

# ATOL: Art Therapy OnLine

## Final Thoughts on the Clinical Supervision of Art Therapists

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## **Abstract**

In the UK, all registered counsellors and psychotherapists – including art therapists – are required to have their clinical practice supervised for the duration of their working life. This article explores this requirement and examines some of the expectations and values that underpin it.

**Keywords:** clinical supervision, contracting, personal therapy, regulatory framework, surveillance culture

## **Preface**

When Tessa Dalley invited former members of the Editorial Board of ATOL to contribute to a special issue to mark the journal's 10-year anniversary I was both flattered and a little unsettled by her gesture. The brief was a very open one and Tessa's suggestions for meeting it included writing something about the journal, about on-going professional issues or some reflection on the passing of time. Having said yes almost immediately I was then left to ponder at my leisure what I might actually contribute. After running through various options, I eventually settled on the topic of clinical supervision. I did so for three main reasons.

Firstly, what I have to say on this topic does, I believe, meet the brief.

Secondly, over the years I have published a number of articles and book chapters on the subject of clinical supervision; see Edwards, 1993, 1994, 1997, 2010 and 2017. Each of these contributions to the literature reflects my developing interest in, and evolving thoughts about, this vitally important aspect of clinical practice. However, none of these articles have been published in ATOL, so the opportunity Tessa kindly afforded me to extend my readership is very welcome.

My final reason is more personal. Like most of its predecessors, this article is also based on a talk; in this instance one given to students on the Art Therapy Northern Programme in Sheffield on 21-05-19. Although I continue to provide clinical supervision to a small number of therapists, my days as an academic and practicing art therapist

are now over. I intend to relinquish my professional registration with HCPC and to retire fully from art therapy by the end of 2020. I mention this fact because that talk, and this article, marks my final public words on the clinical supervision of art therapists. I hope readers will find them to be of interest.

### **What is clinical supervision and what is it for?**

In the British Association of Art Therapists *Guidelines for Workplace Placement Supervisors of Art Therapy Trainees* (BAAT, 2009) you will find the following statement,

‘Qualified Art Therapists are required by the Code of Ethics and Principles of Professional Practice of the British Association of Therapists to undertake supervision of their clinical work. Clinical supervision is part of clinical governance and is required to ensure high standards of clinical practice, and for the protection and welfare of patients/clients. It also contributes to the continuing personal development (CPD) of the Art Therapist. The clinical supervision of trainees ensures that these values are embedded as best professional practice from the start of their training’ (BAAT, 2009).

This article explores and critiques these expectations and values.

In the UK, all registered counsellors and psychotherapists – including art therapists – are required to have their clinical practice supervised for the duration of their working life. This is primarily because, as Wheeler and Richards (2007) note,

Supervision has an impact on therapist self-awareness, skills, self-efficacy, theoretical orientation, support and outcomes for the client (Wheeler and Richards, 2007: 63).

The importance of clinical supervision in developing and maintaining sound clinical practice is underscored by the British Association of Art Therapists in its Code of Ethics and Principles of Professional Practice for Art Therapists (BAAT, 2014), where it is specified that,

‘Members must monitor their own professional competence through clinical supervision in accordance with the Association’s supervision guidelines and clinical supervisors should apply to be accredited by the Association’ (BAAT, 2014).

As Case and Dalley (1992) argue, for art therapists ‘Access to regular, good supervision is important for on-going working practice and extending the dialogue of understanding’ (Case and Dalley, 1992: 167). The emphasis here is placed upon developing the clinical skills and understanding of the art therapist. In other words, clinical supervision is intended to provide new and experienced art therapists alike with the opportunity to gain creative, original and objective insights into the clinical work being undertaken.

### **Definitions of clinical supervision**

When applied to psychotherapeutic work such as that undertaken by art therapists, the term ‘clinical supervision’ is generally used to describe the process by which the therapist receives support and guidance in order to ensure the needs of the client are understood and responded to appropriately. That is to say, with – amongst other things – empathy, understanding, wisdom and compassion. In practice, this requires that we grapple with the conscious and unconscious dynamics operative in the client-therapist relationship – with not knowing – and avoid drawing conclusions prematurely. It also requires that we are mindful of the organisational dynamics that may impact upon this relationship.

Since the term first began to appear in the professional literature numerous attempts have been made to define what supervision is and what it is for. However, as the following examples illustrate, none of these definitions does full justice to the complexity and subtlety of the practice of clinical supervision. Although the wording may be similar, each definition tends to reflect the diverse expectations and theoretical models underpinning the practice of supervision and the clinical work it supports. The term ‘clinical supervision’ remains open to differing interpretations.

The British Association of Counsellors and Psychotherapists (BACP) Ethical Framework for the Counselling Professions, for example, includes the following statement on supervision,

‘Supervision is essential to how practitioners sustain good practice throughout their working life. Supervision provides practitioners with regular and on-going opportunities to reflect in depth about all aspects of their practice in order to work as effectively, safely and ethically as possible. Supervision also sustains the personal resourcefulness required to undertake the work’ (BACP, 2018).

The BACP Ethical Framework also includes the following statement on clinical supervision,

‘Good supervision is much more than case management. It includes working in depth on the relationship between practitioner and client in order to work towards desired outcomes and positive effects. This requires adequate levels of privacy, safety and containment for the supervisee to undertake this work. Therefore, a substantial part or preferably all of supervision needs to be independent of line management’ (BACP, 2018).

In its 2018 policy statement on clinical supervision, the UK Council for Psychotherapy states,

‘Supervision is understood as a reflective and evaluative process conducted within an articulated working relationship between a qualified or trainee psychotherapeutic practitioner and an appropriately knowledgeable supervisor as defined by College or Organisational Member in their written Supervision Statements/policies’ (UKCP, 2018).

A little later in the document UKCP add,

‘Supervision can take a number of easily identifiable formats such as in facilitated groups; peer groups; on a one-to-one basis; by telephone; online; in writing, verbally or by use of digital media.’

In the guidelines for supervision for State Registered Art Therapists (BAAT, 2014), the British Association of Art Therapists state the following about clinical supervision,

'Art Therapists are required by The Code of Ethics of The British Association of Art Therapists to retain their State Registration, to undertake supervision of their clinical work. Supervision is required to support the protection and welfare of patients/clients, for good clinical practice, to contribute towards the continuing working development (CPD) of the Art Therapist. The BAAT wishes to emphasise that the provision of supervision falls into two categories, firstly, clinical supervision and secondly, managerial supervision, although some tasks will be common to both' (BAAT, 2014).

Within these two categories, clinical supervision is understood to be primarily concerned with clinical matters such as techniques, the appropriate use of theory, transference and counter transference issues and the delivery of a safe and ethical service to clients. Managerial supervision, by contrast, is intended to provide a forum within which the supervisee might review areas of difficulty arising out of day-to-day operational and administrative tasks they are required to undertake, discuss future developments, set tasks and targets, monitor training needs and levels of stress and explore the impact of organisational dynamics on their work.

According to BAAT's guidelines, the tasks common to both clinical and managerial supervision include addressing organisational issues and report writing. For BAAT,

'The main aim of Clinical supervision is to support safe and best practice. To this end, Clinical Supervision provides time in which the supervisee's practice may be enhanced by considering the following.

- To look at ingrained patterns of practice and challenge them where relevant.
- To expand clinical techniques and theoretical structures.
- To examine the therapeutic relationship between therapist and patient/client and the way in which this impacts on the progress of the therapy.

- To understand organisational issues that affect the work context and how these impact on the clinical work.
- To endeavour to comply with the supervisee's code of professional practice and the delivery of a safe service to clients.
- To analyse the clinical material and its expression through the particular art form.
- [To] Periodically to review the original aims of the therapy and discuss time scales of the intervention.
- To mark turning points within the therapeutic relationship.
- To provide a framework for understanding the unspoken process and agendas.
- To decide on appropriate changes and adjustments within practice.
- To evaluate whether these changes have been appropriately implemented.
- To engage with preparing appropriate feedback and verbal and written reports to colleagues.
- To support [the] further learning and professional development of [the] supervisee' (BAAT, 2014).

I intend to say more about the explicit and implicit functions of clinical supervision later, but before doing so I wish to turn to the art therapy literature on clinical supervision.

### **The art therapy literature on supervision**

The first, and possibly the most important thing to say about the literature specifically concerned with the clinical supervision of art therapists is that it is modest in scale; especially when compared to the much more extensive literature on the clinical supervision of nurses, social workers, clinical psychologists, social workers, counsellors and psychotherapists. It is also worth noting, I believe, that what has been published on the supervision of art therapists has very largely been written by art therapists working in North America; see Appendix.

The key text in the literature on the supervision of art therapists written by UK based art therapists is Joy Schaverien and Caroline Case's 2007 book, *Supervision of Art Psychotherapy* (Schaverien & Case, 2007). In her survey of the literature on art therapy supervision in *Supervision of Art Psychotherapy*, Caroline Case identifies a number of key themes in contemporary art therapy supervision. It is beyond the scope of this article to address these themes in detail here, but they may be summarised as follows,

- Supervision as a form of teaching, particularly in the placement setting
- Supervision as self-reflection
- Supervision as a forum for sharing experience and concerns, again particularly during training
- The difficulties associated with balancing the need to be seen to be doing something with what Case refers to as 'staying with' and resisting the need to know or understand the meaning of client images. An approach that may lead to reductive interpretation.
- The use of art to explore the supervisory relationship itself. Case makes the point that far from being universal, the images and objects made in therapy, and seen in supervision, are embedded in both personal and cultural frames of reference and that both art therapists and clinical supervisors need to be sensitive to this. Case also addresses the issue of how the supervision process is transformed by the physical presence of images and objects. In doing so she touches on the

ways in which images and objects are brought to supervision – carefully, thoughtlessly or not at all – and how they are – literally – seen; on the floor, pinned to a wall, or on the screen of a smart phone. In her discussion of these and related issues Case is drawing attention to the physical (embodied) presence of images and objects in art therapy supervision and how through them this offers unique access to the inner life of the client.

- Whether supervision ought to be concerned with helping the supervisee learn about her or his own emotional responses to clients and their images or learning about therapeutic techniques and strategies.
- The role of difference (gender, sexuality, class, disability) and cultural diversity in supervision. Case makes the point that far from being universal, the images and objects made in therapy, and seen in supervision, are embedded in both personal and cultural frames of reference and that both art therapists and clinical supervisors need to be sensitive to this.
- The importance of the physical presence of images and objects in clinical supervision.

Case concludes her review of the literature on art therapy supervision by discussing the work and ideas of those supervisors who employ non-verbal approaches – image-making, role-playing, using objects and so on – with the intention of ‘trying to access knowledge and understanding that a supervisee has about a client that is at the edge of awareness’ (Case, 2007: 23).

### **Clarifying the Task**

As the forgoing discussion makes clear, the function of clinical supervision in relation to the work undertaken by art therapists is complex and multi-faceted. As such, the supervision process includes a number of functions concerned with developing and supporting art therapists in their therapeutic role. This includes,

- Clinical governance.
- The exploration of feelings.

- Enhancing self-awareness
- Addressing professional concerns
- Improving the service provided to the client

In addition, clinical supervision should – in my view – help to support therapists in their clinical role through,

- Providing psychological containment
- Providing a means of addressing the stresses involved in psychotherapeutic work
- Helping the supervisee work in more effective and/or creative ways.

Clinical supervision is not or should not be,

- A means of surveillance.
- Part of a formal performance review aimed at improving efficiency and reducing costs.
- A substitute for counselling or psychotherapy.

There is – I believe – a tension at the heart of clinical supervision in all settings, including training placements. This tension is between supervision in the service of clinical governance, quality assurance, resource management and the protection of clients, and supervision as a means of facilitating the professional and personal development of the supervisee. Supervisees need to be able to learn from their experience and this includes acknowledging mistakes, vulnerabilities, doubts and uncertainties – amongst other things – and seeking help or support in understanding and addressing these.

Set against this is the understandable need supervisees have to demonstrate their clinical competence, that they are conducting themselves professionally and meeting

expectations. For qualified art therapists this tension may encompass fitness to practise issues in addition to demonstrating their ability to meet specified clinical outcomes and targets. The challenge facing supervisees and supervisors in such circumstances is to establish a climate of trust in order to avoid supervision becoming defensive and/or persecutory.

### **Normative, Formative and Restorative Supervision**

In the 1980s Brigid Proctor (Proctor, 1987) – a counsellor – developed the idea that supervision has three main purposes; namely, that it was normative, formative and/or restorative. These three criteria provide a useful basis for helping to clarify what I believe to be the primary tasks of clinical supervision.

**Normative supervision:** When supervision is normative, the focus tends to be on issues such as accountability, quality assurance and the maintenance of professional standards. In other words, the focus of supervision is on whether the supervisee is conducting themselves professionally in relation to issues such as confidentiality and other potential boundary violations; including inappropriate personal disclosure, the development of proscribed dual relationships (including sexual relationships), the emotional or financial exploitation of clients and the therapist's fitness to practise<sup>1</sup>.

The normative function of clinical supervision is derived from the expertise, authority and 'gate-keeping' responsibilities assumed by supervisors. These responsibilities invest supervisors with considerable power and both they and their supervisees may at times struggle with this. The very real inequalities of power in the supervisory relationship, particularly during training, may also be heightened by transference issues arising out of past good or bad experiences of being in similar power relationships.

**Formative supervision:** When supervision is formative – as it is during training, for example – the focus tends to be on issues such as the development of skills, knowledge and understanding. This may be local, in terms of the specialist skills, knowledge and

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<sup>1</sup> When considering fitness to practise cases, HCPC assess whether the matters complained about could amount to a breach of standards. The two sets of standards used are the standards of proficiency and the standards of conduct, performance and ethics. These standards and other guidance can be found on the HCPC website at [www.hcpc-uk.org/standards](http://www.hcpc-uk.org/standards) [Accessed 10-03-20]

understanding required to work in a particular setting, with a particular client group or to practice within a particular model. The aim, broadly defined, is to enhance the therapist's knowledge and understanding. For art therapists this aspect of supervision will be primarily concerned with enriching the supervisee's emotional and intellectual response to client's psychological difficulties as expressed through their imagery.

**Restorative supervision:** When supervision is restorative, the focus tends to be on helping the therapist manage the impact clients – including the client's imagery – may be having upon them and their emotional responses to these; including fear, irritation, fascination, boredom, distaste, erotic attraction and enchantment; see Schaverien (2007) for a thoughtful discussion on this last point. As Kraemer (1990) observes,

The novel idea which supervision has to get across is that therapy is not so much about trying to influence the patient as seeing in which ways the patient is influencing the therapist (Kraemer, 1990: 1).

It is, I wish to argue, in the interests of both therapists and their clients that supervision provides a safe, containing and healing space; a space for thinking, feeling and playing; a space where not knowing can be tolerated, the supervisee's anxiety might be reduced and understanding increased; a space 'in which peripheral thoughts, feelings and fantasies in relation to the patient [or client] can be brought into awareness and examined' (Mollon, 1989: 120).

### **Supervision and personal therapy**

Any consideration of the restorative function of clinical supervision will, I think, inevitably touch upon the relationship between supervision and personal therapy. Just as there may be a degree of overlap between clinical supervision and managerial supervision – as previously noted – there may also be a degree of overlap between clinical supervision and personal therapy. As Ekstein and Wallerstein (1972: 251) for example observe, both clinical supervision and personal therapy involve addressing 'affective problems, interpersonal conflicts, [and] problems in being helped'. Despite these areas of commonality, necessary and important functional differences exist between clinical supervision and personal therapy. Clinical supervision, unlike personal therapy, is primarily oriented toward helping therapists help the patients or clients they work with.

The difference between the two forms of helping relationship is essentially one of purpose (Edwards, 1993: 218).

Nevertheless, rarely are the lives of therapists untroubled, and our personal lives – past and present – will inevitably have an impact on our work with clients. As Adams (2014: 14) observes, ‘Our histories are what they are, and our motives for becoming therapists are rarely straightforward or simple’. This is important and relevant to clinical supervision because it is generally assumed that the personal therapy trainees undertake before or during training will be sufficient to help ensure they are ‘aware of their own psychopathology and what personal issues may be triggered by transference and projections from the client’ (Hogan & Coulter, 2014: 215).

Even in those instances where the art therapist has had an opportunity to recognise and address their own unresolved problems through personal therapy, meeting this expectation remains a daunting task; particularly if the art therapist is repeatedly exposed to very powerful projections, transferences and unconscious dynamics without the containment provided by being a member of a supportive team or organisation. We are all, to some extent, ‘wounded healers’ and these wounds may be exposed through our work with clients and in clinical supervision (Wheeler, 2007)<sup>2</sup>.

When discussing the restorative aspects of clinical supervision, it also needs to be borne in mind that art therapists in training, as well as those already qualified, may find themselves working with very traumatised, disturbed, distressed or distressing clients and are consequently exposed to the risk of experiencing vicarious trauma.<sup>3</sup> For art

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<sup>2</sup> The term ‘wounded healer’, as attributed to psychotherapists, was first used by Carl Jung. As Zerubavel and O’Dougherty Wright (2012: 482) observe, ‘The wounded healer is an archetype that suggests that healing power emerges from the healer’s own woundedness... and that the wounded healer embodies transformative qualities... It is important [therefore] to differentiate between the wounded healer and the impaired professional. The latter refers to therapists who are wounded and whose personal distress adversely impacts on their clinical work’.

<sup>3</sup> See <https://www.bma.org.uk/advice/work-life-support/your-wellbeing/vicarious-trauma> [Accessed 10-03-20]

therapists employed in organisations such as the NHS, therapy may be taking place in a context that is itself 'dysfunctional and disabling' (Copeland, 2005: 125).

### **Establishing a Working Relationship**

Although a broad consensus now exists within the art therapy profession regarding the importance of supervision, individual supervisors and different organisations will have diverse views on how supervision should be organised and structured (Schaverien, & Case, 2007). The form clinical supervision takes, and the extent to which it is able to help the supervisee learn, develop and provide a safe service to clients will be determined by a number of factors, including:

- Whether the supervisee has a choice regarding who they see for supervision or its mode of delivery. Due to the financial restrictions within which mental health and social service organisations now operate – including those in the voluntary sector – much of the clinical supervision that was once externally funded is now provided in-house. For many art therapists, this very often means their clinical supervision will no longer be provided by an art therapist or on a one to one basis. In these circumstances, art therapists seeking specialist supervision, on a one to one basis, from a suitably qualified and experienced art therapist will be obliged to self-fund this.
- The experience, professional background and theoretical orientation of the supervisor. While many art therapists are supervised by more experienced members of their own profession, during or after their training, not all are.
- Whether the supervisor has received any supervision training. In recent years this has become much more of a requirement, especially for organisations that continue to fund external supervision.
- The mode of supervision. Supervision has traditionally been provided individually or in a group; with – or in the case of peer supervision, without – the presence of supervisor. With the development of new technologies, however, the supervision can now be provided online via Facetime or Skype.

- How case material is presented in supervision. Most accounts of clinical work given in supervision are verbal. For art therapists, however, there may be some practical as well as ethical dilemmas related to the manner in which client images are brought to or worked with in supervision. Some supervisors require their supervisees to bring detailed verbatim notes as well as images to sessions, while others – myself included – prefer a less structured, more spontaneous approach. Case material may also be presented in supervision through the use of audiotape, videotape, role play or through using other forms of creative expression; see, for example, Lahad, 2000 and Skaife, 2019 (Chapter 10). In family therapy work supervision is often provided live, using a one-way screen or other recording techniques (Vetere and Sheehan, 2017).
- Other important variables likely to influence the supervision process are the personality, teaching and learning styles of the individuals involved (Kitzrow, 2001), along with such factors as the supervisor and supervisee's gender, age or ethnicity.

Arguably, the most important factor in determining whether the agreed aims and anticipated outcomes of clinical supervision are met, however, is the quality of the working relationship established between the supervisor and supervisee. As Ormand (2010) observes,

‘Supervision involves a relationship and so, like any relationship, it provides ample scope for the experience of anxiety, frustration, conflict and misunderstanding, as well as excitement and satisfaction’ (Ormand, 2010: 379).

It is essential, therefore, that both supervisee and supervisor are as clear as possible regarding their mutual expectations from the outset.

### **Contracting**

The main purpose of contracting in clinical supervision is for each party to be aware of – and agree or consent to – the practical and psychological components of the relationship in which they are about to enter. It is generally accepted as good practice that clinical supervision – like the clinical work it supports – should be guided and

informed by some form of contracting and that this should, preferably, be in writing (Skaife, 2019).

Where the supervisee is paying for their own clinical supervision this is a relatively straightforward process and will – as a minimum – cover such matters as the location, length and frequency of supervision sessions, cancellation arrangements, the style and theoretical orientation of supervision in addition to its cost.

Matters may be further complicated where ‘external’ clinical supervision is either provided by or paid for by an organisation or by the supervisee’s employer. In these situations, who is responsible for what is not always as clear as it perhaps could or should be; another reason why it is helpful to have some form of written contract or agreement from the outset (Edwards, 2017).

If supervision is to meet its agreed or intended aims and objectives – however these might be defined – both supervisors and supervisees have roles to play, and responsibilities to assume, in relation to this; see Hawkins and Shohet, (1991) for a thoughtful discussion of this issue. Whether the clinical supervision we provide or receive is ‘good’ or ‘bad’, helpful or unhelpful, is always likely to remain to some extent subjective. Nonetheless, we do have some clues as to what may or may not be helpful about clinical supervision. The British Association of Art Therapists recently conducted a survey of the supervision its members offer and receive. The survey results may not be definitive, but they are revealing.

For example, in reply Question 16 – *On the whole, how would you rate your supervision?* – of the 345 replies received, 44.06% (152 individuals) rated their supervision as excellent; while a further 33.62% (116 individuals) rated it as very good. Only 0.58% of respondents (2 individuals) rated their supervision as poor.

As regards what might be considered ‘good’ or ‘bad’ supervision, Question 24 – *Could you sum up what for you is good supervision and why?* – elicited the following responses:

- Mutual trust and openness

- Managing sensitively potential 'shame' dynamics
- Trust in supervisor's skills and knowledge
- Empathy, containment and reliability
- Good reliable boundaries
- Reflective, exploratory, listening stance
- New perspectives
- Maintain optimism and strength
- Prevent burnout
- Internalising supervisor to build resilience
- Transparency
- Client-centred and empathy-building

By way of contrast, Question 25 – *Could you sum up what makes for poor supervision and why?* – prompted the following replies:

- Either not challenging enough or over-critical
- Boundaries between managerial/organisational issues and clinical work blurred
- Too narrow on theory
- Dated experience of clients and context
- Talking about self and own issues – burdening supervisee
- Not thinking about how to meet challenges in the real world/not offering actions
- Shutting down thinking
- Over-prescriptive
- Under active – nothing given

Choosing the 'right' supervisor can be as important as choosing the 'right' therapist. Faced with the task of identifying a suitable clinical supervisor, the forgoing lists may provide a helpful starting point, but they can do no more than that. Depending on our circumstances and needs we may have very different requirements when drawing up a list of essential and desirable qualities we would wish a clinical supervisor to offer. Is it, for example, essential the supervisor is an art therapist or that they have undertaken a training in clinical supervision? Is the distance required to travel from home or work to see the supervisor a factor? And if your supervision is being arranged privately, how much can you afford to pay for it?

As noted at the beginning of this article, trained and qualified art therapists intending to work clinically are required to access clinical supervision and to continue doing so throughout their career. Clinical supervision is an essential aspect of professional practice and is one that ultimately relies on all the parties involved being able to establish a mutually trusting and collegial relationship in order for it to succeed and, ultimately, be of benefit to clients.

### **Postscript**

At its heart this article remains what it originally was; a talk given to art therapy students in training that is now seeking a wider audience through its publication in ATOL. Although originally written with a specific audience in mind, I believe this article nevertheless highlights a number of issues likely to be of interest to a wider audience, particularly those art therapists at the beginning of their careers and clinical supervisors who do not themselves have a background in art therapy. This is not, however, to deny its limitations. Despite having used the word 'Final' in the title, there is always more that could, and possibly should, be said about the clinical supervision of art therapists. As a postscript to this article I have, therefore, added a few more personal reflections on the clinical supervision of art therapists.

### **Plus ça change, plus c'est la même chose<sup>4</sup>**

In one of my first published essays on art therapy – *Five years on: Further thoughts on the issue of surviving as an art therapist* (Edwards, 1989) – I described the three main problems facing art therapists who wished to work psychotherapeutically in institutions such as the large psychiatric hospitals then found on the edges of our major cities and towns. I identified these problems as being those of recognition, integration and validation. In concluding my essay, I discussed the role clinical supervision – as I then understood it – might play in helping art therapists survive the internal and external conflicts these problems gave rise to.

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<sup>4</sup> The more things change, the more they stay the same:

<https://www.collinsdictionary.com/dictionary/english/plus-ca-change-plus-cest-la-meme-chose> [Accessed 10-03-20]

'Whether we are just beginning or are art therapists with many years of experience, our first concern that we do not harm those we seek to help... Above all, as the psychotherapist Robert Hobson (1985) has so succinctly put it, 'We need to go on learning how to learn - about others, about relationships, about ourselves' (Edwards, 1989:175).

What strikes now as I re-read my own words some thirty years on since they were first written is both how much and how little things have changed over the intervening years. The large psychiatric hospitals of the kind I trained and worked in during the 1980s may have been repurposed as upmarket housing or disappeared from the landscape altogether, but art therapists continue to struggle to have their work recognised, integrated and validated in today's mental health and social care systems. What has remained as a constant throughout my subsequent career has been the importance of clinical supervision as a way of continuing to learn, develop and survive as a clinician.

### **Supervision and surveillance**

An early lesson learnt during the period I worked at Stanley Royd Hospital (from 1982 to 1989) was the institutional suspicion of anything that took the form of a 'private' conversation. This, of course, included the kinds of conversation that might take place in an art therapy session. Privacy was viewed as being synonymous with secrecy and was therefore to be discouraged. If a patient left a session in distress an explanation was expected. To diminish the likelihood of such occurrences in art therapy sessions, the institutional response during the early part of my tenure was to insist that nursing staff accompany patients to the Art Therapy Department and remain with them for the duration of their time there. This, it was argued, was to the benefit of all. An alternative perspective, mine, took the view that I simply wasn't trusted to do what the institution required of me; to keep a lid on things<sup>5</sup>.

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<sup>5</sup> The surveillance culture in operation within Stanley Royd Hospital had a long history. The oldest part of the hospital architecture included a central surveillance point from which patients could be observed reminiscent of Jeremy Bentham's popular 'Panopticon' vision for prison design; <https://en.wikipedia.org/wiki/Panopticon> [Accessed 10-03-20]

Fast forward four decades and art therapists and their work remain under surveillance, more discreetly perhaps, but often to the same ends. The institutions and organisations that employ art therapists still want to know what is going on behind closed doors. In some ways, of course, this insistence on transparency is important and necessary. As Rizq (2019) observes,

‘Transparency nowadays carries connotations of openness, democracy, accessibility and truth... Our determination to disinfect the cobwebby corners of public life – our insistence on open government, freedom of information, informed consent and the public’s right to know – has resulted in a culture privileging not only the visibility of information, but also the visibility of the self.’ (Rizq, 2019:3).

While it might well be argued that a measure of transparency is essential in order to ensure that art therapists and other mental health professionals are conducting themselves professionally and meeting expectations, such scrutiny is not without consequences; some of which, I wish to suggest, impact negatively upon the clinical supervision of art therapists.

As Rizq also notes,

‘The transparency agenda not only produces swathes of data incomprehensible to the lay person, but also leads to a range of conflicting opinions and interpretations. This undermines trust in professionals like doctors, lawyers, teachers and psychotherapists whose ‘expert systems’ cannot be rendered completely transparent.’ (Rizq, 2019:3).

The number of sessions we offer clients, along with the number of client DNAs we experience and our clinical outcomes measured against institutional expectations, are all subject to bureaucratic surveillance. Simply put, accountability has replaced trust.

Those of us who have found supervision helpful tend, in my experience, to value its restorative and formative functions and are inclined to overlook or turn a blind eye to its normative or regulatory ones. And yet the quality control aspects of clinical supervision are not insignificant. For the supervisors of trainees, these ‘normative’ or ‘gate-keeping’

functions – as evidenced through placement reports, for example – are intended to ensure the latter are able to achieve and work to agreed professional standards. Whether such reporting mechanisms always fulfil their intended purpose, however, is a matter for debate.

For HCPC registered art therapists in clinical practice, clinical supervisors are often delegated responsibility – more implicitly than explicitly – for ensuring professional standards are maintained and that the art therapist is fit to practise. To ensure accountability, some employers require regular written reports on the supervisee's use of supervision. While the writing of such reports may, arguably, be useful and necessary during training, the value of such reports to qualified and registered art therapists – or their clients – is more difficult to establish. Indeed, this continuous surveillance may serve only to diminish the therapist's sense of professional autonomy through making it more risk averse, while also undermining trust in the supervisory relationship.

In a society where surveillance in one form or another has become the norm – from the proliferation of CCTV cameras to the data collecting activities of Google, Amazon and Facebook – perhaps we should not be entirely surprised by this trend. We may not yet have reached the point where all therapy sessions are recorded and all therapists are required to wear bodycams, but there can be little doubt that the privacy and integrity of both the therapist/client and supervisor/supervisee relationship are increasingly being impinged upon. As I have previously argued elsewhere, rather than providing a safe space in which to facilitate the professional development of the supervisee, supervision is at risk of becoming a form of surveillance focused on managing organizational anxiety, improving efficiency and reducing costs (Edwards, 2017).

### **The use of image making in supervision**

A criticism made of the original draft of this article when I submitted it for publication was that it lacked a critical exploration of 'the dynamic potential of the image in supervision, the use or not of art making, etc'. I freely acknowledge this limitation. However, it was never my intention to offer such an exploration either in this article or in the talk on which it is based. The primary function of both has been to provide an introduction to the policies and procedures – the regulatory framework – that now govern the clinical

supervision of art therapists and other mental health professionals and to open up a conversation about some of the expectations that inform these<sup>6</sup>.

While it is clearly beyond the scope of this postscript to provide a critical exploration of the use of image making in supervision, readers looking for a discussion of the role making or looking at images might assume in clinical supervision may find some of what they are looking for in my paper, *Keeping Creativity Alive* (Edwards, 2010). In that paper, I argued that an essential part of the clinical supervisor's role is to help create a space for thinking, feeling, reflection and learning; that is to say, a facilitating or holding environment (Winnicott, 1980) in which the therapist/supervisee is free to play, with metaphors and with images.

Creative play in the service of learning, while not without its challenges, offers the supervisee an opportunity to reflect upon and learn from clinical experience and arrive at a fresh understanding of the client, their difficulties, their images and their own responses to these. Unfortunately, this view of clinical supervision as learning through

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<sup>6</sup> Readers may disagree with me on this point, but I believe it is helpful for practicing art therapists, and those who supervise them, as well as trainees, to be mindful of the regulatory frame within which the clinical supervision of art therapists now takes place. As the development of clinical supervision trainings specifically designed to meet the needs of trainees and practicing art therapists demonstrate, even experienced art therapists and clinical supervisors might benefit from revisiting and rethinking the ideas and theories that inform and sustain the clinical supervision they offer or receive. Nevertheless, over emphasising the importance of the regulatory frame can be less than helpful. In her critique of Robert Lang's rather 'stringent' approach to establishing and maintaining the therapeutic frame, Siegelman (1990) offers the following observation.

My own metaphorical speculation is that frames should be steady and secure, but perhaps they can be made of a material that is somewhat elastic and resilient, that conforms in some way to the shape of what is being framed. To pursue the analogy, one type of material cannot be used to frame every painting (Siegelman, 1990:182).

Much the same applies, I wish to suggest, to the regulatory frame that borders clinical supervision. To pursue the analogy a little further, we need to be aware of the frame in order to best match it to that which is being framed.

play – in addition to potentially inviting the criticism that it is neither serious or purposeful – does not sit comfortably with the clinical governance and/or quality control functions it is nowadays expected to fulfil. This is perhaps particularly problematic for art therapists employed in public or private sector services where the tick box, target driven culture of the market place have all too frequently led to time and compassion being regarded as unaffordable luxuries. Where this is the case, anxieties regarding the regulatory framework within which art therapists currently practice may serve only to inhibit the disclosure of any perceived shortcomings the supervisee fears they may have, thus further stifling creativity in supervision and possibly leading to a collusive or controlling relationship (Mander, 2002). Such a relationship is, I wish to argue, antithetical to that which is most valuable about clinical supervision; for art therapists, the organisations that employ them and the clients they work with.

### **Acknowledgements**

As this article marks my final published words on clinical supervision of art therapists, I would like to take this opportunity to thank all those former supervisees, supervisors and colleagues who have helped me think about and develop my art therapy and clinical supervision practice.

### **Biography**

David Edwards trained as an art therapist at Goldsmiths College, graduating in 1982. Since qualifying, he has worked in a range of clinical and educational settings; mainly with adults. His book *'Art Therapy'* was first published by Sage in 2004. A second edition was published in 2013. Semi-retired, David currently works as a clinical supervisor in private practice in Sheffield.

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### **Appendix 1: An incomplete list of art therapy supervision references**

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