A PERSON-CENTRED VIEW OF THE AIM, GOALS AND TASKS IN CLINICAL SUPERVISION.

PROPOSALS ON TOPICS FOR EXPERIENTIAL LEARNING.

Michael D. Callifronas[1] and Susan Brock[2]

[1] Michael D. Callifronas*, MD, ECP
michael@callifronas.com
The Hellenic Institute for Psychotherapy, 17 Kalvou St, 15452, Psychiko, Athens, Greece.

[2] Susan Brock MSc, RN (MH), ECP
s.brock@derby.ac.uk
UDOL and Learning Enhancement, the University of Derby, Kedleston Rd, Derby, UK.

ABSTRACT.

Aim: This paper intends to highlight 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, as 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 the supervisee's experiential learning and development.

Discussion: Details of the aim, goals and tasks of person-centred supervision are explored, and the essential differences from other supervision models are discussed. Areas of ethical concern receive particular exploration. This paper proposes areas of experiential learning that 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 conceptualisation, 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 therapeutic 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, are likely to become the cornerstones of their therapeutic experience through the clinical

supervision process. 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 amongst clinical supervision, teaching, counselling 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 their self-development for as long as they remain within professional practice. It will be suggested that the supervisory process provides support, continued personal growth, professional competence and 'protection' for clients. Hence, we also suggest that a lack of a continued satisfactory supervisory relationship can open the door to inadequacy, helplessness and burnout for the therapist.

This article will outline the aim 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 explained in section 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 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 to identify, the differences are not without problems; Patterson [6] argues that the aim of person-centred supervision, whilst not being a therapy in its own right, becomes therapeutic through the supervisory relationship.

Within this view, every human being is born with their own internal power. Humans are resourceful and are 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 secure and therapeutic relationships that offer warmth and respect, in order to heal the traumas of 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 their terms*, guiding *them* in unleashing *their* internal power and resources. This will subsequently help the supervisee with client relationships.

As far as the goals are concerned, the person-centred therapist has 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 explicitly, the 'hotspots' of the supervisee's therapeutic session and gradually focus on the supervisee's conditions of worth. These conditions may be projected during her/his therapeutic sessions. This empathic and accepting climate therefore assists the personal and professional development of the supervisee.

The above is in contrast with the views of 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, as well as creating positive therapeutic outcomes. This then secures both the development of the supervisee and the development of the client.

Moreover, 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, by 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 whilst 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 personalities 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 the supervisee's personal and professional development. It is believed that this will improve the supervisee's relationship with their client and the therapeutic outcome. So, the goals in person-centred supervision – like in therapy – are 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-centred supervisor accepts the supervisee as a person *in process* and trusts 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 the supervisor. In their attempt to revise Bordin's [16] definition of the 'working alliance', Horvath and Greenberg [17] argue that the supervisory bond embodies 'issues of mutual trust, acceptance and confidence'. In addition, the supervisory goal includes the mutual agreement of objectives, and the supervisory tasks illustrate mutual acceptance of responsibility for jobs and practices. In practice, we believe that the bond is the tender gut feeling that motivates collaboration, so as to determine goals and to plan tasks. In our view, the creation of a secure bond is a haven; it allows for the mutual determination of supervisory goals and the planning of (to be) 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 an impact beyond the immediate context. 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 [13,19,20].

One effective way of understanding the importance of this type of clinical supervision is to consider a personal experience. The first author of this review has a strong memory from his first steps as a therapist (and as a supervisee). He was conducting sessions, in a psychiatric ward, with individuals who had been diagnosed with severe depression. Patients' despair, long intervals of silence and deep anger were frequent companions in those sessions. He recalls a woman who had made three suicide attempts; she had lost her husband and was living alone and lacked friends or relatives. On one specific occasion, she spoke powerfully to him: 'As you know, I have 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 realised that 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 him.

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 when to warn and inform others). She could have shaped the work into the cognitive part of the deeply touching experience. Secondly, she could have been facilitative in order to help her supervisee to acquire experiential knowledge. She chose the latter.

The first author (of this paper) felt that the relationship had become almost maternal in nature. His supervisor created a secure supervisory bond, with deep empathy and acceptance (of him). This facilitated him to find his own strength and courage to continue working. She trusted his internal power and resources and assisted him to differentiate – being an ex-depressive himself – his attitude towards depression. She helped him to discover his potential in order to overcome that psychic burden, subsequently using this learning to help 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 of critical importance that supervisors working with supervisees who have weaker attachment abilities and development levels [23] should respond and act as caregivers 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 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, or a 'working alliance' [16]. In order to have desirable outcomes, they will work on the relationship with the supervisee and also create a climate conducive for collaboration on the tasks comprised in the initial contract. In more detail, Carroll [25] lists a series of eight supervisory tasks. The supervisor is to:

1. have self-knowledge to pay attention to their interior conditions and to know the origins of motivation
2. be present emotionally, mentally, psychologically and motivationally
3. provide a 'safe container' for the supervisee's strong emotions 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 and learn from experience
7. give feedback on the supervisee's work

8. generate hope by being restorative, resilient and optimistic

Hawkins and Shohet [26], Inskipp and Proctor [12] and Bond [27] propose three main supervisory task areas. These are 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 supporting the supervisee. To achieve 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 sessions

As 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 reduce the supervisee's tension. It should then be periodically revised. According to Carroll [30] and Van Ooijen [31], supervisory roles and tasks should be combined, in order to achieve desirable outcomes. Some of the tasks can be rendered more explicit in a contract. In addition, Proctor [29] suggests that one of the first tasks is the establishment of the supervision contract to both determine explicit needs, commitment and fields of interest and to provide a clear, safe and honest agreement.

Carroll [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'. Carroll [25] reports that he usually uses an oral contract but also utilises a form of written contract. He has 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 both supervisor and supervisee 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 as 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 '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] states 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 the 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 by high levels of anxiety and, dependent on the supervisor, has concerns 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. According to Porges [35], it is likely that in the case of insecure attachment, where fear

plays an important role, the social engagement system is deactivated. Anxiety can hinder personal development; as such, an emotional burden reduces the accurate symbolisation level significantly, 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 takes control through GABAergic activity, the hippocampus and the 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, it is only then that the supervisee can start to discuss their client. The supervisee may slowly approach their view on, and 'truths' from, their sessions. This process promotes reflective learning, enriches meanings, increases motivation and deepens the practitioner's knowledge. Thus, in this work, there can be no set agenda. There can be an agreement for partitioning the supervision session; however, in time, there may be discussions on session notes, as well as acknowledging and descriptively praising the therapeutic shifts observed.

When the client's worries increase the supervisee's anxiety, the supervisor can listen to selected session recordings. This is done to understand, to symbolise the emotional context of difficult moments and 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 described above, and Skovholt and Rønnestadt [40] define it as a process with three aspects: 'ongoing professional and personal experiences; a searching process with others within an open and supportive environment; and an active reflection about one's experiences'. Johns and Freshwater [39] propose a model for structured reflection (MSR), consisting of specific questions that can be useful for the supervisee in order to trace therapy obstacles and personal 'hotspots'. 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 the facilitation of the supervisee's experiences and thoughts; this is the main difference from 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 directive, 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 generalisations' [42]. Allstetter-Neufeldt [43] proposes that a supervisee should be encouraged to 'develop hypotheses about the client', in order to conceptualise the case. Encouragement is not often utilised within a person-centred supervision process; we acknowledge, however, that it does permit the supervisee to be 'the one who knows'. When a supervisee reflects and conceptualises, they create an environment (both in themselves and in the room) in which they undertake new therapeutic initiatives and actions. Ornstein

[44] argues that the right brain is responsible for concrete experiencing, whilst the left-brain function concerns abstract conceptualisation.

The supervisee's learning style is important too [45]. They learn about 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 mainly comprises the timbre, speed, 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 or empathic reactions, as well as process-directive or content-directive interventions, can also be discussed ad hoc [41,48]. The supervisor can show this through 'modelling' the 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. However, we are concerned with *the means by which*, or the way in which, other (experiential) learning may take place. Carroll [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 the 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 in academic measures, intelligence quotient (IQ), disciplinary problems and creativity through facilitated experiential learning. So, dependent on the 'contract', the 'supervisee' and the 'client', the person-centred supervisor may promote experiential learning through a 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, neuro-endocrinology and epigenetics, which are essential to understand the reactions of the body in psychotherapy
- discussion of common ethical issues and dilemmas through reading papers and articles [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
- discussion of specific subjects, like client outcomes and developments in anger management [54], stress management, parental skills, etc.

5.4. Supervision in groups

Despite the obviously essential interpersonal 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 them with their difficulties. The supervisor can acknowledge with descriptive praise their efforts to bypass their obstacles. This seems to give them confidence and helps them to 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 to supervision [55]. They recommend that clinical supervision should be provided for anyone offering services that are therapeutic. They state that supervisors must model high levels of good practice regarding 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 clients.

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 that the client is not receiving 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 the use of empathy, honesty and warmth when working with the developing supervisee (therapist) will result in the supervisee's development. The therapist will then subsequently 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 herself/himself using tools such as SWOT (strengths, 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, as Carroll [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 more 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.

Rogers [8] stated that counsellors have an ethical choice of values [58]. However, what are the principles by which we can judge whether certain behaviours lie outside ethical boundaries? This is obviously by no means clear or uncontroversial. The duty of the physician to their 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 also add autonomy, fidelity and justice as principles to guide us with ethical dilemmas.

In a 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. These aspects 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 aspects, but others are more problematic, such as the suggestion that a virtuous psychotherapist should engage in supervision (and seek advice and guidance). These latter points (in brackets) are contained within the same bullet point. It is 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 a virtuous psychotherapist should work with various principles: 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 commit 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 that 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 Scaife [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 parties. This is because the involved others will have received a false alarm, and the confidence in the therapist–client relationship is likely to be compromised. On the other hand, if the client has decided to harm themselves and the supervisee has succeeded in warning others after the supervisor's suggestion, then her/his relationship with the supervisor will be reinforced, although it 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 people. 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, the fidelity between the client and the supervisee will very likely be negatively affected, especially if the client considers the therapist's act as a breach of confidence and not as a protective act. Justice will 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 for the least harm. Obviously, such ethical principles are only notions that 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 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. 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 his practice. Several times since then, he has worked with clients who declared an intention to harm themselves or other people, and he (the author) realised that he was often reluctant to breach confidentiality.

Breaching confidentiality (in relationships with clients and supervisees) is a major dilemma that must be examined ad hoc, as such an act can or will disrupt the fidelity within the therapeutic and supervisory relationships. One approach is to draw on the framework offered in the UKCP ethics consultation document, which suggests that a practitioner and supervisor could move through acknowledging/recognising, understanding the impact, taking responsibility for what is known, demonstrating outcomes and, finally, implementing new learning. This framework would be used whilst taking into account the notion of the virtuous psychotherapist and the principles mentioned previously.

Another ethical problem arises through the different (ethical) codes that are applied in medicine and psychotherapy concerning confidentiality. Within the medical model, certain members of clinical staff have agreed access to the medical record of every patient. On the contrary, in psychotherapy, confidentiality is very strict, as 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. It becomes very difficult for the psychotherapist (and supervisee) to work out what to document and what to leave undocumented. This is especially pertinent 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 educative and philosophy-of-life-oriented supervision have been untangled. Supervision using the latter is accomplished mainly through a relationship and an experiential process and is 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 therefore is to respect the supervisee's own internal power and focus upon their personal and professional development. We trust that every therapist has their own resource(s) 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** of person-centred supervision, it is proposed, amongst others:

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

Furthermore, reflective discussion is essential, targeting the approach methods, the therapeutic process, the therapist's countertransference and 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 the cornerstones of supervisory work and in the experiential learning process.

Learning may comprise **focusing** methods, **psychobiology** and reactions of the body in psychotherapy, and **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 – amongst others – two elementary qualities. Firstly, it examines 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 would be interesting to examine in a future paper the use and application of person-centred supervision with both supervisees who specialise in the use of other psychotherapeutic approaches and those who work in both medicine and education.

8. CONSENT

Not applicable.

9. ETHICAL APPROVAL

Not applicable.

10. COMPETING INTERESTS

No competing interests exist.

11. REFERENCES

1. Bernard J and Goodyear RK. Fundamentals of clinical supervision. Boston, MA: Allyn & Bacon. 2004.
2. Carroll M. Key issues in coaching psychology supervision. The Coaching Psychologist. 2006 May;2(1):4-8.
3. Loganbill C, Hardy E, Delworth U. Supervision: A conceptual model. The Counseling Psychologist. 1982.
4. Goodyear RK. Psychotherapy supervision by major theorists [Videotape series]. Manhattan, KS: Kansas State University Instructional Media Center. 1982. Cited in: Allstetter-Neufeldt, S. A. Supervision strategies for the first practicum. American Counseling Association. 1999. Bernard JM. Goodyear
5. Doehrman MJ. Parallel processes in supervision and psychotherapy. Bulletin of the Menninger Clinic. 1976 Jan 1;40(1):4-104.
6. Patterson CH. Supervision in counseling: II. Contemporary models of supervision: A client-centered approach to supervision. The Counseling Psychologist. 1983.
7. Rogers CR. Client centred therapy. Constable, London. 1951.
8. Rogers CR. On becoming a person Boston. MA: Houghton Mifflin. 1961.
9. Purton C. Person-centred therapy: The focusing-oriented approach. Palgrave Macmillan; 2004 Oct 29.
10. Mearns D. Person-centred counselling training. 2nd Edition. London. Sage. 2003.
11. Bozarth JD. Person-centered therapy: A revolutionary paradigm. Ross-On-Wye. PCCS Books. 1998.
12. Inskipp F, Proctor B. The Art, Tasks and Crafts of Counselling Supervision. Part 2: Becoming a supervisor.
13. Patton MJ, Kivlighan Jr DM, Multon KD. The Missouri Psychoanalytic Counseling Research Project: Relation of changes in counseling process to client outcomes. Journal of Counseling Psychology. 1997 Apr;44(2):189.
14. Villas-Boas Bowen MC. Personality differences and person-centered supervision. Person-Centered Review. 1986 Aug.
15. Lambers E. Supervision in person-centered therapy: Facilitating congruence. Person-centered therapy today: New frontiers in theory and practice. 2000:196-211.
16. Bordin ES. Supervision in counseling: II. Contemporary models of supervision: A working alliance based model of supervision. The Counseling Psychologist. 1983.
17. Horvath AO, Greenberg L. The development of the Working Alliance Inventory: A research handbook. Psychotherapeutic processes: A research handbook. 1986:529-56.
18. Holloway E. Clinical supervision: A systems approach. Sage; 1995 Jun 16.
19. Alpher VS. Interdependence and parallel processes: A case study of structural analysis of social behavior in supervision and short-term dynamic psychotherapy. Psychotherapy: Theory, Research, Practice, Training. 1991;28(2):218.
20. Patton MJ, Kivlighan Jr DM. Relevance of the supervisory alliance to the counseling alliance and to treatment adherence in counselor training. Journal of Counseling Psychology. 1997 Jan;44(1):108.
21. Ramos-Sánchez L, Esnil E, Goodwin A, Riggs S, Touster LO, Wright LK, Ratanasiripong P, Rodolfa E. Negative supervisory events: Effects on supervision and supervisory alliance. Professional Psychology: Research and Practice. 2002 Apr;33(2):197.
22. Miller GR Explorations in interpersonal communication. London: Sage. 1976.

23. Angus L, Kagan F. Empathic relational bonds and personal agency in psychotherapy: Implications for psychotherapy supervision, practice, and research. Psychotherapy: Theory, Research, Practice, Training. 2007 Dec;44(4):371.
24. Riggs SA, Bretz KM. Attachment processes in the supervisory relationship: An exploratory investigation. Professional Psychology: Research and Practice. 2006 Oct;37(5):558.
25. Carroll M. Effective supervision for the helping professions. SAGE; 2014 Jun 28
26. Hawkins P, Shohet R. Supervision in the helping professions: an individual, group, and organizational approach. Milton Keynes [England]. 1989.
27. Bond T. New challenges for professional ethics and good practice guidelines for counsellors, psychotherapists and counsellors. Cited in Jenkins P. A consideration of the new BACP Ethical Framework and its implications. Dec 2015. Accessed 29 August 2016. Available: http://counsellingni.co.uk/2015/12/consideration-new-bacp-ethical-framework-implications/
28. Whitman SM, Jacobs EG. Responsibilities of the psychotherapy supervisor. American journal of psychotherapy. 1998 Apr 1;52(2):166.
29. Wosket V, Page S. The cyclical model of supervision. Integrative approaches to supervision. 2001 Mar 30:13.
30. Carroll M. Counselling Supervision: Theory. Skills and Practice. 1996.
31. Van Ooijen E. Clinical supervision: a practical guide. Churchill Livingstone; 2000.
32. Proctor B. 3 Training for the supervision alliance. Routledge Handbook of Clinical Supervision: Fundamental International Themes. 2010 Oct 6:23. Accessed: 7th August 2016. Available: https://www.routledgehandbooks.com/doi/10.4324/9780203843437.ch3
33. Scaife J. Supervision in the mental health professions: A practitioner's guide. Psychology Press; 2001.
34. Stoltenberg CD, McNeill B, Delworth U. IDM supervision. San Fransico: Jossey-Bass. 1998.
35. Porges SW. The polyvagal theory: phylogenetic substrates of a social nervous system. International Journal of Psychophysiology. 2001 Oct 31;42(2):123-46.
36. Siegel DJ. The Mindful Therapist: Attunement. New York (Norton) 2010.
37. Creswell JD, Way BM, Eisenberger NI, Lieberman MD. Neural correlates of dispositional mindfulness during affect labeling. Psychosomatic Medicine. 2007 Jul 1;69(6):560-5.
38. Kolb, DA. Experiential Learning: Experience as the Source of Learning and Development, New Jersey: Pearson. 1984
39. Johns C, Freshwater D, editors. Transforming nursing through reflective practice. John Wiley & Sons; 2009 Feb 5.
40. Skovholt TM, Rønnestad MH. The evolving professional self: Stages and themes in therapist and counselor development. John Wiley & Sons; 1995.
41. Tudor K, Worrall M, editors. Freedom to Practise: Developing Person-centred Approaches to Supervision. PCCS Books; 2007.
42. McMullan WE, Cahoon A. Integrating abstract conceptualizing with experiential learning. Academy of Management Review. 1979 Jul 1;4(3):453-8.
43. Allstetter-Neufeldt, SA. Supervision strategies for the first practicum. American Counseling Association. 1999.
44. Ornstein RE. The psychology of consciousness. 1972. Cited in : McMullan WE, Cahoon A. Integrating abstract conceptualizing with experiential learning. Academy of Management Review. 1979 Jul 1;4(3):453-8.
45. Honey P, Mumford A. Using Your Manual of Learning Styles. Maidenhead, Berkshire. 1986
46. Rogers CR. The necessary and sufficient conditions of therapeutic personality change. Journal of consulting psychology. 1957 Apr;21(2):95.
47. Mearns D, Thorne B. Person-centred therapy today: New frontiers in theory and practice. Sage; 2000 Aug 25.
48. Rice LN. The evocative function of the therapist. Innovations in client-centered therapy. 1974:289-311.
49. Rogers CR. Freedom to Learn for the 80's. Charles E. Merrill, Columbus, OH. 1983.
50. Aspy, D.; Roebuck, F. Our research and our findings. 1969. In: Rogers, C. R. Freedom to learn: a view of what education might become, p. 199-217. Columbus, OH, Charles E. Merrill. Columbus, OH. 1983.
51. Gendlin, ET. Focusing. new York: Everest House. 1978.

52. Dryden W. Therapists' dilemmas. London, Sage. 1997.
53. Tribe R, Morrissey J, editors. Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists. Routledge; 2015 Jan 30.
54. Callifronas MD, Kontou G. Psychoeducative Programme in Anger Management. J Psychol Psychother. 2016;6(237):2161-0487.
55. British Association for Counselling and Psychotherapy (2016) Ethical Framework. Extracted No 50- 61. Available at: http://www.bacp.co.uk/ethical_framework/supervision.php
56. Davenport DS. Ethical and Legal Problems With Client-Centered Supervision. Counselor Education and Supervision. 1992 Jun 1;31(4):227-31.
57. Bernard JM, Goodyear RK. Fundamentals of clinical supervision. 1998. Cited in Allstetter-Neufeldt, SA. Supervision strategies for the first practicum. American Counseling Association. 1999.
58. Steen RL, Engels D, Thweatt III WT, 2006. Ethical aspects of spirituality in counseling. Counseling and Values, 50(2), p.108.
59. Hippocrates. Epidemics, Book I, Ch. 2. 400 BC. (translated by Francis Adams, 1849). Accessed: 21 July 2016. Available at: https://en.wikiquote.org/wiki/Hippocrates#Oath_of_Hippocrates_.28c._400_BC.29 , and http://classics.mit.edu/Browse/browse-Hippocrates.html
60. Page S, Wosket V. Supervising the counsellor: A cyclical model. Routledge. 1994. Cited in: Scaife, J. (2001) Supervision in the mental health professions: A practitioner's guide, Psychology Press
61. United Kingdom Council for Psychotherapy (2016) A new code of ethics for the UKCP. Consultation Document. June. Available at: http://www.ukcp.org.uk/UKCP_Documents/consultations/New%20draft%20code%20of%20ethics/A%20New%20Code%20of%20Ethics%20-%20draft%20consultation%20document.pdf
62. Bernard JL, O'Laughlin DL. Confidentiality: Do Training Clinics Takes it Seriously. Law & Psychol. Rev.. 1990;14:59.
63. Buber M, Rogers CR, Anderson R, Cissna KN. The Martin Buber-Carl Rogers dialogue: A new transcript with commentary. SUNY Press; 1997.