

PERSONAL CONSTRUCT MODELS OF GROUP SUPERVISION: LED AND PEER

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Supervision models based on different theoretical approaches to psychotherapy have been developed. The predominant emphasis of these models has been directed to individual supervision, with little attention to approaches of group or peer group supervision. One of these models is the personal construct model of supervision developed by Viney and Epting (1999). We have now applied this model to the two supervisory approaches, group supervision with a leader, and to leaderless peer group supervision, and the group processes are discussed. The clinical implications of applying this personal construct model to group and peer group supervision are also provided.

Keywords: *Personal construct models; group supervision; led supervision; peer supervision*

CLINICAL SUPERVISION

The purpose of supervision is to influence the ability of the therapist to provide efficacious treatment (Wampold & Holloway, 1997). Recent research (Bambling, King, Raue, Schweitzer, & Lambert, 2006) has been able to demonstrate that clinical supervision impacts significantly on client/therapist working alliance, a factor shown in previous research to have a strong relationship with client outcome and symptom reduction (Blatt, Zuroff, Quinlan & Pilkonis, 1996; Krupnick, Simmens, Moyer, Elkin, Watkins & Pilkonis, 1996; Wampold, 2001). In line with these research findings and personal construct theory to be explored, we present this model of supervision, which we believe leads to efficacious treatment by having as its primary focus the development of the client/therapist working alliance. The processes of courage, in led supervision group (LSG), and support, in peer supervision group (PSG), facilitate the development of the alliances. The clinical implications of the approaches are that factors such as, the ability to influence the therapy/supervisory processes, and saying what needs to be said in led supervision group, and in the peer supervision group, establishing optimal therapeutic distance, and dispersion of supervisory dependencies, are generated.

Various models of supervision have been proposed, many tapping into psychological theories, to deliver to the therapist, a theoretical ap-

proach they can use in therapy. The models behind the approaches to psychotherapy supervision have included cognitive therapy (Liese & Beck, 1997), psychodynamic (Andersson, 2008; Binder & Strupp, 1997), interpersonal (Hess, 1997), rational emotive behavior (Woods & Ellis, 1997), client-centered (Patterson, 1997), and gestalt therapy (Yontef, 1997). Approaches to supervision have also involved an integration of different approaches to tailor the supervision provided (Bernard, & Goodyear, 2004).

PERSONAL CONSTRUCT SUPERVISION

Approaches to personal construct therapy supervision have also been available. Kenny (1988) provides a model of supervision with the overall aim, "to articulate and elaborate the trainer's construct system to the point where they may effectively and professionally subsume other construct systems and know how to trigger structural movement within systems manifesting 'complaints'" (p. 156). While Kenny's model focused primarily on the therapist "clarifying and unpacking the systems of personal meanings therapists bring to supervision" (Viney & Epting, 1997), Feixas (1992) proposed a model centred on the reflexive nature of the supervision process. Another model by Viney and Epting (1997), based on the psychotherapeutic concepts detailed by Kelly (1991a; 1991b), sought to en-

hance the understanding by both the supervisor and therapist of the processes of change in therapy. It is the subsequent development of this model which will be used to understand the processes involved in group supervision, led supervision group (LSG) and peer supervision group (PSG). In this account, we use the term "supervisor" for the leader in led supervision groups, and the term "supervisee" for group members in both the led supervision group (LSG) and the peer supervision group (PSG).

GENERAL MODEL OF PERSONAL CONSTRUCT SUPERVISION

This model of personal construct supervision has two aims. The first aim, is to assist supervisees to reconstrue the therapy context using personal construct concepts. Secondly, the model aims to have therapists learn to work with their own personal contributions to psychotherapy. Personal construct supervision is defined, and this definition is based on the assumption of reflexivity, the psychological functioning of therapists and clients is seen as very similar. While exploring the relationship between supervisor and supervisee, the model discusses the establishment of a role relationship, of sociality. Other factors identified in the earlier model (Viney & Epting, 1997), such as hope, transference and countertransference, and therapists undergoing their own therapy, are considered factors shared by the two pivotal processes of personal construct supervision, courage and support.

GROUP SUPERVISION: LED AND PEER

While some models propose a group leader (e.g. Ettin, 1995), the role of the leader can move along the continuum of supervisor to that of consultant (Altfeld & Bernard, 1997). Consultative

group leaders in LSGs were described by Counselman and Weber (1994) as serving firstly as facilitators, and secondly as experts to allow the development of group process. On the other hand, leaderless peer supervision groups (PSGs) share the tasks of leadership. These tasks may be shared by appointing a leader for each meeting (Markus et al., 2003), or where each member has equal responsibility for the group process. Counselman and Weber (2004) propose a model of PSG where the tasks of leadership, adherence to contract, gatekeeping and boundary management, and working with resistance are shared by members. The PSG's primary goal is providing professional consultation to each other and is not a therapy group. "The fundamental factors that produce and maintain a well functioning psychotherapy group also apply to PSGs. A culture of respect, openness, a curiosity is important. Confidentiality is crucial if members are to take risks necessary for real growth" (p. 136).

RESEARCH

Three types of supervision groups have been identified by Billow and Mendelsohn (1987). They are case-centred, process-centred, or dual focus, and the successful groups were found to be able to shift focus when needed. Hoffman, Hill, Holmes and Freitas (2005) believe group supervision, "... helps draw out difficult conversations about clinical issues that might not come up in individual supervision. The group can be effective because peers can be attentive to identifying such issues as anger or attraction toward a client and are good at confronting trainees on such issues" (Dittmann Tracey, 2006). The characteristics of successful group supervision groups involve the effective management of gate-keeping, norm-setting, and protection of the group contract (Todd & Pine, 1968) or aim and objectives (Counselman, 1991).

Personal construct models of group supervision: Led and peer

Table 1. *Two Models of Supervision*

Led	Peer
Relationships build on sociality	Relationships build on commonality
Processes of Courage	Processes of Support
Develop abilities to influence therapy/supervisory processes Develop feelings of competence and support risk-taking	Experience and Develop understanding of: optimal therapeutic distance dispersion of dependencies

TWO MODELS OF PERSONAL CONSTRUCT GROUP SUPERVISION

Sociality for led supervision groups

In the personal construct model, the personal construct supervisor attempts to understand the therapy processes, to construe the constructions of the therapist (Viney & Epting, 1997), and enter into a role relationship with the therapist. Developing a role relationship with the therapist, is an integral process of this form of personal construct supervision. In this supervision, the relationship building is shared, construing the constructions of each other, depends on the input from each other. The group leader will actively encourage the members to try to develop role relationships with each other, and will aid these processes by demonstrating a capacity to understand each member's ways of understanding what is going on in their therapy processes (LSG) (Viney & Epting, 1997).

Commonality for peer supervision groups

In PSGs, there is not one person like a supervisor to model the professional role. Understandings are usually more varied and diverse, and the feelings associated with these meanings less intense. There is a greater emphasis on commonality of construing, meanings being shared in the group. As a consequence, the role relationships are slower to develop, but nevertheless once they are established, can be as productive as those in group supervision.

Process of courage (LSG)

As in the therapeutic relationship, creative changes in supervision require “both the courage to confront experience at the most deeply personal levels and the integrity to bring those core constructions into form that can be explicitly considered, and thus shared, confirmed, disconfirmed, and ultimately revised” (Harter, 2007, p. 170). In led supervision group, courage is an important aspect of the relationship between supervisor and supervisee (Viney & Epting, 1997). In our model, we define courage as the ability to influence the therapeutic/supervisory processes, and as the development of feelings of competency to take professional risks. It is the courage by the supervisor to point out what might be limiting the therapist's “ability to establish a full and open relationship with their clients” (Viney & Epting, 1997, p. 7). In the processes of courage, there is the willingness of supervisors and group members to voice observations or perceptions they feel are of clinical significance in the relationship, with each other.

Process of support (PSG)

In the personal construct supervisory model for peers, the relationships between the therapists are developed through the processes of support. Support is the process in which therapists feel they can try things out with their clients, that they have the validation of other supervisory members “for experimenting and finding out what is possible for them to be able to do in the therapy situation” (Viney & Epting, 1997, p. 6). To facilitate these processes, the peers subsume the construing of the supervisee, as the therapist undertakes to subsume the construing of the

client. All are struggling together on the same problem (Fransella, 1993), the problem that brought the client to therapy.

The processes of support are illuminated in the following account of a well-functioning supervision group of 16 years duration, described as “truly a leadership-shared group” (Counselman, 1991, p. 255). This group began as peer consultation to discuss clinical case issues and theoretical material, but broadened their focus over time to include more personal issues and interpersonal processing (PSG). Nobler (1980) reported on the group’s history, and described three stages in the group’s development. The first stage was marked by the needs and anxieties of each member to present themselves as “the competent therapist”, and Nobler reported on the feelings of discomfort and uncertainty of the group members. However, these negative feelings decreased during the second stage, and were replaced by a greater willingness by group members to take risks and disclose more, although there remained an unwillingness to criticize each other. During the third stage, there was greater evidence of intimacy and a sharing of perspectives and reactions to each other. Rather than become a peer therapy group, the group remained focused on their group contract, and as Nobler noted, their success was due in part to maintaining realistic expectations of the supervision group, and by avoiding the development of an idealized leader: “The path to equal sharing, learning, and intimacy lay in working directly with each other and not having a leader as a buffer” (p. 59).

Similar stages of development were described by Todd and Pine (1968) in their account of a long-running peer supervision group. While the group began with a contract to be case-focused, it was able to provide support to members during personal issues, and never lost its primary focus as a supervision group.

CLINICAL IMPLICATIONS GENERATED BY THE PROCESSES OF COURAGE AND SUPPORT: TWO MODELS

The two processes, courage and support integral to the supervisory relationship, generate a number of clinical implications. We will now discuss

these clinical implications provided in our two supervision models, beginning with the implications generated by the processes of courage, followed by those generated by the processes of support.

Clinical implications generated by the processes of courage

In LSG, the supervisor seeks to facilitate the development in the supervisee, of a sense of her or his own abilities as therapists, to influence for the good the happenings in the therapy sessions (Viney & Epting, 1997). The supervisor develops these feelings of competency as part of their role as clinical educators. An illustration of this is when a supervisee can comment, “It was good that the supervisor played a more supportive role, rather than imparting knowledge.” A sense of doing good, of being useful, is a necessary part of feeling competent. LSGs provide encouragement. In LSGs, it is important that the supervisee has a sense of their own ability to influence the content and dynamics of the supervisory sessions (Viney & Epting, 1997). One strategy recommended by Viney and Epting, and generated by the processes of courage, is that of supervisees taking control over what is to be initially presented in the supervisory session. An example of this is when the supervisor can reflect “the structure we set up made it possible for the therapist to make very good use of our sessions.”

While there is greater possibility that “saying what cannot be said” (Viney & Epting, 1997, p. 8) will occur in LSG, as there are multiple people construing the group dynamics, there is also the danger that members may feel reluctant to take risks. This may occur because the member may feel to do so is pushing themselves forward, or if they do take the risk, it may project back on them and reflect on their behaviour, and trigger feelings of shame (Counselman & Gumpert, 1993), and inadequacy. In LSGs, the supervisor has the opportunity to encourage risk taking by members by role playing such behaviours, or by supporting group members when they raise such issues. In such supervision, ‘the courage’ is shared by all the group members. As it is a role-taking relationship and not primarily a one-on-

one relationship, members can engage in greater risk-taking, and demonstrate greater courage by sharing professional thoughts. It is often easier for the members to not only be courageous in giving opinions but also courageous in receiving feedback. This occurs when the supervisor is able to say "I was able to encourage Jane (the therapist) to express her deepest fears."

Clinical implications generated by the processes of support

Processes of support are facilitated by joint supervisors in PSGs, allowing the supervisee to experience boundary setting and develop an understanding from first hand experience of the importance of maintaining an optimal therapeutic distance (PSG). Optimal therapeutic distance is a clinical implication generated by the processes of support. Optimal therapeutic distance "...implies being close enough to the other to experience the other's feelings, while being distant enough to recognize them as the other's feelings-not (one's) own" (Leitner, 1990, p. 11). It grows from the sharing of commonality in this form of group where modeling occurs.

The characteristics of optimally functioning supervisors/therapists include discriminations, flexibility, creativity, responsibility, openness, commitment, courage, forgiveness, and reverence (Leitner & Pfenninger, 1990). Developing these characteristics, an elaboration of empathy (Leitner & Dill-Stanford, 1993), is facilitated when the therapist has experienced them being applied to his/her self in supervision. Experiencing optimal therapeutic distance in the peer supervisory role relationships, helps the therapist develop this strategy in therapy. It improves the therapist's ability to recognize resistances because as the client contributes to the process of resistance so too does the therapist (Leitner & Dill-Stanford, 1993).

"If the client demonstrates that he is not seeing the problem as the therapist does, some reconstruing is required on the part of the therapist" (Fransella, 1993, p. 118). The same could be said for joint supervisors in the PSG model of supervision. These notions of 'resistance' and 'defense' are experienced in supervision as well.

The joint supervisors work within supportive processes, with shared construing, demonstrating a reverence for their ways of construing the world.

Behaviours that occur in therapy are also present in the supervisory context, lateness, absences, monopolizing, being silent and forming sub-groups (Rosenthal, 1999). A distinction has been made by Rosenthal (1999) in group supervision between nondestructive resistance such as members always presenting successful cases, and destructive resistance such as when there is severe and continued criticism of another member's presentations. Rather than attempting to eradicate the resistance, Rosenthal (1999) recommends the group seeks to resolve the resistance by recognizing, studying, investigating, resolving and it working through. However, there are unique difficulties to resistance resolution in PSGs. In the beginning stages of the group, there is greater dependency on the members' willingness to be curious and possibly the courage to follow through is not there. There are also the difficulties when presenting personal information. When is this information, resistance, or just discussing feelings producing countertransference resistance. Clearly, the latter is within the brief of supervision. So in PSGs, much of the group's development appears to be focused on managing resistance and shame (Nobler, 1980).

By supporting the common constructs in supervision, joint supervisors will also draw on another strategy, that of actively encouraging themselves to spread their dependencies (PSG). In this personal construct supervision, it is argued that supervisors need to encourage supervisees to disperse their dependencies (Viney & Epting, 1997), to see themselves as therapists actively seeking help from a wide range of clinicians (Viney, 1996). As Kelly (1991b) saw that it is crucial for clients to elaborate the field of their dependencies, so when this notion is used reflexively to joint supervisors, it is equally valid (Viney & Epting, 1997). By the nature of its structure, that of a leaderless peer group, dispersion of dependencies in PSGs is better understood.

In this second model (PSG), there are always alternative ways of looking at any event. The group members, like therapists in personal con-

struct psychotherapy, are scientists, testing hypotheses and facilitating experimentation by their clients: "All interventions are based on hypotheses about the client and the therapeutic interaction, they can regard everything that happens in session with curiosity" (Allstetter Neufeldt, 1997, p. 204). Rather than asking the question 'Did I do this right?', the question becomes for the joint supervisors, 'What did we learn when we said or did that?' or, 'Do we have now information that will allow us to make new hypotheses?' (Allstetter Neufeldt, 1997). In this form of supervision, there are always alternative ways of looking at any event. The joint supervisors here expose their peers to a wide range of clinical voices, which provide feedback on their experiences and activities. Not only does it lead to professional growth, it also mirrors the therapeutic processes needed to be undertaken by clients.

Dependency issues between joint supervisors are minimized in group supervision and further reduced in PSGs. In PSGs, there is not the 'expert', the relationship is more equal, with a range of perspectives being provided and received by its members. More varied hypotheses are available to the supervisee. Support from peers to the fellow members that she/he does not need 'to fix things up', can be very powerful and strengthening because there's a sense that her/his peers truly understand, as they are experiencing much the same.

CONCLUSIONS

We have presented two models of personal construct group supervision, led and peer, and have discussed their clinical implications. Both models, we believe are useful because they can be tested and will be tested. Although, it is hard to establish cause and effect relationships between supervision and treatment outcome, we believe our models will possibly lead to efficacious treatment as they have as their focus the development of the therapist/client working alliance. The processes of courage in led supervision groups, and support in peer supervision groups, have been identified as the facilitators of the development of these working alliances. The clinical implications of these models are provided, with the factors generated by the processes of

courage and support, being identified as, the ability to influence the therapy/supervisory processes, and saying what needs to be said, for the led supervision group, and establishing optimal therapeutic distance, and dispersion of dependencies for the peer supervision group.

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