, the therapeutic session from a 'here and now' point. **Secondly, it** considers the supervisee as being 'the one who knows', they are the expert for her/his client.

Finally, it will be interesting to examine in a future paper, **the use and application of** person centred supervision **with both** supervisees **who specialise in use of other** psychotherapeutic approaches, **and also those who work in both** medicine and education,

8. CONSENT

Not applicable.

9. ETHICAL APPROVAL

Not applicable.

10. COMPETING INTERESTS

No competing interests exist.

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