3 Training for the supervision alliance
Attitude, skills and intention

Brigid Proctor

This chapter focuses on the ‘supervision alliance model’. It was originally presented in *Fundamental Themes in Clinical Supervision* (Proctor 2001: 25–46) and in this book we offer an edited version of the chapter. It now offers a brief description of the key components of the model, and then explores the training process the author uses and the open learning structure. Brigid Proctor’s model is perhaps the most commonly used clinical supervision model within health care. It is based on very important and seminal works and is, therefore, a classic and timeless model. For those interested in the development of the model, its antecedents and a detailed discussion of its foundational elements, it is well worthwhile to refer to the author’s exposition in *Fundamental Themes in Clinical Supervision*.

We believe that this is an important chapter for any practitioner interested in clinical supervision. Because the model has been very popular, not all representations of it are fair or accurate. It is then, very interesting to note that Brigid herself highlights that the principal function of her model is its supportive function. Effective supervision requires a supportive underpinning as the foundation upon which the formative and normative aspects of supervision are built.

A model geared to practice

*Practitioners – of supervision and health care – need support and help in ‘seeking virtue and embracing wisdom’ in a complex and multi-cultural world. One way they can get this is by being offered regular space to reflect on their moment-to-moment practice.* The picture in Figure 3.1 sketches the outline of the supervision alliance model transposed into health care settings. *Editors’ comment: These values and assumptions have been discussed in detail in Fundamental Themes in Clinical Supervision (Proctor 2001: 25–46).*

Contracts and agreements

*The overall contract*

The model emphasises that clinical supervision always involves more than two stakeholders. All have a right to be respected in the process of clinical supervision. However, the central figures are, first, the recipient of the supervision – the practitioner. In the world out there, he or she is the channel through which the service is offered – the public face of the service and a person in his or her own right.
Second, there is the supervisor who is responsible for creating a climate and a relationship in which the practitioner can reflect on his or her practice within clear boundaries of freedom and responsibility.

Those clear boundaries are first set by the contract that the employer makes with the supervisor and practitioner as to the purpose and manner of clinical supervision in a particular context. This will necessarily be bounded by guidelines or codes regarding wider professional ethics and practice.
The working agreement

Within the overall contract, I suggest that a working agreement for a particular supervision alliance is made between supervisor and practitioner. At one level, its clarification and negotiation is practical, identifying such key matters as responsibilities and roles, contextual factors, administrative arrangements, supervisor’s methods of working in supervision, practitioner’s developmental needs and learning goals, preferred learning styles, and supervisor and practitioner resources. At another level, it is a shared process of clarification and negotiation that begins to establish the degree of trust, safety or wariness there may be in this relationship and to shape a suitable working climate.

A working relationship

The contract and the working agreement are not seen as bureaucratic devices, but as a means of establishing sufficient safety and challenge. The overall contract signals continuing accountability to the other stakeholders in the supervision enterprise – this is both opportunity and responsibility to mature in practice and offer a better service. The working agreement signals the co-operative nature of the enterprise and the complementary roles of each party. The process of discussing and establishing the alliance is the vehicle through which an intentional and unique relationship is initiated between this particular practitioner and this particular supervisor, in this particular context.

Tasks and tension of clinical supervision

This brings us to the best known feature of the model – the complementary but sometimes contradictory tasks of clinical supervision – normative, formative and restorative. In health care contexts, the constituent tasks of supervision should probably be transposed.

- Clinical supervision will be a major opportunity for professional and, hopefully, personal refreshment so the restorative task in these stressful times should, I think, be placed first. If supervision is not experienced as restorative, the other tasks will not be well done.
- Second, the opportunity to become increasingly reflective on practice, and to learn from one’s own experience and the experience of another qualifies clinical supervision as a uniquely formative process.
- Whereas in counselling contexts supervision may be the major forum of professional accountability, in most health settings there will be other places where account is rendered. Nevertheless, there will necessarily be self-monitoring elements to the work, for the practitioner. At best, clinical supervision is the safe enough setting where he or she can share and talk about practice and ethical dilemmas without jeopardising him- or herself.

The supervisor has responsibility for making clear his or her own criteria of good practice, and comparing that with the practitioner’s perspective. She/he may nevertheless have to decide to take things further if they consider or suspect that the practitioner continues to practice unwisely or unethically. So, for both practitioner and
supervisor, clinical supervision will always be a forum where normative issues are addressed and engaged with and the supervisor may, very occasionally, become a whistle-blower (see Cutcliffe et al. 1998a, 1998b).

By whatever means clinical supervision is distinguished and detached from formal managerial assessment procedures, this element of monitoring will be present and both practitioner and supervisor will need to recognise the tension between the restorative and the normative tasks. In training, most supervisors and supervisees find it difficult to develop the ability to manage this tension skilfully and with integrity within a single role relationship.

Role flexibility

Each task carries attendant informal roles, which will be reciprocal for practitioner and supervisor. It can be helpful for both to recognise this, because it allows them to ‘play’ at relating flexibly and appropriately to the task they are engaged in at any one time. Figure 3.1 suggests a number of complementary roles, and we have already seen that aspects of the ‘preceptor-initiate’ and the ‘mentor-evolving practitioner’ dialogue may also find a place in supervision (Morton-Cooper and Palmer 2000).

However, the overall role responsibilities are those of supervisor and supervisee (or practitioner-in-supervision) as negotiated in the working agreement for the supervision. Any settling down into a single set of roles (for instance, taking only restorative roles or falling regularly into a teacher-learner dyad) will not be fulfilling the working agreement.

Attitudes

Attitudes are the outward expression of what we value and understand. We engage in tasks with certain attitudes towards them, based on the values we consciously or unawarely espouse, and also on the understanding we have about them. A supervisor who uses this model needs to understand the underlying values of working in alliance (as opposed to hierarchically) and be prepared, at least, to test these values out in his attitude to the task. For instance, he needs to believe that agreements are co-operative, and act on that. He has to assume that the practitioner he is supervising has good will to her work, at least until he has clear evidence to the contrary. He has to understand that clarity of roles and responsibilities is a safeguard against oppressive supervisor (or supervisee) behaviour. He has to ‘act in’ to the understanding that this is a human relationship between two (or more) adult practitioners, rather than, say, a pedagogic relationship between master and pupil. A human relationship implies that either party may feel, and be, vulnerable within the relationship from time to time, so attitudes towards vulnerability need to be accepting and helpful, for the well-being of both participants and for the furtherance of the task of supervision.

The practitioner coming for supervision, in turn, has to develop certain attitudes to the task if she is to make good use of her opportunity for reflection and learning. These attitudes may be unfamiliar and countercultural. The title ‘supervisor’ has strong hierarchical connotations. A practitioner new to this kind of clinical supervision may have well-founded scepticism of being apparently trusted and valued as an equal contributor. The first initiation in clinical supervision will be crucial in allowing practitioners to get a feel for the potential of this unfamiliar process.
Interpersonal communication and reflective skill

These are examples of implications of the model’s values for appropriate attitudes. But even if supervisor and supervisee identify with those values and have a similar understanding of the tasks they are engaged in, their lack of skill in communicating in this rather unusual interpersonal arena may still defeat their intentions. Attitudes are what the ‘receiver’ sees, hears and imagines, not necessarily what the ‘protagonist’ intends or imagines. So the final strand to this model is the spelling out of specific jobs which need to be done within the overall tasks and the micro-skills which the supervisor and practitioner need to have at their disposal if they are to do ‘this supervision alliance stuff’ well.

Both parties need the skills which go with his or her job. For the supervisor, there are the jobs and skills of:

- **climate building**, through setting up a physical environment which is welcoming, inviting information, listening without prior judgment or prejudice, checking what has been heard, sharing appropriate information, gauging the degree of appropriate formality/informality for this practitioner, licensing lightness and humour;
- **clarifying and negotiating the contract and working agreement**, through the key skills of clear *purpose stating* (‘we/you must’) and *preference stating* (‘you/we may’) as well as listening, clarifying, and checking shared understanding;
- **furthering the supervision process**, using all of the above skills, plus
- **challenging** in an authoritative (as opposed to authoritarian) manner; *giving and receiving feedback* – both evaluative and non-evaluative; acknowledging and respecting experiences and feelings; for instance, distress, vulnerability, confusion, anger, shame, guilt, remorse, pride, pleasure; *co-managing agreements* within boundaries – time management, reviews, administrative responsibilities.

For the supervisee, there are also jobs and accompanying skills to be developed. Consisting of ability to reflect and skill in communicating, these include:

- **preparing** for supervision, including log-keeping; identifying puzzling, interesting or upsetting experiences which could benefit from reflection; setting priorities;
- **presenting issues** in a way that makes them accessible and lively to herself and to her supervisor and is economical of time;
- **setting** and monitoring learning aims;
- increasingly being *open* to the supervisor’s perspectives, and being able to discriminate what is useful;
- being *open to feedback*, and learning to identify if it is useful, and if necessary, to ask for no more at the moment;
- **giving feedback** to the supervisor, both spontaneously at the time when some response is helpful or confusing; and in a more considered way, at reviews.

The range and flexibility of communication asked for by this model is quite formidable when spelled out in this way. Either or both parties may already be skilled in this sort of relationship and process and everyone will have a range of transferable assets. However, in such a time-limited situation, which by its nature needs to
feel unhurried and to offer space for reflection, acquiring unselfconscious competence takes time, attention and openness to feedback.

**Box 3.2 Supervision skills for helping practitioners reflect, learn and change**

This framework for the Helping Process is adapted from the work of Gerard Egan (1994). It is based on the systematic processes of **Exploration, Deeper Understanding, Action** – usually though not necessarily in that order. It is a useful compilation of helping skills derived from a wide range of sources which can be used flexibly. There are other frameworks – e.g. the 6 Category Intervention Model, Heron (1990) – which can be used in its place within the wider model.

**Exploration**
- Listening empathically
- Reflecting back what has been heard about the experience being described, in its subjective and its objective aspects
- Clarifying, paraphrasing and summarising what has been heard

**Deeper Understanding**
- Enabling the storyteller to focus in a way that makes for increased understanding
- Exploring and developing the story through, for instance:
  - open-ended questioning
  - awareness-raising enquiry – thinking, feeling, sensation, imagining etc.
  - deeper level empathy – testing hunches
  - making connections
  - offering alternative perspectives
  - informing
  - challenging
  - confronting.

**Action**
- Enabling appropriate action through, for instance:
  - envisaging outcomes
  - exploring options
  - cost-benefit analysis
  - rehearsing
  - considering unintended consequences
  - goal setting
  - action planning.

**The training process**

Training is a slightly misleading word. The task is ‘to assist practitioners to use the reflective opportunity of clinical supervision’ or ‘to assist the formation of clinical supervisors’. It is not ‘about’ supervision, but about learning ‘how to do it well’. Clinical supervision is a process which has no set procedures or regimen like many
practical disciplines. It depends for its success on the attitudes, qualities and interpersonal skill of the participants.

How educators assist participants to develop supervision skill, in usually very limited time, will depend on the particular skill, experience and qualities that they bring and the resources and experience that course participants bring. The guidelines and methods offered here are those which my colleagues and I use and adapt for differing course formats and participants. Box 3.3 outlines those guidelines and methods.

The training experience

Excellent working alliances between more and less experienced workers are still relatively rare in work settings that are systematically hierarchical. This is not because workers and managers, or other senior colleagues, are inherently incapable of working co-operatively. Rather, the culture trains us in role behaviour which is appropriate to hierarchy, and can appear to punish us if we experiment with more co-operative relating. If clinical supervision is to be welcomed rather than mistrusted, these residual attitudes have to be counteracted.

So I conclude that the experience of the supervision course will be the major learning medium.

Box 3.3 Guidelines and methods for facilitating the development of supervisors and practitioner/supervisees

We seek to:

• Offer a training experience which consciously models co-operative working on tasks, values, attitudes and skills.
• Make careful working agreements for the course and respect them; and spend time on creating a culture of participation, safety and challenge.
• Offer opportunities for progressive development – that is, first offer participants good clinical supervision (or audio/videotaped examples) and encourage them to practice attitudes and skills for using supervision well; subsequently offer opportunities for developing the abilities for supervising.
• For those who necessarily start at ‘supervisor’ level, we still begin with the skills for using supervision.
• Encourage preparation through Open Learning Materials. These include:
  – simple and graphic theoretical frameworks
  – audio or video examples of the process and skills of supervision, acting as a trailer for the subsequent course
  – simple and inviting self-awareness exercises which can help participants realise that they will be expected to develop self-awareness and self-management.
• Offer opportunities to learn by experience and by doing: so courses – even one day courses – will include:
  – experiential exercises, to help people know from inside what the theory is talking about; attitude and skills modelling; and practice with feedback
  – skills modelling allows for people to see for themselves what is being talked about; practising with feedback in a safe-enough setting develops skill and self-awareness.
Careful working agreements

As in supervision, safety is created by clear and open statements of set parameters and honest negotiation of what is negotiable. Overall course aims, content and any assessment methods and criteria, the extent of the staff members’ responsibility and the members’ responsibilities for their own learning, and the limits of staff confidentiality, can be stated ahead of time. This is the direct equivalent of the clinical supervision contract.

The working agreement is paralleled by inviting participants to share and then write up the kinds of ground rules they would like in order to make this a learning forum which would be both safe and risk-taking enough for them. Special needs are identified, and participants told that they will be invited to join in experiential exercises. They are also told that they can choose not to join in these and this will be honoured. They will be offered alternative ‘observer’ tasks, which again they have choice about taking. Time is given to set and share their own personal learning aims for the course. These aims may be shared publicly on flip chart, or shared only with a partner or small group. Either way, time is allowed for revisiting the aims along the way and at the end of the course.

As with the clinical supervision alliance, this process serves a practical purpose while it also allows the rapid building of a culture and relationship suitable for this group to work well.

Progressive development

Learning about using supervision is always the first step in becoming a supervisor within the supervision alliance model. We have found that informed and skilled supervisees can work well even if their supervisor is new to the role or feels less than expert. Supervisors who have experienced good supervision have already done much of the crucial learning they need in order to offer fruitful working alliances (Cutcliffe and Proctor 1998a, 1998b) and have increased awareness of the potential vulnerability of the supervisee role.

Open learning materials

Editors’ comment: In Fundamental Themes in Clinical Supervision, Proctor (2001: 25–46) suggested using open learning materials such as those created and produced for counsellors (Inskipp and Proctor 1993, 1995, 2nd edition revised 2009). They consist of short blocks of information; self-management, self-awareness and practice exercises; and extensive audiotaped (now on CD) illustrations and discussions.

Subsequently, those materials have been revised and re-edited and the authors have also produced two DVDs and an accompanying booklet, Creative Group Supervision (University of Wales, Newport).

Experiential and creative exercises

Creative exercises are those that invite participants to engage senses rather than just words. The object is to help people access what they ‘know’, which they had not
realized. So, for instance, we often ask participants to create the supervision alliance model (as depicted in Figure 3.1) as kind of sociogram. The method is described in Box 3.4.

**Box 3.4 Experiential portrayal of the Supervision Alliance Model**

Having made name cards for all the characters and words in the picture (see Figure 3.1) we invite participants in turn to take a card, starting with the patient (or client), and to take up a position in the centre of the room. Moving through supervisor, professional manager, Trust manager, GNC, to positions representing the working alliance, the contract, normative, formative and restorative tasks – and so on (depending on available numbers, of course.) until all who choose to join in have a position. When all are in their chosen place, they speak for that role and reflect on what they realise when standing in that position. The exercise sounds complicated, but in practice is simple to set up.

It is invariably surprising, enlightening and humbling to hear the various insights.

**Box 3.5 Experiential and creative activities**

*Exploring resources*

Mull over your network of colleagues, friends, family, supervisor, other professionals etc. and identify and write down who or what could meet the needs listed.

1. Sharing your work in confidence;
2. Getting feedback/guidance;
3. Developing professional skills, ideas, information;
4. Letting off steam if you are angry, discouraged, fed-up;
5. Acknowledging feelings of distress, pleasure, failure etc.;
6. Feeling valued by those you count as colleagues;
7. Widening your horizons;
8. Increasing your physical, emotional or spiritual wellbeing.

(There follows some suggestions, including dog/cat, your local community organisations, yoga, political activity)

- Which needs do you consider well enough met at the moment?
- Which of them are, or might appropriately, be met in supervision?
- Which need some topping up?
- How might you do this?
- Which are not at all well met?
- How might you meet them within your available resources?
- Have you other professional needs?

(These questions can also be used in a kind of musical questions exercise to break the ice near the start of a course. Participants mill around and when the music stops, speak about one of the questions with their nearest neighbour for half a minute. Then the music starts again and at the next stop, the next question is discussed. It invariably produces quite a buzz.)

Adapted from Inskipp and Proctor (1995, 2nd ed. 2009)
Attitude and skills practice with feedback

Since one of the most difficult learnings for beginning supervisors seems to be managing formative, restorative and normative tasks within the same alliance and relationship, recognising what it takes, behaviourally and emotionally, to challenge authoritatively while remaining respectful and empathic is a first step. Developing verbal range and accuracy for communicating differing intentions follows from that. Instant feedback, about the impact on the receiver of the way chosen, or better still, on oneself when hearing or seeing video or audio recordings – is invaluable.

Participants who are learning to be supervisors need to have seen and heard a variety of supervisory interventions which illustrate specific micro-skills either on the course or in pre-course materials. When they recognise what is expected, they can go on to find ways of using those interventions in their own style and manner.

Feedback skills are some of the first that need modelling and playing with. Giving and receiving feedback and ground rules for making feedback useful are essential for both supervisee and supervisor in the working alliance and they are also a requisite for fruitful skills learning on the course.

Doing supervision

To enable participants to develop their version of a helping process in supervision, we set up structured exercises for practicing particular responses. Since supervising puts pressures on the supervisor to find solutions, we focus on reminding people about the skills of reflecting, paraphrasing and summarising what is being talked about, the exploration phase, before moving into focusing and action. It is this that encourages the practitioner to ‘hear’ what she is saying and begin to ponder and reflect.

Focusing

We have developed ways of thinking about and practising a variety of focus points to aid deeper understanding in the supervision process. These are based on the process model of Hawkins and Shohet (1989). However, I believe that a framework for focusing in settings in which practitioners are not solely, or predominantly, concerned with interpersonal issues needs to be developed. For instance, at any particular time, would it be helpful to focus on the practical aspects of a situation, on issues of responsibility, on interpersonal dilemmas, on the practitioner’s feelings or thinking at the time, or on the buttons which the issue had pressed for her? Without an awareness of the range of possible foci, supervisors tend to become routine in the areas they focus on or the factors or perspectives they ignore.

Having noticed the range of possible foci, it is also important to raise awareness about how focus is determined. Experienced practitioners, when developing as supervisors, tend to feel it is their responsibility to identify and pick a focus for the supervisee. However, the alliance model entails reminding them that this need not – often should not – be the case. Needs will differ with the developmental stage of the practitioner, but increasingly supervisees should be able to respond to an offer of choice of focus points, and often themselves determine where the appropriate focus lies. If, in training to use supervision, a framework of possible foci is given to them, they will quickly become more self-directing.
Action

Skills for encouraging action planning can also be taught specifically before being incorporated in supervision practice.

Practicing ‘doing supervision’

To enable participants to juggle with the responsibilities of setting up working agreements, ‘doing supervision’, monitoring learning aims and reviewing, we encourage practice for real with a partner or in threes. Where time is limited, live peer practice between course sessions can be taped and used for identifying particular skills or tracking the course of a specific piece of supervision work. The tape can also include feedback and comments from the supervisee and observer, if there is one.

Changes that are to do with the way we are with other people can be uncomfortably close to the bone if they call into question our sense of self. For experienced practitioners, especially, changing may mean acknowledging shortcomings of which they were previously unconscious. Self-conscious incompetence is very painful. That is why it is so important to allow for free choice on a course and why time is well spent in helping people identify what is in it for them in learning to become a competent supervisee or supervisor. This means acknowledging and accepting reluctance, incomprehension and resentment.

However, like supervisors, educators and trainers are also in an advocacy relationship for the off-scene stakeholders – employers; professional colleagues; and, most particularly, patients, clients, or whatever. While accepting and understanding reluctance, they also have a responsibility to speak for the obligation to offer our best service. Becoming competent at offering and using opportunities to reflect on practice can be both personally and professionally rewarding.

In summary

This supervision alliance model spells out aspirations and tensions which will be inherent in non-hierarchical (or co-operative) supervision, wherever it is practiced. The training programme outlined is extensive. It can be offered in progressive modules which need to be adapted for specific contexts. Experience suggests that the learning opportunity offered is of use in many settings other than clinical supervision.

For some trainers, and some participants, aspects of it might be quite alien and unhelpful. However, any training which results in the good use and provision of the kind of clinical supervision advocated in this book will necessarily have to address, in some way, appropriate attitudes and skills, and offer frameworks which make clear the intentions behind the complex task of clinical supervision.

References


