Reflections on the use of technology in clinical supervision: The medium and the message

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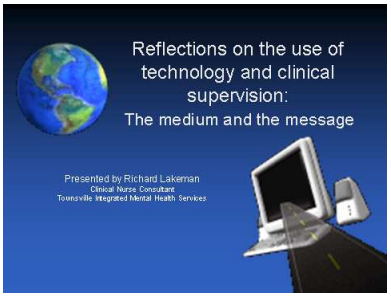

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Abstract:

Clinical supervision has established a long pedigree in the helping professions as a tool to assist people hone their practice, sharpen their skills, and endure the traumas associated with working with people in distress. It has provided a means by which the otherwise private exchanges between health professionals and recipients of care can be reflected upon, examined and improved. The seeds for clinical supervision were planted and germinated in another age in which face to face therapy developed well beyond the gaze of the public, and the knowledge of health practitioners and therapists were inaccessible to all but a few initiates. In a little over a decade, as a consequence of the evolution in digital technology, the ground has shifted. In 1964 McLuhan coined the phrase “The medium is the message” and urged us to consider how we are shaped by the tools that we create. This paper reflects on the changes being wrought through evolving media on our notions of personal identity, community, helping professions and practices such as clinical supervision. If clinical supervision is to continue to bear fruit in the coming years then it will need to be a cultivar of the original variety, firmly rooted in concern for the intimate person-professional relationship but adapted to evolving media and shaped by the global context of professional practice.

In 1964 McLuhan coined the phrase “The medium is the message”. By way of explanation, although less quoted, he also stated “We become what we behold… We shape our tools, and thereafter our tools shape us”. A medium according to McLuhan is any extension of ourselves which effects change. For example language extends our thoughts from in our minds to others, a telescope extends our sight, a shovel extends our hands. We are whom we are both as a consequence of and through the methods we extend ourselves to others. This has profound implications for our interpersonal relationships, our identity, our occupation and how we think about and proceed with innovations such as clinical supervision.

All helping professionals have an interest in extending ourselves in order to influence others. Communication (at least for mental health professionals and clinical supervisors) is our bread and butter and concepts such as relationship, identity, communication, insight and learning are central constructs in the

theorizing about the work we do. The message of any medium is the change of scale, pace or pattern it introduces into human relationships and in our lifetimes we have witnessed change of unprecedented scale in human history.

Until relatively recently the most formative influences on peoples learning, development of identity and culture were other people we interacted with face to face. Communications technologies have radically changed this. The invention of the printing press by Gutenberg in 1452 had a huge impact on the world putting flight to the European dark ages and ushering in the European Renaissance. Rapidly the written word became accessible to lay people and stimulated commerce, scholarship and the rise of nationalism. By the end of the fifteenth century, more than one thousand printers had printed between eight and ten million copies of more than forty thousand book titles. We would not be here today even discussing the idea of clinical supervision, wearing our different professional hats, reflecting our plethora of different roles or enjoying the quality of life that we do without the invention of this communication technology and the subsequent extensions that have enabled the sharing and development of knowledge.

"The charm of history and its enigmatic lesson consist in the fact that, from age to age, nothing changes and yet everything is completely different." Aldous Huxley, 1894-1963, British writer, "The Devils of Loudun"

In this address I want to share some reflections on technology and clinical supervision. I also want to briefly touch upon some research I am involved in on on-line clinical supervision. However, first it is worth locating the clinical supervision in a historical context. Clinical supervision has its historical routes firmly in psychoanalytical psychotherapy.

As Yegdich and Cushing (1998) point out it was and is but one component of training in psychoanalytical work which also includes a trainee analysis and formal education. Initially supervision was a technology by which the therapist could identify 'counter transference' which was initially seen by Freud as "…the analyst's unconscious, conflict-based reactions to the patient's transference" (Hayes, 2004, p.22) and an impediment to effective therapy (Eagle, 2000). However, counter transference has come to be understood much more broadly as a crucial means to understand the patient's transference and world.

Money-Kyrle (1956 in Bateman & Holmes, 1995) famously stated that the emotional work of the analyst is to distinguish his own unconscious phantasies from those of the patient. Clinical supervision is one tool to enable this to occur. Whilst, psychoanalysis from its conception has been something of an exclusive club there is no doubt that derived psychodynamic concepts and assumptions have been a formative influence on the theorizing and practice of most helping professions and the purpose and process of clinical supervision.

In psychiatric nursing it has long been held that nurse and patient have a mutual impact on each other and that our motivations, responses or the pattern in our relationships are often obscure or determined unconsciously (Barker, 1994; Peplau, 1952, 1989). Clinical supervision therefore serves as a vehicle to clarify what is obscure and provide an awareness of what is really going on, in order as

Barker observes (1994, p.67), “to protect people in care from nurses and to protect nurses from themselves”.

Main (1957) in a much-cited article called the “Ailment” illustrates the utility of this process of reflection. Main (1957, p.9) asserted that “…a sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment”. By way of example he observed that no matter what the rationale a nurse would only give a sedative at the moment when she had reached the limit of her resources and was no longer able to stand the patient’s problems without anxiety, impatience, guilt, anger or despair. He noted that it was always the patient and never the nurse who took the sedative. After examining these matters in the investigative style of clinical supervision, with the freedom to recognize both negative and positive emotions the use of sedatives dropped. Main goes on to describe the process by which the impact of recalcitrant and very difficult patients, (whom today would be labeled borderline) were examined by staff:

> *Private ambitions, omnipotent therapeutic wishes, guilts, angers, envies, resentments, unspoken blamings, alliances and revenges, moves towards and against other nurses, doctors, and patients’ relatives, were shown now to have both animated some of the nursing procedures and to have been concealed behind them.* (p.132)

This vision of the potential and the practice of clinical supervision to shed some light on the dynamics or mutual influence of staff and patients evolved in a vastly different context to that which many of us know today. Then sustained therapeutic contact was considered the norm or at least the ideal and psychotherapy had a privileged place in the psychiatric armoury or the role repertoire of nurses and allied health professionals.

At the time when Freud was publishing his famous case studies see (Freud, 1990) an alternative and radically different school of behavioural psychology was being developed by John B Watson (see: Watson, 1913). This eschewed the unconscious and introspection as a means to understanding people and asserted that the proper focus of psychology ought to be observable behaviour.

There remains to this day something of a schism along similar lines about the nature of clinical supervision i.e. whether it is intimately concerned with mutual influence - the conscious and unconscious interplay between one or more people, or whether it is or ought to be considered along the lines of observable behaviour and observable outcomes.

We are likely to agree that clinical supervision is a good thing. However, our experience and expectations of it either as supervisors or recipients is likely to be very different. In part because rarely is the practice open to observable scrutiny and because most of us learn supervision via the apprenticeship of being supervised and are both constrained or enabled by the capacities, orientation and imagination of our selves and our own supervisors. We might at least agree that it more or less serves several functions (Procter in Winstanley & White, 2002):

- Regulatory or normative – that is a process by which another's practice can be scrutinized with a view to maintenance of standards.
- Supportive or restorative – that is assisting the therapist to work through issues and transference that might arise in therapy.
- Developmental or formative – that is processes to assist in role development of the supervisee as well as imparting information and teaching.

Despite the conceptual opaqueness about what clinical supervision is, it is generally considered a good almost miraculous thing. Nevertheless, many nurses continue to view CS with suspicion and are skeptical about the motives behind its promotion and about the potential benefits.

The same is generally true with the introduction of novel communications technologies. When these become assimilated as extensions of ourselves they are quickly taken for granted, although there are always skeptics. According to a Western Union memo from 1876, the 'telephone has too many shortcomings to be seriously considered as a means of communication. The device is inherently of no value to us'. In the same year on the other side of the Atlantic, Sir Richard Preece, the chief engineer of the British post office stated "The Americans have need of the telephone, but we do not. We have plenty of messenger boys". When I had my first experience of community nursing not that long ago, mobile phones were playthings of yuppies and health visitors made do with phone boxes or waited until they got back to the office before using the phone. Today they are considered indispensable. In the recent past there were a fair number of sceptics regarding the usefulness of the telephone for crisis assessment. Today this is taken for granted and groups such as Lifeline field in excess of 450,000 calls a year (LifeLine Australia, 2004).

The mobile phone is ubiquitous presence infiltrating almost every social space. In 1990 one in 100 Australians owned a mobile phone and by 1999 this had increased to forty in 100 (Australian Bureau of Statistics, 2002). Few would have failed to noticed that mobile phones appear to be a 'must have' accessory for adolescents and young adults who often appear more adept at sending text messages than holding oral conversations. We can speculate on the impact of the mobile phone and text messaging on social relations. For example, we now expect people to be available at any time… and for a ringing phone to take precedence over almost any face to face encounter. To what extent is the narcissistic part of us stroked when our phone rings in company? We are noticed, important, maybe an indispensable part of the in-group. It is hardly surprising that adolescents have so rapidly assimilated the technology as it appeals to a primal, tribal pack instinct and a yearning to be part of the group… everyone can own a message stick. We need never be alone… uncomfortable interactions on public transport or waiting alone can be avoided by texting, chatting or surfing the net. The ring tone is a part of people's identity … the buying and selling of which occupies the cash registers of over 200,000 web sites and is obviously lucrative enough to justify prime time television advertisements.

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When we extend ourselves with technology we also amputate other parts of ourselves and there is often a reaction, a backlash, a harkening back to simpler times. With the printing press came a diminishment in the capacity of people to maintain the art of oral history, the telephone led to the diminishment of letter writing… the wheel… and further extensions to the point of the automobile has led to urban sprawl, congested roads, fast food and obesity. Is it possible that with the capacity to reach out to others across vast distances by phone, the Internet and other technologies we are perhaps more alone now than every before? That our capacity to sit in silence, to sit with ourselves or with the suffering of others may be diminished?

The mobile phone is a graphic, visible and sometimes irritating example of evolving and rapidly morphing technology. It is but one example. Don Pember from the University of Washington proposed ‘If ALL HUMAN HISTORY were just 1 CALENDAR YEAR and NOW were midnight on DEC. 31, mass media history would appear like this’:

> Jan. 1 to Dec. 26 -- NOTHING
>
> Dec. 27 -- printing press (1450 A.D.)
>
> Dec. 28 -- news books (1610)
>
> Dec. 31, 9 a.m. -- radio & film (1890s)
>
> Dec. 31, 3 p.m. -- TV (1930s)
>
> Dec. 31, 10:50 p.m. -- CDs VCRs (1980s)
>
> Dec. 31, 11:35 p.m. -- Internet, WWW
>
> Dec. 31, 11:58 p.m. -- digital cameras, cell phones, Ipods, DVDs, etc.

Updated 2005

http://hope.journ.wwu.edu/tpilgrim/j190/timeline.short.html

The Internet is yet another evolving medium. In 1996 I addressed a conference about the experience of psychiatric nurses using e-mail groups. At that time only a handful of the audience even had an e-mail address and most had only a vague idea of what the Internet was. Things are certainly different only nine years latter.

In February 1996, only about 260,000 households (fewer than 4%) had access to the Internet in Australia. By November 2000 this figure had risen to 2.7 million (37% of households). According to the latest estimates some 65% of households now have Internet acess (Miniwatts International, 2005). The Internet is big with more than 47 billion unique domains (not just web pages) registered http://www.whois.net/ (20/2/05). The offshoot of this shifting, changing, growing and evolving media revolution is that not only has the world become a smaller place but also the clock seems to tick faster.

Within seconds we can be exposed to images generated on the other side of the world. We can watch and be moved by tragedies such as September 11 or the Tsunami disaster in real time and feel connected with the suffering of many

across the globe. This is a good thing but possibly it has also led to a long sightedness that blinds us to the suffering of individuals and communities close by to us. The world is open for business twenty-four hours a day. Rapidly, local ideas become global concepts. Whether in London, Hamburg or Melbourne the language of health has been infiltrated by the international languages of commerce and marketing. The business of health has usurped the discourse of compassion and care.

Technology and global trends towards narrowly defined, universally applicable and measurable outcomes, and a blinkered view of the kind of evidence we ought to base our practice on has conspired to forced us into seeking and accepting quick solutions to the most complex of human problems.

> *No commercialized product would exist today were it not a juicy business; obviously, the fight for human dignity, for freedom and justice, or to attenuate extreme social inequalities, to live a serene and frugal life, to gain a reflexive experience where critic (sic) flourishes, are not and do not contribute to 'good business'*. (Velázquez, 2000)

Who isn't somewhat overwhelmed by the vast amount of information and misinformation that we can access at our fingertips any time of the day or night? The need to stay current even in highly specialized fields of interest has become an ideal that few can realize let alone those of us who have a broader concern for the promotion of health and wellbeing generally. The enormity of the challenge has given rise to a collective neurosis that is palliated by recourse to oversimplification, and a discourse populated by essentially vacuous catch phrases and clichés. As Menzies Lyth (1988) observe we can, both as individuals and institutions select from any number of plausible pretexts to avoid patients as a defense against our anxiety. One consequence of technology has been to provide even more. Even in low-tech, high-touch areas such as mental health the demands to enter data for various purpose, complete paperwork and fulfill administrative requirements is not only used as a pretext to avoid clinical supervision and the anxiety that it may uncover but also to avoid patients. We risk becoming slaves to the machine.

Perhaps there has never been more of a need for clinical supervision, to assist us in acknowledging our anxieties in working with and witnessing the suffering of others. Technology, whilst causing the world to speed up, requires more than anything for us to slow down. Main (1957) suggested that the kind of work he facilitated in group supervision could not have occurred quickly, and indeed some time needed to pass before participants could even begin to reflect on the dynamics at play in their workplace.

Evolving media such as the Internet has inextricably altered the relationships between health professionals but also between health professionals and service users. For better or worse, our patients have access to the same information as we do and it is naïve to think that they cannot process it with at least the same degree of sophistication as us. At times we may have greater need for a skilled librarian than a clinical supervisor. Relating to medicine (Radley, 2002, p. 702) observes that:

> The particulars of medical advances (such as telemedicine) provoke not a general change but disturbances in the *intricacies* of people's biographies. Inasmuch as patients feel that they have more control over their health agendas, it is likely that they will expect less of their general practitioner in respect of advice about life in general. However, the correlate of this is that, in future, patients will come to the consulting room with more specific requests, particular concerns, and suggestions.

Indeed, the idea that patient's will even physically visit a consulting room, except in states of dire need is likely to prove quaint in the future. Given the rapid update of various communications media many patients will choose some kind of on-line consultation or therapy on-line. Yellowless (2000) urges, Australian psychiatrists to get on-line or risk being out of touch. A plethora of people already make the Internet their first stop when seeking help. In 2003 the U.K. Samaritans received over 99,000 e-mail contacts (Samaritans, 2005).

It is not hard to imagine some of the advantages of on-line counselling over face-to-face encounter and similar advantages exist for clinical supervision. For example the virtual disembodied nature of on-line communication has been suggested as an asset, which enhances communication and a sense of safety in online support groups for women with eating disorders (Walstrom, 2000). Many manualised based interventions may be readily implemented over the Internet (Castledine, Gaggioli, & Giuseppe, 2003; Marks, 2002). A recent RCT of psycho education and CBT via the internet found both to be effective and with lower drop out rates than in comparable face-to-face trials (Christensen & Oei, 1995). How many people suffering from agoraphobia don't actually make it to the clinic but who might be able to interact on-line?

It is widely recognised that people interact in a more disinhibited manner via the Internet and consequently are much likely to disclose information that might otherwise carry negative sanctions in face-to-face interactions. For example disclosing alcohol or illicit drug use via a computer may yield more honest responses than when screening is undertaken face to face (Cloud & Peacock, 2001; Cunningham, Humphreys, & Koski, 2000). A colleague of mine who lives in a small rural town is receiving her analysis by phone twice a week. This is certainly different from face to face but far from inferior. Indeed it approximates more closely Freud's ideal of the abstinent therapist who presents something of a blank screen for the analysand to project her phantasies onto. Internet mediated therapy or supervision also at least theoretically enables the development of intense projections and transference reactions.

These same dynamics are potentially at play in on-line supervisory relationships. With asynchronous methods of communication such as e-mail both the supervisor and supervisee have time to better consider what to reflect on what is said and consider what to say free from the encumbrances of face management that contaminates much face to face interaction. Prejudicial biases based on visible characteristics or personal appearances are reduced (Stebnicki & Glover, 2001)

For many people the Internet may be the first place they look for help for all problems of living but it might also be the place they find it whether it is via on-

line support groups or health professionals. If this is the case then clinical supervision or at least some approximation to what we now understand it to be is required to address on-line professional relationships.

One much touted rationale for clinical supervision is the supportive function. In the surveys that I have undertaken on the international psychiatric nursing list since 1996 (Lakeman, 1998, 1999) a dominant and reoccurring theme has been the supportive nature of interactions. E-mail is one of the most egalitarian of media with people much more likely to contribute to conversation without regard for social status (Stebnicki & Glover, 2001). Although some respondents stated they used the Internet to access for formal clinical supervision a great many more stated they simply felt supported and kept up to date through the Internet. Watkins (2001) suggests that it is the responsibility of the individual to assess whether and to what extent their needs are being met to share their work with colleagues, get feedback and guidance, develop skills ideas and information, acknowledge their feelings and feel valued and affirmed. It seems at least some if not all of these functions may be met via formal and informal relationships forged over the Internet. If people are able to have their formative and supportive needs met via different methods then perhaps the regulatory or normative functions may be better met at a local level using a mechanism other than clinical supervision, for example through operational or professional supervision.

There are of course some compelling pragmatic reasons why some might take advantage of communication technologies for formal clinical supervision in Australia. The Northern Zone of Queensland covers some one million square kilometers (or roughly three times the size of Britain). Clinicians may be isolated from peers with the appropriate skill and psychotherapeutic orientation… whether they live and work in the city or the bush. In the city congestion, location and time constraints may severely limit the opportunities for supervision from therapists of one's preferred orientation, particularly if the therapist works in private practice.

In Australia, one solution has been video conferencing. Facilities were introduced to Queensland health services in 1995 with 150 video conferencing units having been set up around the state by the end of 1999 (Kennedy, Blignault, Hornsby, & Yellowlees, 2001). Mental Health professionals have been the heaviest users of the technology. In North Queensland video conferencing to access education, clinical supervision, a family consultation or specialist service is now an unremarkable and daily occurrence. Despite Australia's successes in using telemedicine it remains very expensive, poorly co-ordinated at a federal level and under-resourced.

Psychiatric consultations undertaken via video conferencing have been found to be reasonably well accepted and satisfactory to patients and staff (Bishop, O'Reilly, Maddox, & Hutchinson, 2002; Simpson, Doze, Urness, Hailey, & Jacobs, 2001). Nevertheless, the technology is not available to all, is expensive and if every mental health nurse were to use this technology to access clinical supervision our health services would soon be bankrupted. Furthermore, one still has the problem of finding someone with the appropriate orientation, access to technology and time within the organization to provide supervision.

Whilst local or wide area networks may provide the infrastructure to achieve similar purposes, the Internet provides numerous ways to engage in supervisory relationships with others anywhere in the world without the expense of videoconferencing. Quite aside from the obvious means of discussing clinical work synchronously via on-line chat, video or audio conferencing, or asynchronously via e-mail, e-mail groups or bulletin boards… Clinical supervisors might observe therapy on-line. The supervisor as observer, participant is well established in many forms of family therapy and there are few impediments to using the Internet as the means to achieve the same purposes. However with only a few exceptions (Cummings, 2002; Ndiwane, 2001; Oravec, 2000) clinical supervision using the Internet is under-explored and certainly under-researched.

To address this gap, I and a number of other collaborators got together in 2002 to develop a long term research study to: explore the experience of computer mediated clinical supervision; establish the extent to which online clinical supervision matches the expectations of supervisees and meets professional standards; describe differences between computer mediated clinical supervision and face-to-face clinical supervision; and evaluate how communication practices are adapted using different computer applications in the process of online clinical supervision.

We are in it for the long haul and I am not in a position to present any definitive findings. In all 421 people provided an initial expression of interest via a web based form. Respondents were from 43 countries with well over half from the United Kingdom. 3 countries could not be identified. Whilst, all completed the form in English, 32 countries were represented where English was not the first language. These initial respondents were invited by e-mail to respond to a further web based questionnaire which asked about their willingness to engage in on-line supervision, their experience and qualifications. 161 people responded of which the majority identified as being employed as individual psychotherapists, counsellors or psychiatric nurses.

Sixty five returning respondents expressed an interest in providing supervision. 61% identified as a counsellor, psychotherapist or psychiatric nurse. Respondents were asked what their principle psychotherapeutic orientation was and this revealed a very eclectic mix of approaches. I was rather surprised by the lack of CBT therapist participation which may be for several reasons e.g. that CBT therapists may be more ‘manual based’ in their practice and may thus not value supervision as more psycho-dynamically orientated therapists in which transference issues are often grist for the mill for analysis; Or CBT may be subsumed in the group of therapists who like me see themselves as providing an eclectic or integrative approach to therapy.

Qualifications of potential supervisors thus far also appear fairly impressive with 61% being prepared at bachelors level or above in their field of therapy. 58 of the 63 supervisors had worked in their fields for more than 10 years. Most were also well versed in Internet technology with over 80% having 5 or more years of experience using the Internet. I won’t elaborate in any detail on the research methodology as the full research protocol is accessible on the net except to say

that the project is designed to describe the subjects' experience of on-line supervision via a combination of quantitative and qualitative measures.

Those that wish to take part, give or receive supervision must first register interest at online-supervision.net in which basic details are recorded. They are then issued with a password, which allows them to register interest in providing and or receiving clinical supervision. Once registered the user may then search for supervisors, supervisees, or review and change their details held on the secure database. The user can access secure video or voice conferencing facilities, web based chat and e-mail, archived messages, secure file areas, supervision contracts and administration pages for any supervision groups or dyads that they are engaged in. Relatively detailed information is requested of potential supervisors such as registration details with statutory authorities if applicable, membership of professional organizations, contact addresses, liability insurance information etc. Registration, qualifications and membership of organizations are authenticated before the individual is able to provide supervision.

For those that may wish to use the Internet for clinical supervision guidelines have been development, which I will briefly summarize:

Online supervisors and supervisees need to be satisfied of each others' identity, qualifications, competence and scope of practice. This may be facilitated in many ways, including (but not limited to):

a. Sharing off-line contact details such as telephone and snail mail addresses and workplace contact details;

b. The provision of certified copies of qualifications, testimonials etc;

c. The provision of registration numbers of professional organisations, which can be verified against on or off-line registers.

During on-line encounters e.g. in chat rooms or instant messaging sessions it is important to verify the identity of participants e.g. by agreeing on how communication will be opened, for example by sharing some pre-agreed statements, personal details previously shared or an agreed code.

People must be mindful of the legal and professional regulations as they apply in the country, state and professional organization of both the supervisee and supervisor in relation to the supervisory relationship. Law and institutional policy is likely to govern the collection, transmission and storage of health related information and these might differ across jurisdictions.

As with face-to-face supervision it is advisable that supervisees and supervisors negotiate an explicit contract outlining roles, responsibilities, goals, fees, frequency of contact and dates for review of the contract.

A clear understanding needs to be reached regarding

- when the supervisor or supervisee is willing to be contacted
- how frequently they may wish to be contacted

- how quickly they will respond to e-mail and other asynchronous communications
- how they will notify the other of their being unavailable.

Further consideration also needs to be given to record keeping and how grievances will be dealt with.

Like the telephone, few forms of Internet mediated communication may be considered absolutely secure. Names and details of clients, which may be potentially identifiable to third parties, should not be used in Internet communication. Communication from clients should not be forwarded to anyone without their explicit consent. Internet videoconferencing allows the possibility of synchronous transmission and recording of therapy sessions. However video recordings of therapy sessions should not be transmitted to the supervisor without the client's informed consent. Lastly the fields of on-line psychotherapy, counselling and supervision are new and evolving disciplines. Revisit the policy statements and guidance documents on on-line counseling and supervision frequently.

In summary… The Internet and computer mediated communication technologies challenges the traditional notion that the context of clinical supervision need be face-to-face or undertaken by a supervisor intimately acquainted with the local practice setting. It is reasonable to expect that it will become the norm for Clinical Supervision to be undertaken either solely or as an adjunct to face to face encounter via various communication technologies. McLuhan however urged us to think beyond media and technology as mere tools. He said (p.19), "Our conventional response to all media, namely that it is how they are used that counts is the numb stance of the technological idiot". "The use of any medium or extension of man alters the patterns of interdependence among people, as it alters the ratios amongst our senses" (p.97). Whether we choose to actually use technology in the process of clinical supervision there is no question that we are affected by it. Technology has altered and is rapidly changing the nature of the relationships we have with people, how we think about ourselves and our place in the world, and how we think about the work we do. Reflecting on how technology has altered human relationships reaffirms the need to slow down and perhaps consider afresh the original purposes of clinical supervision to try and better understand what drives or impedes our actions. This needn't be anything to be afraid of and will serve to protect us from being slaves to the machine. McLuhan (1964, p.53) suggested "The artist is the man in any field, scientific or humanistic, who grasps the implications of his actions and of new knowledge in his time". Clinical supervision is an artistic process and those of us who care about developing clinical supervision will do well from time to time to reflect on the medium and the message.

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