Using Role Theory in Clinical Supervision

by Mike Consedine

Mike Consedine is a psychiatric nurse, psychotherapist, Psychodramatist and TEP-in-training. He developed and taught clinical supervision based on psychodramatic thinking and practice during his work as in-service training supervisor in a large psychiatric hospital. During the last 10 years in private practice he has taught this structure and thinking to many health professionals in Australia and New Zealand. Mike teaches at the Christchurch Institute for Training in Psychodrama, is a former chairperson of the Christchurch branch and the immediate past president of ANZPA.

Clinical supervision has long been a part of health delivery systems. It is used substantially in the training of psychotherapists and is a frequent requirement for ongoing certification. In various guises it has been a part of the training of psychiatrists, social workers and psychologists for many years. Nurses are increasingly accepting clinical supervision as they begin to experience its value in preparing practitioners to deliver the best available standard of care to the client.

Over the years different approaches to supervision have evolved. Initially the emphasis was on ensuring that staff adequately fulfilled their job descriptions to meet administrative expectations and requirements. In more recent times a different emphasis in supervision has emerged. I have been actively engaged myself in developing new forms of supervision.

The purpose of this article is to expand the vision of practitioners and senior trainees of the psychodramatic method about the use of role theory in supervision. Toward this end a description of the supervisory emphasis is given and a number of conclusions are drawn. In particular the paper discusses the use of role theory as a means of deepening the experience of the supervisee with respect to the systemic nature of life and relationships. It is suggested that this experience provides a basis for an integrated assessment and planning process and that the subsequent new role development that occurs becomes the focus of further ongoing supervision.

AN INTRODUCTION TO CLINICAL SUPERVISION

Clinical supervision has been widely discussed both in writing and in peer interaction. Many see it as an educational process. Others see it more as a healing

and integrative process. Some see it as a directive process where the senior actively teaches a more junior colleague how to go about things. Others see it as a journey of self-discovery and self-growth.

Dr Bertram Lewin, a highly regarded psychoanalyst, in his forward to *The Teaching and Learning of Psychotherapy*, points out that supervision originated naturally in the older psychoanalytic institutes of Europe with the simple need of young practitioners to learn practically from older colleagues. Subsequently, the understanding of the process of supervision and the subtleties of human communication have developed considerably.

In this paper clinical supervision is viewed as a journey of personal/professional discovery and growth. Fergus (1989, pers. comm.) puts it this way: 'The function of supervision is to provide and create an environment that permits and provokes the emergence of the supervisee's spontaneity and creativity, that will support them past their impasse, so that they can re-enter the client system to do what they have to do with confidence.'

MORENEAN ROLE THEORY

Many theories are used in an attempt to make sense of relationships. Earlier examinations of the concept of role tended to focus on sociological aspects and uses. The more personal definition of the concept of role as developed by Moreno came about through his reflections on the enactment of roles in the theatre. Moreno (1953) saw himself leading a European trend which was marked by the publication of his book *Das Stegreiftheater* (1923), republished in English as *The Theater of Spontaneity* (1947). His concept of role and role relationships is developed and explained in *Who Shall Survive?* (1934) and is set out again in *Psychodrama Vol. 1* (1946). Role theory has also been discussed by other authors, notably Clayton (1992, 1993) and Williams (1990). The concept of role playing as a form of psychotherapy is extensively discussed by Kipper (1986).

In this article it is assumed that the reader has a working knowledge of role theory. Those who do not are referred to the above literature.

AN APPROACH TO CLINICAL SUPERVISION

The development of the use of clinical supervision amongst health professionals has brought about increased interest in how it is delivered and in its functions. This section focuses on the basic structure of a session and on clinical material which demonstrates the approach taken.

Grief and Distress – Familiar Experiences

Joanne sits in the chair and sobs quietly. She is recalling the death of her father and the circumstances in which she found him. She is a mental health nurse who has recently been asked to identify the body of her patient who had committed suicide by drowning. The memory of his distorted features has haunted her. Often she has woken in the night distressed in a way she cannot quite identify. 'Somehow, I cannot find a place to file this experience,' she says. During the first 45 minutes of a clinical supervision session she has talked about the recent death of her patient and many other deaths. Finally and almost casually she mentions finding her father who had died of a stroke some 18 months previously. The recognition of this loss and its connection with her most recent loss finally triggers a release of this

expression of her distress. She recalls many other upsetting events and releases the distress associated with these as well.

Joanne's experience is not uncommon amongst health professionals. She comes to a supervision session fortnightly. Usually she talks about her relationships with her clients but sometimes about difficulties with other staff. More recently she has begun to focus on events and experiences in her work which have caused her considerable distress. Many of these experiences are talked through again and again. The effect of having someone regularly listening and assisting her to make sense of her experience is marked. As her confidence in this process increases, so her view of herself and her relationship with her clients deepens and develops. New experiences and perceptions are generated and fresh effective functioning is apparent. The supervision session, which is now a regular, familiar and necessary part of her professional life, is a potent factor in the development of an enlarged professional identity and flexible relevant actions.

Basic Approach to Supervision

A well-organised supervision session has a clear structure. It begins with a warm-up of supervisor and supervisee separately. When the two come together a joint warm-up to each other and to the work of the session occurs. The supervisee raises the matters on which they intend to focus. This is thought of as a broad area of concern. In the process of working towards a focus on specific experiences and reflecting on the dynamics involved, meanings attached to experiences can emerge as the supervisee becomes more conscious. When specific interactions have been identified as important, a role analysis may be carried out. The supervisee's responses to this will indicate directions to be taken in the remainder of the session. The role analysis is central in assisting the supervisee to look more objectively at relationships and to become more conscious. In the section which follows, examples from clinical practice will be used to illustrate the use of role theory in clinical supervision.

CLINICAL SUPERVISION WITH A NEW SOCIAL WORKER

Description of Supervision

Megan is a 23-year-old social worker. She has recently graduated and her work experience in a psychiatric setting is limited. This fact and a lack of adequate orientation have contributed to Megan experiencing uncertainty in her relationships with other staff. In previous supervision sessions she has demonstrated herself to be very quick on the uptake, enthusiastic and keen to get down to work. This is her third session with me.

The work begins with Megan focusing on an interaction between herself and a patient, Jo, who has come to her crying and clearly very angry. Jo says she has just been told by one of the nursing staff that she is manipulative and a liar. Megan responds by asking Jo for more information about this incident. Jo continues to express her anger and distress, now generalising it to all the staff. She says she does not understand what they mean when they call her manipulative and a liar. She wants to know what manipulative means. Megan, responds by saying that she does not see Jo as manipulative. She goes on to let Jo know that it is all right to feel distressed and angry. While she makes a partial summary of the situation as she sees it she wonders how loyal she should be to her colleagues.

Megan realises that the purpose of the supervision is for her to develop a better understanding of what happened in the interaction with Jo. It is also to become more conscious of her own responses and motivations, and to resolve some of her conflict in the situation with Jo. In the session we make a role analysis of the incident, in particular examining Jo's functioning and Megan's responses both to her and to the other staff. As her supervisor I then display for her in action some possible responses to Jo and we discuss these. As a result Megan develops greater consciousness of the incident and begins to develop a plan that will enable her to respond to Jo's manipulative behaviour in a more progressive way.

Analysis of the Roles in the Supervision Session

After Megan had given her account and expressed her concern we focused on the roles that had emerged during the interaction:

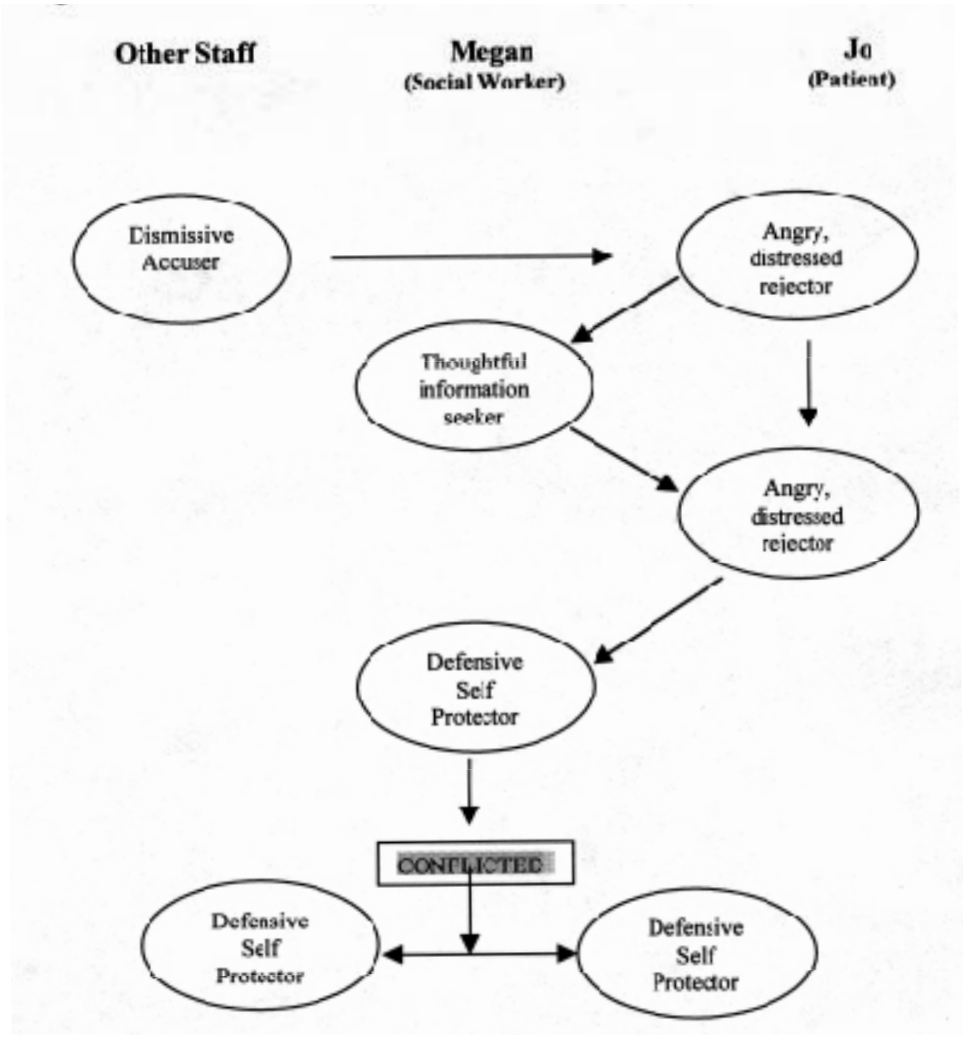

Figure 1: Role relations during the interaction

Initially Megan acts in the role of a thoughtful reflector. She realises that her first response to Jo in seeking information has been adequate. She has given herself the time to develop some clarity about the incident causing Jo's distress. Megan realises that quite probably Jo is again behaving in a manipulative way in taking her anger and distress to her in this rather attention-seeking manner. Jo has attempted once again to split the staff by targeting Megan, a relatively new staff member, rather than take her difficulty to the source. Megan informs her supervisor that she now sees that Jo has once again set up a dysfunctional relationship by triangling with her. She further tells the supervisor that she now sees Jo as a *Manipulative Game Player* who gets major satisfaction from the disruption she causes. In response to this understanding Megan is considerably enlivened as she reflects on her own responses. She now becomes an *Interested Learner* as she begins to identify her conflict as a possible counter-transference response. She begins to appreciate how Jo continually sets up fragmenting relationships.

Megan's attention now turns to the conflict. She realises that it is very important for her to be loyal to the other staff with whom she works. She is new on the job and wants to be accepted by them as a competent professional. She also has a compassionate heart and feels for Jo, whose distress is very obvious. As she reflects on Jo's fragmenting roles she feels very torn. She is reluctant to reject a distressed patient, yet she feels strongly that to undermine her colleagues would simply reinforce the dysfunctional world of the patient. She is stuck.

At this time we set up a small scenario. I have Megan take up the role of Jo and tell her that I will enact two or three possible responses.

Enactment 1: 'Well I don't think he should have done that at all. He has upset you a lot and I feel annoyed that he has done this.'

Enactment 2: 'Well this is not so good. I'll have a talk with the staff about it and see if I can sort it out. I'm sure there's been a mistake.'

Enactment 3: 'It's clearly very distressing to you when you are accused of something. It's obviously something that the person accusing you doesn't like, and you have no idea what it is they are talking about. It's no wonder you're upset.'

Megan responds immediately.

Megan: 'That's it, the third one. That feels much better and I can see why. In the third one you are relating to my experience. In the first two you're relating much more to your own experience. I can see that if I focus on her experience there is no opportunity to be disloyal to my colleagues.'

We then go on to a role enactment where Megan tries out the new role several times until she begins to feel more comfortable with it. Megan is delighted with all of this. She rapidly generates her own response and begins building up the role. She also realises that other staff have undermined her by their dismissive attitudes towards this patient. This has contributed to her conflict. By the end of the session she enacts the role well, staying fully responsive to Jo's experience. Her role system in response to Jo now includes a developing progressive role of *Empathic Validator* which stimulates a very undeveloped but nonetheless recognisable *Distressed Self-Explorer* response in Jo.

Enlivening Effect of Reflection on Roles

The identification of her role relationship with Jo was very enlivening for Megan. She recognised her defensive response as a coping role in which she really did not know what to do. She was very excited and challenged about discovering her tendency to be defensive when she was conflicted. She was immediately able to identify other situations where this had happened.

Megan was also interested in the fragmenting roles of both Jo and herself. She began to see how her defensive roles fragmented relationships. She could also see how Jo's manipulative roles fragmented many relationships in her life, as well as fragmenting her relationships with the staff. Separating out the roles involved in the conflict had a very beneficial effect. She focused at length on her relationships with her colleagues and realised that often she simply did not like the way they responded to and discussed the patients. She did not yet feel able to challenge some of the behaviour or the 'loose talk', but she could see that developing this ability would be a task for the future. She was also able to fully acknowledge her own compassion and her desire to make a difference in the quality of life of the patients. She felt that she was beginning to understand what empathy meant. Her full exploration of the two roles involved in the conflict went a long way toward assisting her in taking the next step.

Effect of Following the Supervisee's Warm-Up

Teasing out the roles in this way and allowing the supervisee freedom to focus where her own spontaneity took her provided the optimum opportunity for integration of new knowledge and the development of new roles. When the supervisor follows the warm-up of the supervisee, noticing their response to the different roles identified, the possibilities for really developing certain aspects of roles is maximised. Thus when Megan articulated her desire to be a loyal colleague and a part of the team it was wise to mirror her emergent understanding and developing roles.

Psychodramatic Techniques Aid Role Development

The appropriate use of psychodramatic techniques enhances integration and aids in progressive role development. In this case, modelling at an appropriate time stimulated Megan's own responses and presented her with possible options. She was readily able to identify a progressive response and then with coaching and enactment make the response her own and begin to develop and further integrate the role. Once the conflict had been explored and greater consciousness developed, modelling provided a stimulus for progressive role development.

Using the Role Language of the Supervisee

In the session described above the supervisor accepted the supervisee's role description without criticism. The rationale for this is that supervision is aimed at providing an opportunity to reflect on the dynamics of the patient relationship in a supportive and non-critical environment. Supervision can correct the supervisee's role descriptions on the grounds that they are demeaning of others, including patients. Supervision may correct the use of the word 'manipulative' to ensure the supervisee differentiates between someone whose functioning is consciously manipulative and someone who is unaware

that their functioning is causing confusion for others. Such teaching by the supervisor, designed to refine the clinical acumen of a supervisee, may very well be helpful in some supervision sessions. This was not done in the session described as the focus of the work was in a different area.

SUPERVISION WITH AN ANXIOUS SUPERVISEE

The Beginning of Supervision

Jane initially functions as an anxious person and maintains this. She talks very fast. She includes much that is off the point and unnecessary for completion of the work at hand. She maintains that she does not, and never has, felt anxious. Jane manages her designated job reasonably well although several colleagues have expressed doubts about this. She is frequently off work sick with somatic disorders such as a painful back and itchy skin. Her speed of delivery; her reactive, almost anticipatory, responses; and the lack of any pauses between sentences; are disturbing for me. In our first two sessions Jane and I begin to develop a method of working with one another. In the third session we start to focus on some of her interactions.

Fourth Supervisory Session

The purpose Jane presents for this session is to examine an interaction with her client, Margaret. She is attempting to persuade Margaret that she is having an upward mood swing, and that unless she takes some action the swing will continue to the point where she will once again require admission to hospital. Jane starts to tell me about this in a non-stop way. She is sidetracking herself and does not stay focused on the interaction with her client. In the early part of the session I attempt to stop her and she says: 'Oh yes, I'm doing it again, aren't I? I'm going on and on, not really pausing very much and bringing in far too much material.' I privately conclude that Jane's approach will result in Margaret's mood becoming more elevated; that Jane's anxiety is producing more anxiety in Margaret.

At this point I decide it will be useful to slow down the session and investigate the nature of the role relationships. I want to provide Jane with an opportunity to reflect on her relationship with Margaret. I suggest to her that she sets up my office as Margaret's living room, making it as it is when she is discussing things with Margaret. I then assist her to enact a scene with Margaret in which she portrays her own role and also plays the role of Margaret. After each element of this interaction I have her pause and I re-enact what I have observed, taking both roles. We then work together to name the roles and map the interaction in role terms. The dominant roles or part roles are identified in Figure 2.

The separate behaviours depicted in Figure 2 each represent slightly different manifestations of a single role, the *Anxious Persuader*. The common purpose of each display was to persuade Margaret to a particular viewpoint. Margaret's role in response was *Frightened Rabbit*. She was determined not to acknowledge that anything was wrong for fear of the consequences. Later on we used this diagram to identify what a role actually is. In this session, however, by teasing out the elements of the interaction step by step, and naming each slightly differently, the aspect of the role that revealed fear was enacted and recognised.

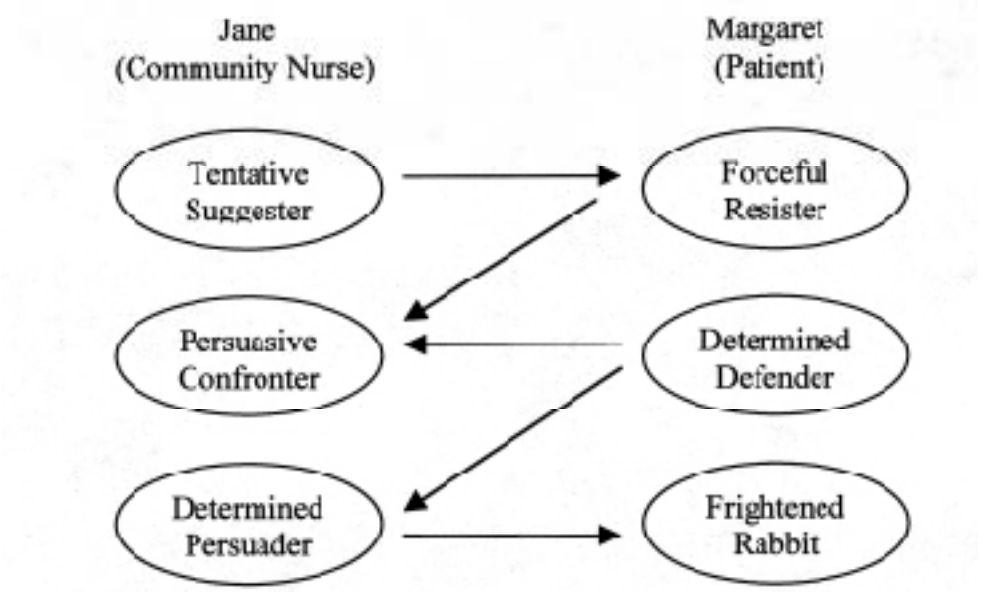

Figure 2: Role enactment of Jane and Margaret

Discussion on Role Enactment and Development of a New Role

The real breakthrough came for Jane when we identified the role of *Frightened Rabbit* in her client. She really had no idea that Margaret was frightened. She had been thinking that the determined resistance of her client was simply symptomatic of the lack of insight often associated with mood-elevated illnesses. On reflection, however, she could see that Margaret was frightened – frightened that if she acknowledged any changes in her behaviour or any increased activity or mood elevation, she would be acknowledging that she was getting ill again, and in her mind this was associated with a return to hospital. This was what she feared above all else. Once Jane was able to identify the role of the *Frightened Rabbit* she could see quite clearly that in Margaret's mind any acknowledgment that things were not quite right was automatically coupled with the fear associated with being readmitted to hospital. Therefore she could not own that anything was even slightly wrong.

After some further discussion and reflection Jane entered into some role training in which she began the development of the role of *Empathic Listener*. She was able to acknowledge Margaret's fear, which had the effect of addressing the real thing, instead of tilting at the windmills of lack of insight and defensiveness. Initially Jane found it difficult to remain empathic. However, when she took up the role of Margaret she was able to experience the effect of the role she was developing. She then took up the role of empathic listener again and gradually made it more her own, selecting her own responses and developing more confidence in her ability to do so.

The Power of Role Analysis in the Supervision Session

The breakthrough in the session came as a thoughtful role analysis enabled Jane to recognise Margaret's fear and the dynamic involved. As the session progressed she became more deeply involved and more thoughtful. By the end of the session she was

calm, reflective and even a little amazed. She was no longer over-inclusive and racy, but was beginning to appreciate the real value of the session for her. The use of role theory and role analysis in examining the interaction had been crucial. The slow, thoughtful identification of the roles had enabled her to identify and appreciate what had previously eluded her.

Entering the World of the Client through Role Reversal

It was interesting to discover in working with Jane in this session that during role reversal she slowed down. In subsequent sessions, interviewed in the role of her client, there was little evidence of the over-inclusive, racy expression that had characterised the early sessions. In the role of her clients Jane took on a different persona. She sat still, she was more relaxed and she was thoughtful and insightful. This, in fact, became a preferred way of conducting supervision sessions. I warmed her up to the role of the client – What was she wearing? Where was she? What had she been doing lately? What was her life like? I would enact the client role myself, responding to her in the client role. Following some enactment, together we would identify roles and role systems. Insights into her client's views about life and her own, and how these were displayed in action were rewarding outcomes. Once the nature of the role relationship was clear Jane was able to practise different interventions until she was satisfied with what had been developed. This assisted in the development of her practice and in the reduction of her pressured behaviour.

A Positive Outlook in the Face of Not Knowing What to Do

The development of the supervisee's capacity to tolerate the experience of not knowing what to do is an important aspect of effective supervision. In the session outlined Jane developed the capacity to maintain a positive outlook until something clinically relevant had been brought to birth. She had no idea that Margaret was afraid. She had assumed that the rejection of her interventions and the denial of the difficulty were symptomatic – a part of Margaret's fragmenting role system. As a result she continued to pressure Margaret who increased her determination to resist.

Bion (1967) gave weight to the aim of developing such a capacity to tolerate feelings born of not knowing what to do. This session exemplifies that approach. Jane had no idea what to do. She continued to pressure Margaret in ways that tended to increase Margaret's determination to resist. By using enactment and role analysis Jane was enabled to further tolerate feelings born of not knowing what to do until something more clinically relevant did emerge – namely an appreciation of Margaret's fear.

Her further investigation revealed that Margaret was afraid that any acknowledgment of difficulty would mean a return to hospital. In the roles of *Thoughtful Investigator* and *Sympathetic Listener* she was able to develop a greater clarity about the real nature of the difficulty and a more functional intervention.

SUPERVISION IN A GROUP SETTING

Description

This is the third session of a supervision group, in a planned series of eight. Kirsten, who works as a psychotherapist, brings to the group a difficulty she is experiencing in her work. In her most recent session with a 28-year-old client – a client who has been severely obsessive compulsive – she

has felt distinctly uneasy. She is working with the client to assist her to relinquish the last remaining compulsive behaviours. This client is phobic about germs and has repetitive cleaning compulsions. Kirsten says that she feels in this moment that she just does not know how to unhook her from this remaining compulsive behaviour. She does know that somehow what she is doing is affecting her client quite markedly, but she doesn't really know how. She feels inadequate and ashamed.

The scene with her client is set out and enacted. The group warms up further as Kirsten enquires about the behaviour, is thoughtful and reflects back her client's responses and confronts her with her stubbornness in refusing to give up her compulsive washing. The client remains unmoved. She maintains that if she does not continue to carry out the compulsive behaviours she feels dirty. When Kirsten enquires further about this she says that she feels as if she is covered in germs. They are on her face. They crawl all over her face, nose, eyes and mouth. With Kirsten in the role of the client the germs are concretised and the enactment of their crawling on her face maximised. At this point Kirsten as the client suddenly realises that the drama is all about her guilt and shame around her rape which occurred when she was just 16 years old. She feels dirty, covered in germs.

In the moment Kirsten enacts this, she realises that the feelings relate to her own massive shame and guilt around being caught making love with her first boyfriend by her father. She clearly remembers her father saying, 'My life is ruined because of what you are doing now.' She sensed his enormous disappointment, despair, disapproval and shame.

Kirsten sobs strongly expressing her guilt and her shame. She goes on to angrily reject her father's interference in her life at a time when she most needed his love and support. Kirsten returns to her client in the role of *Empathic Appreciator* and enables her client to further explore and express herself about her rape and her feelings about it. The session ends with relevant sharing in the group.

Sustaining the Warm-Up of the Supervisee and the Group

The warm-up of the group to enactment was strong. In this session role analysis was enacted through the drama. Once Kirsten was warmed up through the enactment with her client, an understanding of the role system came quickly and her warm-up was toward further enactment. It was clear that pausing to make a role analysis would have significantly cut across the warm-up of the whole group. It might also have used up the available time. In retrospect, taking time out to tease out the roles and thus expose the role system more fully would have slowed down the group and probably fragmented it.

Focus on the Most Warmed-Up Person in the Group

Kirsten's connection to the group and to the supervisor was strong. Early in the session several group members tentatively raised issues as part of the group warm-up. Once Kirsten spoke there was never any doubt who would be the first protagonist. She spoke in a strong voice expressing clearly her unease and her desire to investigate this further. The roles of *Assertive Self-Presenter* and *Clear Thinker* were attractive and ensured that group members would warm up quickly to their protagonist.

The Development of an Effective Role System

In the early part of the enactment of her relationship with her client, Kirsten functioned as a *Frustrated Mrs Fix-it*. She was attempting to persuade her client to a particular viewpoint rather than create the conditions where the client would warm up to her own inner world and begin to express it more fully. Following the enactment and increased warm-up, Kirsten gave up this fragmenting role in favour of the progressive roles of *Empathetic Appreciator* and *Insightful Creator of Connections*.

Conducting a Role Analysis

While the value of role analysis has been highlighted, there are many situations in both individual and group supervision where it is not indicated. The situation described above where Kirsten developed a new role system is one.

In deciding to conduct a role analysis it is necessary to assess whether or not such an intervention is likely to serve the supervisee's process. When a role analysis is developed by a group of supervisees there is a purpose. On one level the purpose may be to elucidate the roles enacted. Beyond that, however, our purpose is to provide opportunities for the supervisee or protagonist to reflect on the dynamics in which they are involved, in order to become more conscious and thus to develop a more adequate warm-up. In the session described above Kirsten became much more conscious during the enactment.

This occurs often in supervision sessions, when long before the role analysis is complete the supervisee develops a greater consciousness. When this occurs the supervisor can decide to pursue the role analysis to further educate the group or to abandon it in order to continue to follow the warm-up of the supervisee.

The Importance of a Clear Supervisory Contract

Supervision groups working in action often raise the question: 'What is the difference between therapy and supervision?' or 'Where does supervision end and therapy begin?' One answer lies in a clear supervisory contract.

The primary purpose of supervision is to assist the supervisee return to the client system with more spontaneity. In this session the supervisory purpose of Kirsten dealing effectively with her client was achieved. This came about as a result of her resolving a conflict. In work with other supervisees in the group resolution of a conflict occurred as a result of working with their family of origin with subsequent focus on their professional work with clients.

This is consistent with the ideas of Ekstein and Wallerstein (1958). They conclude that the major difference between supervision and therapy lies in the purpose. The main task of therapy, they maintain, is the resolution of inner conflict. The main task of supervision is the development in the supervisee of greater skill in their work with patients (Ekstein and Wallerstein 1971, p. 254). The group in which Kirsten was a participant was advertised as a supervision group. The people in it were expecting to be involved in supervision. The supervisory purpose of resolving Kirsten's conflict and developing an effective role system for work with the client was achieved and therefore to enact the scene with Kirsten's original family would have gone outside the contract. It was neither necessary nor desirable.

CONCLUSION

Role analysis in clinical supervision enlivens supervisees and gives them a new perspective by highlighting the dynamics of their relationships and increasing awareness of their experience. The accurate naming of the roles is in the service of understanding the dynamic psychological forces and raising personal consciousness. These processes aid in the development of personal abilities so that the supervisee is able to return to the client with greater spontaneity.

Concretisation, role reversal, role analysis, mirroring and modelling are interventions that clarify and make more conscious the development of professional identity during clinical supervision. They provide a way of working in which the clinical supervisor does not simply give the supervisee a set of ideas but makes interventions which stimulate their own creativity, producing more spontaneous responses to the client. The interventions are integrative – they have emerged and developed from within the supervisee. They are building on or developing previously integrated aspects of the supervisee's personality and functioning. They are not just ideas which have to be thought, but spontaneous responses which emerge without concentrated thought. The supervisee develops on all levels of functioning without necessarily consciously realising that the development has taken place, even though an increase in consciousness may be a part of the developmental process.

The supervisor as a spontaneous and creative individual is constantly assessing the supervisee to prompt or challenge them to respond with greater spontaneity – to become more alive. Supervision is a clinical seminar in which the relationship between the supervisor and the supervisee itself, the very processes of this relationship, may become the vehicle for the development of the supervisee.

Clinical supervision is a developing activity throughout the health services. As the abilities of supervisors develop and their relationships with supervisees become stronger, greater appreciation of the benefits to the practitioner and the client will become apparent. More people are seeking supervision and the abilities of practitioners in relating to their clients are developing. In this environment where all encounters with the client can be brought under scrutiny, the likelihood of distortion in the relationship is reduced, and the possibility of truly therapeutic encounters and the healing that accompanies these is enhanced.

BIBLIOGRAPHY

Bion, W. (1967) 'A theory of thinking', in *Second Thoughts, Selected Papers on Psychoanalysis*, Heineman, London.

Clayton, G. M. (1992) *Enhancing Life and Relationships: A Role Training Manual*, ICA Press, Melbourne.

Clayton, G. M. (1993) *Living Pictures of the Self* I.C.A. Press, Melbourne.

Ekstein, R, & Wallerstein, R. (1958) *The Teaching and Learning of Psychotherapy*, 1971 edn, International Universities Press, New York.

Kipper, D. A. (1986) *Psychotherapy through Clinical Role Playing*, Brunner Mazel Publishers, New York.

Moreno, J. L. (1934) *Who Shall Survive?*, 3rd edn, 1978, Beacon House Inc., New York.

Moreno, J. L. (1946) *Psychodrama Vol 1*, 6th edn, 1980, Beacon House Inc., New York.

Moreno, J.L. (1947) *The Theatre of Spontaneity*, 3rd edn, 1983, Beacon House Inc., New York.

Williams A. (1989)*The Passionate Technique: Strategic Psychodrama with Individuals, Families and Groups*, Tavistock/Routledge, London.

Williams, A. (1995) *Visual and Active Supervision*, W. W. Norton, London.

E-mail Address:

Mike Consedine can be contacted by e-mail at m.consedine@netaccess.co.nz