Integrating Reflective Practice in Family Therapy Supervision

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This paper discusses how to integrate reflective practice in the family therapy supervisory relationship. This enables family therapists to think creatively, be insightful, and develop a range of perspectives regarding systemic formulation and practice. It encourages review of the past and promotes understanding in the present with the aim to improve therapists work with families in the future. Reflective practice encourages independent thinking and learning and helps therapists to develop a systemic process of critical enquiry to investigate and critique their own practice. It encourages therapists to be self-reflective and develop confidence to think hypothetically regarding change. This allows them to pose questions for exploration, construct a new lens to conceptualise therapy and the therapeutic relationship and develop awareness of the personal as well as the professional self.

Keywords: family therapy, supervision, reflective practice, reflectivity, professional self

Key Points
1. Reflectivity promotes independent thinking, improved self-awareness and creativity.
2. Clinical supervision is a collaborative process that promotes therapist knowledge and skills and safeguards client care.
4. Therapists develop the capacity to apply reflectivity during the session as a ‘self-supervision’ strategy.
5. Family therapy supervision refines skills of observation, listening and questioning.

‘Don’t instruct me: let’s walk together. Let my riches begin where yours ends.’
(Humberto Maturana quoted in Carroll & Gilbert, 2008)

Clinical supervision has long been regarded as a distinct practice crucial to safeguarding client care and developing and maintaining professional practice (Barnett, Cornish, Goodyear & Lichtenberg, 2007; Carroll & Gilbert, 2008; Falender & Shafranske, 2007; Hawkins & Shohet, 2006). There is consensus across disciplines that it should be at the forefront of training and ongoing accreditation (Hawkins & Shohet, 2006; Gilbert & Evans, 2000; O’Donovan, Halford & Walters, 2011; Mill, France & Bonner, 2005; Milne, 2007; Munson, 2002; Roche, Todd, & O’Connor, 2007; Watkins & Scaturo, 2013; White & Winstanley, 2011). Clinical supervision transcends discipline boundaries and remains at the forefront of professional education and skills development (Aten, Stran & Gillespie, 2008; Bernard & Goodyear, 2009).

This paper discusses supervision as a reflective and collaborative practice that enables family therapists to think creatively and systemically in therapy and the therapeutic relationship. After defining supervision and reflectivity, strategies to integrate reflective practice in family therapy supervision and practice are discussed.
Defining Supervision

In its broadest definition, clinical supervision is a professional activity involving a practice-focused relationship between a designated supervisor and the therapist. The aim of this collaborative interpersonal process is to maintain and promote standards of care by developing theoretical knowledge, skills and confidence (Falender & Shafranske, 2004). Supervision is a regular, facilitated meeting where the therapist is able to discuss their work practice issues in a protected individual, peer, group or team setting, which allows for review of practice and learning. Models of clinical supervision deviate in the emphasis placed on different aspects of the supervisory context and can include a focus on the self as therapist, the therapy content, therapist behaviour, and/or the therapeutic process (Aten, Stran & Gillespie, 2008; Livini, Crowe & Gonsalvez, 2012; Vandenberghe & da Silveira 2013).

Clinical supervision is an intervention with its own theory, framework and techniques that is increasingly recognised as requiring specialist training before competence can be achieved to fulfill the role of supervisor. Typically therapists have often ‘fallen into the role of supervisor,’ such as taking students on placements from university as interns in training or supervising junior colleagues (Scott, Ingram, Vitanza, & Smith, 2000). More recently, specific training programs within Australia have been developed to train health professional groups to be supervisors covering knowledge about registration, supervision guidelines and where necessary, reporting requirements (e.g. AHPRA, 2013; HETI, 2013). Typically standardized supervision training programs have focused on ensuring the acquisition of certain knowledge and skills abiding to ethical guidelines of practice.

Much attention has been focused in the literature on the supervisory relationship (Holloway, 1995), the tasks of supervisor and supervisee (Baker, Exum & Tyler, 2002; Campbell, 2000; Carroll & Gilbert, 2005; Inskipp, 1999), models of practice (Carroll & Holloway, 1999; Stotltenberg, 2005) and best practice (Accurso, Taylor & Garland, 2011) regarding how to deliver supervision in the field. Supervision is an ongoing process encompassing a range of facilitative and evaluative functions involving both supervisor and therapist, which enhances the therapeutic relationship together with positive therapy outcomes (Bambling & King, 2001; Bambling, King, Raue, Schweitzer & Lambert, 2006; Proctor, 1997; Ramos-Sánchez et al., 2002; Watkins & Scaturro, 2013).

As positive therapist outcome is consistently linked to the quality of therapeutic alliance (Orlinsky, Ronnestad & Willutzki, 2004; Rober, 2011), it is imperative that supervision play an integral role in promoting therapeutic knowledge, skills, insight, creativity and confidence (Lambert & Barley, 2001). By encouraging reflectivity the therapist can further refine clinical skills of observation, listening and questioning thus enhancing clinical practice.

Reflectivity in Supervision

In the past few years there has been growing interest in the role of reflexivity and reflective practice in family therapy practice and supervision (Flaskas, 2012). However its ‘seeds’ were sown well over half a century ago, as Dewey (1938) defined reflection it is an ‘active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which
it tends' (cited in Ward, 1998, p. 2). He saw reflectivity as a way to generate solutions using carefully considered problem solving strategies through experimentation. These ideas were further developed by Gibbs (1988) where the focus was the influence of reflection on action: how new understanding changes practice in the future?

Schon’s (1994) theory of reflective practice describes reflectivity as a means of enhancing understanding through empirical knowledge based on skills learnt through education and training and categorised two main types of reflection: ‘reflection-on-practice’ and ‘reflection-in-action.’ This distinction provides clear delineation of the divergent processes available in supervision. Reflection-in-action occurs while events are happening. By observing, recognising, intervening and making adjustments to practice, the therapist is able to respond in the moment, drawing from existing theoretical and clinical knowledge to improve the situation at hand. The literature on live supervision (Hunt & Sharpe, 2008; Lowe, Hunt & Simmons, 2008) and ‘Reflective Team Process’ (Anderson, 1987; Perlesz, Young, Paterson & Bridge, 1994) provides examples of how therapists integrate in the process of therapy by adopting multiple positions of both observer and facilitator.

Reflection-on-practice occurs after the event and is retrospective. Commonly this has been the traditional approach to supervision where case discussion and review of clinical processes takes place.

Both approaches to supervision are useful but what is considered most helpful is when a therapists’ curiosity about their interaction with clients is stimulated, bringing to awareness the feelings and thoughts of both therapist and client. Reflection provides a looking glass approach to clinical practice, promoting self-awareness, harnessing self-knowledge and encouraging a deeper understanding in thought and action in deciphering the possible multiple and often conflicting responses to a situation.

Reflective practice in part parallels other established therapeutic processes. These include the countertransference relationship and examination of the therapist’s inner dialogue (Flaskas, 2004, 2010; Rober, 2011), ‘mindfulness’ when attending to reflection on the interaction (Andersson, King & Lalande, 2010; Vandenberghe & da Silveira, 2013), the work of Balint to promote introspection, empathy and self-awareness for both therapist and client (Lichtenstein & Lustig, 2006) and ‘mentализация’ in making sense of self, the other and relationships (Asen & Fonagy, 2012).

In addition there has been increasing focus on the self of the therapist in the training and supervision of family therapists, which can aim to identify and reflect on family-of-origin issues that help or hinder therapeutic process (Brown, 2007; Deveaux & Lubell, 1994; Framo, 1992; Francis, 1988; Johnson, Campbell & Masters, 1992; Rhodes, Nge, Wallis & Hunt, 2011; Wells et al., 1990). Overall, reflection can provide diverse perspectives of the therapists’ intuitions, feelings and theorizing related to the client-therapist relationship increasing empathic understanding of both the therapist and client’s experience (Regan, 2008).

An important element of reflective practice is the depth of the reflection and understanding a therapist is able to undertake within and between therapist and client systems. The full potential of reflection is best achieved when the therapist deconstructs the therapeutic experience and is able to see the various layers of the situation at hand. Reflection is not simply, I can see that I could have done things differently but requires deconstruction and reconstruction: I can see what happened, why it happened, and how I can change now and in the future. Reflective practice in supervision allows new openings for different thinking outside of what is already known and practiced. It encourages the therapist to ‘step back,’ examine the impact of self in the therapeutic
context and consider alternatives in therapy. Applied in the supervisory context reflectivity pays attention to feedback, ecology, circularity and language, whereby the therapist is able to make connections and consider self in and outside the system.

Within supervision, reflectivity happens all the time, but it is often descriptive and ‘presentation specific,’ where the therapist does not extend new learning to other aspects of their clinical work (Safran, Muran, Stevens & Rothman, 2008). As such, reflectivity in supervision can occur when a shift occurs from a behavioural focus. Its real value is when the therapist learns from the presentation extending this learning to other contexts, either past, present or future and there is greater awareness of patterns and interrelatedness. When this occurs independent thinking and responsibility is promoted in the therapy and supervision contexts.

Reflection can occur on different levels. A useful framework is Betts’ (2004) five tier hierarchy as summarised in Table 1, which explores the progressive variations of reflection on content, process and context.

**Reflectivity and Family Therapy Supervision**

Supervision is a way to investigate therapeutic work where asking reflective questions allows the supervisee to critically consider the implications of their clinical encounters. Through a systematic process of critical enquiry the therapist can learn to pose their own questions and further examine and refine their clinical work (Horvath, 2001). By encouraging reflectivity a range of perspectives regarding clinical care can evolve moving the therapist towards developing greater clinical competence, confidence and independent practice.

Reflectivity privileges the process of inquiry. For this to happen, the supervisor must create an environment for the therapist to focus their attention on the interactions within the therapeutic context, allowing a process of contemplation and review often with limited direction or instruction. Whilst this process can be a challenge for both supervisor and therapist, the aim is independent thinking and the development of alternative interpretations (Stotltenberg, 2005).

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Levels of Reflection</th>
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<tr>
<td>Level 1: Reporting</td>
<td>focus on a recount of the situation only</td>
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<tr>
<td>Level 2: Responding</td>
<td>some thoughts on what happened</td>
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<tr>
<td>Level 3: Relating</td>
<td>review of the events through existing lens/frameworks of thinking (e.g. consideration of response to feeling, action or communication between and within the therapeutic context)</td>
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<tr>
<td>Level 4: Deconstruction</td>
<td>in-depth analysis (challenge to existing frameworks of thinking). Here there is a challenge to existing frameworks of thinking and some alternative explanations are generated</td>
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<td>Level 5: Reconstruction</td>
<td>application of learning based on new frameworks of thinking which might be embedded in hypothesizing, curiosity, reflection on self, meaning and interrelatedness.</td>
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Strategies to stimulate reflectivity

There are a number of strategies that the supervisor can adopt to facilitate reflective practice, which can include both inside and outside session activities. The options provided below are not exhaustive but reflect some of the strategies commonly employed by the author in individual and group supervision.

1. **Family-of-origin.** The exploration of family-of-origin has for many years been considered an integral part of the training of family therapists and is a requirement for some training programs both overseas and in Australia (Mason, Gibney & Crago, 2002; Rhodes et al., 2011). Personal reflection on self and family issues provides an opportunity for improved intentional awareness (Brown, 1999). Whilst not therapy in itself, family-of-origin work in supervision allows for greater insight into strengths that might aid or blind spots which might hinder. Therapists who have opportunities to consider family-of-origin work in supervision are able to differentiate self from family issues and be better positioned to work with stressed families where similar problems exist.

2. **Modelling reflectivity.** By the supervisor modelling reflective dialogue within the supervision session a therapist is able to learn through observation, direction and participation the process of juggling interpersonal, affective, cognitive and behavioural responses to the material being observed or discussed. Modelling analytical thinking, pondering, reflecting and analysing has the dual effect of teaching a therapist how to employ reflectivity whilst simultaneously providing new information on client/family dynamics (Orchowski, Evangelista & Probst, 2010).

   As an illustration, I often find myself thinking about a supervision session after the event, and through critical reflection new insights that might not have occurred to me at the time may come to mind. On return to supervision I will communicate with the therapist any after-thoughts or hypotheses and where these have led in my thinking. New dialogue may occur as a result leading to further exploration. Asking the therapist to reflect on how this information impacts their understanding of self and/or interactions with the client and family system facilitates further analysis. In addition, asking for feedback, either informally or formally about the supervisory session can further enhance an open dialogue about process.

3. **Journal/Diary.** Journal writing and reflective diary keeping has long been a strategy used in education and clinical training (Belton, Thornbury Gould & Scott, 2006; Epstein, 2008; Thorpe, 2004). It is a useful way to monitor progress and encourage therapists to reflect on thoughts and actions between supervision sessions (Raelin, 2002). Keeping a journal or diary helps the therapist to monitor progress, report on aspects of clinical practice, and reflect upon how thoughts about action influence current and future practice. The diary creates a process record of any issue that the therapist might want to discuss in supervision. It promotes a space for relational thinking outside the supervisory context and through mindful contemplation assists in the development of habitual self-reflection and enhanced self-awareness (Senediak & Bowden, 2007).

4. **Reflective questioning.** Using reflective questions can provide a framework for preparation for supervision or review within or between both client and supervision sessions. The prompts provided in Table 2 are not exhaustive but can be used as a
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<td>1. What is my question? (e.g. What am I stuck on, what do I need help with at this time)?</td>
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<td>2. Describe the interaction/s (e.g. What is my involvement and the inter-relatedness of those involved)?</td>
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<td>3. What are my thoughts, assumptions and expectations about the interaction at this time? Have they differed over time and why? (e.g. How do I make sense about the interaction at this time and if changed, why)?</td>
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<td>4. What am I feeling? How do I understand those feelings then and now? What is the emotional flavour of the interactions? Was it similar to or different from my usual experience?</td>
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<td>5. Consider my actions during this portion of the session. What did I want(expect to happen? (On reflection what were my expectations/hopes)?</td>
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<td>6. Consider the interaction/interrelationship between therapist, the client and wider system/s. (Why do I think what happened, happened? How does the therapeutic relationships impact what is occurring? Consider transference – countertransference)</td>
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<td>7. To what degree do I understand this interaction as similar to the client’s interactions in other relationships? How does this inform my experience? (As there parallels in the way the client presented in session compared to other contexts? What might this tell me about the client and what I need to work on in the future)?</td>
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<tr>
<td>8. What theories do I use to understand what is going on? (What guided my thinking and therapeutic intervention at time – should I consider alternatives and what would I need to do differently to be able to apply alternative ways of thinking and working)</td>
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<tr>
<td>9. What past professional or personal experiences affect my understanding? (Consider any personal/professional strengths and restraints both past and present and how these might impact both on my theoretical knowledge and the application of clinical skills both then and now)</td>
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<td>10. How else might I interpret this ‘event’ and interaction in the session? (If I were to view this situation through a different lens how might I see things differently? What lens might that be (e.g. gender, cultural factors) How might this influence what I do next)?</td>
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<td>11. How might I test out the various alternatives? (Summarize where to from here; what steps do I need to take; who/what can help me to do this)?</td>
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<td>12. How will the clients’ responses inform what I do next? (What do I need to be ‘on the lookout’ for when I see the client next)?</td>
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<tr>
<td>13. How can I now and in the future use supervision reflectivity? (What is the role of the supervision)?</td>
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launch-pad for further questioning, either alone as a way of employing self-supervision or through further questioning with the supervisor. Therapists in the first instance are more likely to apply these questions as ‘reflection-on-action’ after the interaction, but with practice such questioning can become automatic and be integrated into questioning with the family in session.

Illustrating Reflective Practice in Supervision

Here I provide some examples of reflective practice in family therapy supervision beginning with my own journey of self-reflection and training.

Example 1: Self-reflective practice

Let me set the context of my practice as a supervisor. I have provided clinical supervision for nearly 30 years, almost as long as I graduated from my clinical psychology studies. I fell into the role of supervision for students on placement from the university where I graduated, that is, the university needed a placement for clinical psychology students and as I had been a reasonably good student I was as worthy as any to embark on this role. This very quick initiation from clinician to supervisor was both unheralded and unmarked. It was some 10 years before I embarked on my first structured supervisory training which allowed me to gain a theoretical framework as a supervisor. Coupled with post-graduate family therapy training, family-of-origin experiences, further structured supervision training both here and overseas and personal therapy, I was able to incorporate this knowledge and experience into a consolidated approach of supervision.

There were three significant experiences that impacted on my development as a therapist and supervisor. The first was my initial family-of-origin experience as a trainee in family therapy, the second followed many years later with an overseas intensive practicum with Professor Maurizio Andolfi at the Accademia di Psicoterapia della Famiglia in Rome, Italy and lastly was my undertaking of personal meditation-based mindfulness therapy. Interestingly, none of the experiences were within the exclusive domain of psychological practice and each provided a stepping stone for further exploration of self as well as clinical and supervisory practice.

My initial family-of-origin experience was at the beginning of my studies in a two year program of family therapy training at the Family Therapy Institute in Sydney with Margaret Topman, Max Cornwell and Ron Perry being my initial teachers. The rawness of the exploration of family history, cultural influences and transgenerational patterns provided opportunities to consider how my family-related issues both helped and hindered my early work as a developing therapist. This initial training exposed personal biases, emotional restraints and strengths and formed the basis for ongoing reflection on how certain family presentations touched me in different ways and influenced the way I approached family therapy. It occurred soon after the time I started supervising psychology students and the disconnect between traditional psychology training (mostly individualised cognitive behaviour therapy) and systemic family therapy was often challenging.

Many years later, the Practicum led by Professor Andolfi was a personal and professional intensive experience which involved reflection on professional handicaps. Our small group of seven family therapists of varied disciplines from around the world took turns over the two weeks to present professional handicaps stemming from our family-of-origin. There was no escaping personal reflection on our past and
present relationships and their impact on our practice as therapists, educators and supervisors. This repeating exercise allowed self-learning not only in relation to my personal handicaps but from those of the six other therapists as well. The experience was profound and opened up a world of experiential learning and teaching.

In addition there was a focus on culture. The experience was intense, novel and something I had never experienced nor expected. Later personal therapy developed further insights of self and professional practice, which have continued to influence my practice. I approach supervision with enthusiasm, guiding those that come to me for leadership, support, direction and mentoring by using what I myself have learnt both theoretically and experientially (Deveaux & Lubell, 1994). Most importantly this involves experiential learning, awareness of self in relation to family-of-origin influences and ongoing reflective practice.

Example 2: Family of origin work
I have provided supervision to a clinical psychologist for over 4 years, initially in a group context at a specialist drug treatment service and then in individual sessions on a fortnightly basis. The psychologist works in the trauma field with complex clients who present with family problems, poor attachment history, substance misuse and mental health problems. Sandra is young, enthusiastic and has been trained predominantly in cognitive behavioural therapy with some exposure to Dialectical Behavioural Therapy, Acceptance Commitment Therapy and mindfulness-based therapies. She has had little exposure to family systems work, yet most clients presented have complicated family histories and marked discord.

In the group supervision with Sandra, from an early stage I gently introduce the use of genograms, systemic formulations and family interviewing techniques. While the group is initially resistant to considering alternative perspectives, perseverance pays off as introducing an alternate lens provides greater depth to their theoretical understanding and ways of working with complex clinical presentations. This is quite foreign to the team and service which primarily employs a case management framework targeting specific behavioural change. Slowly Sandra, along with her colleagues, invites family members to sessions where issues other than the specific substance misuse problems are discussed and managed. There is a shift in presentations, where the team members begin to think beyond the presenting problem and engage more systemically with the client and their wider system.

When Sandra leaves the service she seeks individual supervision and her journey into self-reflection begins. She has already started to apply systems interpretations to presenting problems and begins to consider her relationship to clients. She increasingly talks about her personal responses to her clients, frustrations, anger and anxieties about their progress. I question Sandra on her attachment to clients as she agonizes over those who parallel her early life story. I invite Sandra to explore her family-of-origin, to draw on these parallels and ponder the impact of self in therapeutic relationships. Family-of-origin work provides opportunities for differentiation of self and allows clinicians to better handle difficult therapeutic encounters, identify possible triangulation and manage their reactions in therapy (Kerr, 1984; Murdock & Gore, 2004; Renshall et al., 2013). Initially Sandra hesitates but as she continues to struggle, worn down by the sense of hopelessness for some of her clients, we spend two sessions undertaking family-of-origin work. This focus allows her to better differentiate ‘self’ in relation to her family-of-origin and in turn, set clearer boundaries in her clinical work. Sandra
develops better awareness of her emotional reactions to clients and the subtle triggers that commonly would have previously resulted in an anxious response.

Supervision continues to employ reflective questioning where she is encouraged to consider multiple perspectives, incorporate the use of self, consider the systemic context, apply theory and develop preferred ways of working with clients. In short, Sandra develops a capacity for greater choice in her reaction to clients and as such she is able to maintain improved emotional autonomy over time. The experience of being able to reflect on family-of-origin influences coupled with routine critical reflective questioning outside and within supervision has helped Sandra to develop greater confidence and skills, to recognise and use her emotional reactions to clients and to generate appropriate interventions.

Example 3: Reflective questioning and modelling self-reflection

‘Self-reflectiveness is critical to clinical development’ (Urdang, 1999, p. 144) and it is this premise that has guided my supervisory approach. While reflectivity does not naturally occur for all clinicians it can be taught. Modelling reflective thinking and the use of reflective learning journals are widely recognised as significant tools in promoting active learning about self and clinical practice (Orchowski et al., 2010; Thorpe, 2004). By introducing concepts of reflectivity in supervision sessions, I have been able to promote active participation in individual and group sessions. When students are learning or are newly graduated there is a strong need for answers to complex problems, often at the expense of critical self-analysis, with responses such as ‘tell me what to do.’ It is important to set the stage early for reflective practice within clinical supervision, as this teaches the clinician to engage in personal self-reflection.

For example, Joseph is a mature counsellor who works in an independent private practice with little support and high client load. He predominately works in individual and couple therapy. He engages in both group and individual supervision and actively employs self-reflection. Joseph attends supervision often having completed the reflective questions provided in Table 2, he has answered many of his own questions and is then able to discuss the outcomes of his reflections. The advantage of this is that he can cover a greater number of clinical issues in supervision as he has already undertaken a large part of the reflection in private. He draws on themes that present and are better able to problem solve outside the supervisory context.

Where appropriate, I draw on techniques such as Kagan’s (1980) Interpersonal Process Recall (IPR) when reviewing audio/videoed sessions. I have used the technique of IPR in counselling training for over 20 years, which I have consistently found enable students to actively reflect on therapeutic processes. Such a detailed analysis of a segment of interview allows for meaningful discussion of affective and relational dynamics. This is both analysis of ‘reflection-in action’ and reflection-on-action’ (Schon, 1994).

In supervision I comment on my role as supervisor, guiding discussion and promoting within-session reflectivity and self-reflection outside sessions by supervisees. Also how the exploration of interpersonal, affective and behavioural events better positions supervisees to apply new knowledge in current and future clinical encounters. My reflection on these reflections models ‘reflection-in-action’ highlighting for supervisees the importance of exploring these interpersonal experiences.
Example 4: Supervision diaries and learning journals

I encourage supervisees to keep a separate supervision journal or diary as a way to aid reflective analysis of themes and progress in their professional journey. This is not a new concept but one that is often overlooked if not made explicit. Most come to supervision with their books and use this as a way to track progress with clinical practice and self-reflection. Bernadette approached me for supervision some two years ago after attending my supervision workshop. Having heard about how to structure supervision sessions she came well prepared for her first meeting. Following our first session she used her diary to plan sessions, write questions over the course of each month in-between sessions and to reflect on themes both in and outside of session and track her progress. Interestingly for Bernadette the use of her diary has provided opportunities for self-supervision, where she often answers her own questions prior to the supervision session and we explore her reflective process towards better understanding of self, clients and family systems. Bernadette works in a hospital setting with distressed families where quick answers are needed within her team and self-supervision acts as a preventative procedure providing her with a framework to consider options and alternatives (Morrissette, 1999).

Within the postgraduate Family Therapy program at the NSW Institute of Psychiatry trainees combine distance education learning materials with face-to-face intensive workshops, and as such rely heavily on independent learning and reflective practice both ‘in-and on-action’ (Hickson, 2011). They are required to keep learning journals, engage in reflective discussion with teachers, supervisors and peers on learning materials and complete assignment work that requires the application of critical reflection on course material and the application of theory on clinical practice. Trainees begin the course with family-of-origin exercises and are encouraged to continue their critique on the impact of assumptions, challenging the ways they work with families in distress. This reflective process in supervision is encouraged through the use of diaries and online forums throughout the program and by year 3, when trainees undertake mandatory supervisor training the course relies solely on critical reflection tasks in the form of analyses of learning journals and supervisory practice. By this stage trainees have not only learnt self-supervision and a routine practice of critical reflection, but through their experiential learning, how to apply reflective practice in supervision encounters with others (Moffett, 2009; Senediak, 2013).

Conclusion

Supervision is a complex process and entails a number of roles and responsibilities for both supervisor and supervisee to ensure an effective and rewarding relationship is established and maintained. Supervision in family therapy, more so than for individual therapy, requires the supervisor to be alert to possible emotional alliances. The push and pull of often opposing family members in the therapy room requires specialist skills in family work by a therapist with the capacity to de-triangulate when necessary. The role of the family therapy supervisor to facilitate both skills development and self-awareness in the therapist is an integral part of family therapy supervision.

Supervisors embracing a stance of reflectivity and independent learning are positioned to assist therapist critical thinking and should resist ‘feeding answers’ in directive discussions. Supervisors who initiate reflectivity in supervision and model and
teach these skills invite therapists from an early stage of their career to develop a capacity to understand, connect, problem solve and work creatively with families. Reflectivity can enhance the supervisory alliance, which in turn can facilitate the therapeutic alliance where those involved often exhibit greater compassion, awareness and connectivity with families.

A supervisory relationship based on reflective practice facilitates both a containing and generative space. This paper has illustrated integrating reflective practice in family therapy supervision, which can reap rewarding supervisory relationships and encourage independent, mature and enthusiastic therapists.

Endnote
1 In this section pseudonyms have been used for each supervisee and permission granted for use of supervisory encounters for this paper.

References


