

How My Supervision Impacts Upon My Practise

First and foremost - and in keeping with client-centred beliefs - I mostly take *me* to supervision. So it is probably more accurate to title this: -

'How My Supervision Impacts Upon Me... ...And How I Then Relate With Clients'.

Before I illustrate what I mean by the above, let me note some other aspects of supervision: -

- I use supervision to monitor and manage practical aspects of my client work, such as ensuring an appropriate case load with adequate time (currently three hours a month) allocated for supervision;
- I use supervision to explore and check out any ethical issues that have arisen or that could potentially arise;
- I use supervision to learn from the issues shared by my colleagues - it is inevitable that what they share has some meaning and value for me.

In my original submission for reinstatement of my accreditation, I included (and still include) an article that illustrates how I link my way of being with clients to client-centred theory - and this is a very important aspect of supervision for me. (Incidentally, I consider my knowledge of client-centred theory to be extremely in depth, and I experienced previous supervisors as less knowledgeable. This is one reason why I really appreciate being in a group with Alison, as her knowledge is profound, too.)

When I meet with a client - whether it be a first session or an ongoing session - I strive to come as close as I can to *being* the client-centred core conditions: being congruent, and the client receiving unconditional positive regard and empathic understanding from me. This is a primary focus in supervision - maximising the extent to which I can be authentically respectful and empathic.

If we take the example of the client in *Client-Centred Therapy: Conditions, Process and Theory*, I had engaged in a considerable amount of self-reflecting on my practise *prior* to supervision, as I am not one of those who simply turns up and processes only when *in* supervision! (My peers are frequently heard to say things like 'You've clearly thought about this a lot already...') In supervision, I explored the different 'configurations of self' or personal constructs that the client had shared with me. This, I believe, enhances my capacity to empathise and understand.

However, there is another, more important step for me: once I have explored the nature of my client's psyche, I will then explore myself - with specific reference to the client-centred core conditions - in relationship with each of the client aspects that have been identified. For instance, might I find that I am experiencing more compassion for 'Mr Softie' than for 'Mr Ogre'? If this is so, why? And what can I do about this?

I learned a long time ago - in large part though not exclusively through supervision - that a kind of 'natural tendency' of mine was to lean towards offering more to a person's "inner victim" than to a person's "inner perpetrator" - and that this hardly represented *unconditional* positive regard, and nor did it do full justice to my empathic abilities. Further exploration of such issues also led me to the conclusion that only through acceptance of the whole person was the healing nature of therapy maximised.

To illustrate this further, very often I hear clients say things like "I beat myself up" or "I give myself a really hard time" - which suggests that there is a self that is doing the beating up and a self that is being beaten up. I want to strive to respect and empathise with both of these selves - and in supervision I will both monitor any tendency to 'side' with one self over another (and not to neglect any selves that have been shown to me), and explore any potential blocks to respect and empathy (the biggest block I have discovered is if I become defensive).

However, I am also mindful of client-centred thinking and my experience as a trainer of therapists – in that one possible pitfall is that awareness gained in supervision can detract from client autonomy. By this I mean that if I discover (through self-exploring and processing my client work in supervision) that I am somehow extending more to *Mr Softie* than to *Mr Ogre*, I do not enter the next client session deliberately seeking to engage with *Mr Ogre*. Rather, I am more open and sensitive to *Mr Ogre* should he present himself again. Again, I see this whole process as an attempt to get as close as I can to fully *being* congruently respectful and empathic.

I also like to make links with client-centred personality (and process) theory in supervision. This is especially helpful when it comes to the understanding component of empathic understanding. Carl Rogers was very clear that empathy is to do with sensing both feelings *and meanings* (and it seems to me that all too often the sensing of meanings is either undervalued or even ignored in some person-centred training). Thus if a client expresses anger (as with *Mr Ogre*), I want to spend reflecting and supervision time delving as deeply as I am able into what this means to that client. Behind the anger I discover conditions of worth and introjected values – constructs like 'I should be able to cope', for instance. The experienced inability to cope gives rise to further feelings – like inadequacy. Beyond all the anger and inadequacy lies hurt – the client expressing how it is 'easier' to be angry than to be in pain... As a consequence of such exploring, I find that my ability to be less judgemental is much enhanced, as well as my empathic understanding.

Recent themes in supervision

As an update, I would like to spend a little time illustrating themes that arose within my last two supervision meetings. One is to do with couples work, the other to do with congruent disclosure. However, I also discovered an underlying theme – and this was that in supervision I am somehow seeking affirmation that my work is *okay*, and, in particular, that it is *truly* client-centred. This need for reassurance from external sources seemed to be at odds with a belief in an internal locus of evaluation, so this was explored in some depth, too. As a consequence, I became more aware of my mission to maintain the purity of client-centred therapy, bearing in mind such factors as both private and published correspondence with Professor Dave Mearns, whose research indicated an above average prevalence of complaints against practitioners identifying themselves as client-centred or person-centred when clearly the six necessary and sufficient conditions are not deemed to be sufficient. It is important to me to maintain client-centred integrity – and this is an underlying drive to me in supervision.

Couples Work

I spent a fair amount of time in my November supervision clarifying some of the differences between one-to-one and couples work, as I feel that there is more of the facilitator me present in couples work. In particular I was checking out what I experienced as me being more directive with couples against client-centred beliefs and practices.

When working with couples, I have a belief that I somehow model empathic listening for them - in that the process often seems to be that they hear one another through my empathic communications. Yet I also want to try and ensure that each partner gets roughly equal air space – and this can involve me being somewhat more directive than in individual therapy.

My *experience* of couples work is that it has been therapeutic for clients (and this view is backed up by CORE evaluation results and patient feedback to GP's). However, this does not lead me into complacency – I constantly strive to check out my way of being with reference to ethics and a high standard of client-centred therapy. Very often a consequence of this checking out in supervision is a feeling of affirmation and a sense of confidence and trust in my work – which I believe can only benefit clients.

I feel an analogy coming on! Two car drivers are equally 'technically' competent, yet one lacks confidence: with whom do passengers feel the safest? On the one hand I experience supervision as affirmative and confidence enhancing, yet on the other hand I know that my peers (and especially Alison) would very quickly nip any over-confidence smartly in the bud – so there is a back-up system to my own caution around complacency.

To further this analogy, two car drivers are equally 'technically' competent, yet one knows and trusts the *vehicle*, while the other is less sure. Again, with whom do passengers feel safer? Thus exploring my client work with reference to client-centred therapeutic *process* both maintains and enhances my *trust* in the process – which again, I believe, can only be of benefit to clients.

Congruent Disclosure

The group of counsellors with whom I work differ as to whether assessment sessions are conducted or not – and this in-itself is an issue I have explored in supervision. As CORE evaluation co-ordinator, I have access to statistics that demonstrate that only something like one in a hundred clients is deemed inappropriate for counselling as a consequence of assessment – and, when this is so, it has been due to the client being *below* (*not* above) the CORE clinical cut-off points. In terms of managing the service we provide, it makes more sense to offer one in a hundred clients limited therapy (averaging around 5.5 sessions) than to conduct 100 assessment sessions - in practical terms, this saves the NHS approximately £2,750.00 for every hundred patients...

Anyway, an emerging theme for me was the significant proportion of my own clients (over half, I would say) who presented with something akin to 'My problem is that I am depressed – there is something *wrong* with me because I am depressed.' The client, upon receiving the core conditions, is enabled to disclose what is and has been going on for them – and it seems to me that overwhelmingly there would *really* be something wrong with them – something 'abnormal' - if they *weren't* depressed! Yet their own view that they are 'sick' is affirmed for them by the fact that they have been given a prescription for antidepressants by their GP. So prescribed medication serves to confirm or validate that the patient is *sick, ill* – that there is something very wrong with them that needs fixing...

So although I do not conduct assessment interviews, I have (again in large part through exploration in supervision) devised a way of working that encompasses good practice – including ethical considerations as laid out in previous BACP Codes and the current Ethical Framework. For instance, all referred patients receive a package prior to their first session with me that includes a leaflet containing information about counselling (including client-centred therapy beliefs and practices and the kind of detail usually found in contracts), an evaluation form with explanatory notes, a form to indicate their availability and contact details – and so on.

Thus much of what a few of the counsellors in our group do in Assessment Interviews is addressed pre-therapy.

However, there often arises a moment (and, to keep this in perspective, this moment is usually a minute or two) in first sessions when clients ask me what I think – almost as if they are seeking my professional diagnosis (perhaps understandable if they have been given a prescription for medicine). On the one hand client-centred therapy is not concerned with therapist diagnoses (the client is held to be their own expert – and I do have access to medical consultancy should the need arise); on the other hand, Carl Rogers is on record as saying that a straight question probably merits a straight answer (rather than a kind of therapist evasiveness).

In such moments, I noticed myself saying something along the lines of: 'There is nothing you have said to me that seems like it would be impossible to understand – it does seem very understandable that you feel the way you do. Perhaps it would seem even more strange if you didn't feel down, or depressed, after all that you have experienced. Yet I hear that you do not like feeling as you do and that you would like this to change. Maybe as a starting point we can accept that it is *understandable* yet *undesirable* that you feel as you do and work together towards change, rather than having to fix something broken or believe that you are medically ill.' (I realise that what I have just written as an illustration might seem somewhat verbose – hopefully you can nevertheless catch the essence of my meaning.)

One of the things I explored in supervision was how to be during the moments in a first therapy session that feel like engaging with those issues not addressed in a 'full' assessment interview. Is my disclosure to clients okay or not? I am definitely being congruent in such instances, yet am I embodying unconditional positive regard and empathic understanding as fully as I might? Could it be argued that client self-determination means that clients can see themselves as 'mentally ill' (a view supported by prescriptions) even if they aren't – or might accepting such a view be collusion?

Herein I have only touched on a few of the themes that were explored in supervision – there were many others. However, I would like now to turn to outcomes, of which two main ones spring to mind. I feel that these outcomes are a most fitting illustration, as they represent a balance that I appreciate between *being* and *doing*: -

In terms of my way of being with clients (which is of paramount importance in client-centred therapy), I felt affirmed that it was ethical and permissible to be clear about boundaries – and that these included the parameters within which I feel I can be of some therapeutic assistance. What emerged from supervision was that doing so is *respectful* to clients as well as signifying therapist *authenticity*. (One of the other explored strands I have not yet mentioned was unravelling that not all of the three 'core' conditions have to be equally present all of the time – so while I was concerned that empathy wasn't fully present during such brief moments, we concluded that two out of three ain't bad!) We spent some further time exploring issues around not conducting assessment interviews, maximising the presence of the core conditions, and relating to client-centred personality and process theory.

A second outcome was more practical, in that having explored and become more clear about issues and their meaning, I was enabled to make a brief presentation at the December 2002 General Practice meeting. Feedback from the Doctors was understanding and constructive, and they all agreed to give more thought to the process of referring patients to me – taking care not to convey a message that something was broken that needed fixing, or that the patient was certifiably ill...

Rather, the doctors would take care to communicate that medication might help to calm a patient down, or enable sleep – basically relax the patient enough to enable them to engage with and benefit from therapy: a very positive outcome, in my view.