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Reflective Supervision: The Symbolic Hands That Hold

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Nonprofit organizations, providing psychotherapy services in community-based settings, are often faced with the tensions inherent in both ensuring quality services while limiting program costs. The same is true in private and public health care settings, where services regularly navigate cost reductions and budget cuts. At the Ububele Educational and Psychotherapy Trust, an nonprofit organization in South Africa, reflective supervision is seen as a critical component for effective, ethically sound, and culturally sensitive intervention despite competition for financial resources. This article will provide an overview of the organization's reflective supervision model, motivating for the need to prioritize reflective supervision for frontline staff. It also provides a case example, to demonstrate the value of reflective supervision for promoting practitioner reflexivity and preventing practitioner burnout in a highly traumatized environment.

Impact Statement

Drawing on case material, this article purports that reflective supervision spaces are critical for providing effective, ethically sound, and culturally sensitive mental health services, particularly in highly diverse and distressing contexts. It provides an overview of the model of reflective supervision used by a nonprofit organization in South Africa.

Keywords: reflective supervision, cultural sensitivity, community-based services, psychotherapy supervision, race

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The Ububele Educational and Psychotherapy Trust is a nonprofit organization that provides psychotherapy training and low-fee psychotherapy services in South Africa. Providing clinical training and psychotherapy services in this multicultural, community-based setting presents a tension. As a nonprofit organization, providing scarce but much-needed services, Ububele is often met by the challenges of limited programmatic funding. To manage financial challenges and reduce service costs, as well as to increase clinician diversity, lay counselors, intern psychologists, and newly qualified psychologists are heavily relied on to roll out services. On the other hand, a need for high-quality, ethically sound, and culturally sensitive interventions is paramount. Thus, it is necessary to take measures to ensure that interventions rolled out by lay counselors and students or newly qualified psychologists are such. This article purports that an investment in clinical, reflective supervision (as opposed to primarily administrative supervision) is critical for ensuring quality, ethical, and culturally sensitive mental health practice in all settings, including public and private health care settings, but particularly in those where intensive cost-saving measures are employed and where there is cultural and racial diversity. It is, thus, argued that supervision should be considered a nonnegotiable cost for community-based mental health services.

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The Ububele Educational and Psychotherapy Trust: A Multicultural Team in a Multicultural Setting

The Ububele Educational and Psychotherapy Trust was founded in early 2000, with the specific objective of establishing and conducting a psychotherapy resource center for postapartheid South Africa. As South Africa engaged in a process of democratization, Ububele was established to assist in addressing the psychological wounds caused by the apartheid regime. The intention was to support the development of mental health professionals and provide mental health services to individuals from race and language groups who were oppressed under apartheid and excluded from mental health professions and services (Cooper, 2014; Laurenson & Swartz, 2011; Manganyi, 2013).

Twenty years after its inception, the organization offers a range of clinical trainings. Mental health and caregiving professionals can enroll in several different psychoanalytically informed courses, including courses on group work, child psychotherapy, and parent–infant psychotherapy. Posttraining support through clinical supervision is available to all trainees. In addition to its training arm, the organization also provides a plethora of infant mental health, parenting, and child psychotherapy interventions to the community of Alexandra township. These interventions range from an Ububele-developed home visiting program (Frost et al., 2018), to the internationally developed and World Health Organization-endorsed International Child Development Program (Skar et al., 2015), to child psychotherapy informed by the Tavistock therapeutic model (Harris & Bick, 2018). In a merger of the organization's training and service activities, the organization is largely staffed by intern psychologists, completing their practical year of training in a master's degree in educational or counseling psychology.

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The organization is physically situated in a poignant South African location, bordering both Sandton (the richest square mile on the African continent; Murray, 2011), and the highly impoverished community of Alexandra township (Statistics South Africa, 2011). Despite hope, strengths, and a wish for the country to progress, South Africa continues to have high levels of crime, violence, abuse, and political unrest (Lee et al., 2020). At the time of writing, the COVID pandemic was further exacerbating already existing high levels of unemployment, thus increasing psychosocial stressors (Posel et al., 2021). Already vulnerable and deeply deprived communities, such as Alexandra, have suffered the most and continue to be an extraordinarily difficult place in which to live and grow. Many families lack the support networks to help them through challenging times. All are faced with the risks of living in an overcrowded and crime-ridden environment (Crime Statistics South Africa, 2016, 2019). Generations of families continue to live through elevated levels of poverty (Statistics South Africa, 2011), while living in constant, unprocessed, and often unnamed trauma. Demographically, Alexandra township is representative of the vast ethnic and linguistic diversity characteristic of South Africa—a country with 11 official languages (Statistics South Africa, 2011). It is also home to many immigrants, asylum seekers, and refugees from surrounding Southern African countries (Ekanade & Molapo, 2017; Lekaba, 2014). This is the context in which Ububele exists.

Servicing the diverse community of Alexandra, and training up mental health professionals for the diverse South African context, requires an equally ethnically diverse, multilingual clinical team. It requires that a historical imbalance of racial and language representation in mental health professions is actively addressed. At the time of writing, Ububele's clinical team comprised of staff psychologists, intern psychologists, and lay counselors, from diverse race groups who speak a range of Southern African languages, despite the profession remaining demographically skewed (Cooper, 2014). As part of the organization's intentional efforts to have a clinical staff body that represents the population serviced, Ububele's lay counselors are predominantly local Alexandra residents themselves (Frost et al., 2018).

The Ububele's Supervision Model

From its inception, regular clinical supervision has been centrally embedded in Ububele's clinical work. Each clinician, from the lay counselors to the early childhood teachers, the intern psychologists and the staff psychologists are in at least once a week clinical supervision, both individually and within a group setting. Each practitioner receives, on average, 1 hr of individual supervision and 2–3 hr of group supervision per week. This includes child psychotherapy supervision, adult supervision, training supervision, community supervision, and infant mental health work supervision. Importantly, supervision is equally intensive for both professional and lay practitioners, as supervision does not only provide in-service training but also provides opportunities for debriefing and reflecting as a team, as will be outlined in greater detail below. Further, while the Ububele's lay counselors do not have formal tertiary training, turnover of permanent staff is low, and as a result, many of the lay counselors have years of experience in clinical work, in contrast to the newly trained intern psychologists.

Clinical supervision sessions occur at a consistent time and place each week, with little flexibility. Attempts are made to ensure that the physical meeting space is quiet and private, as described by Tomlin et al. (2014). The supervisor and group members remain consistent as well. Additionally, the Ububele's supervision model calls for a writing up of a detailed transcript about the process of either the home visit, play therapy session, or hospital consultation. Clinicians will record the events of the session but also their feelings and questions to the group. This continues to be an important aspect of the frame of supervision, as it allows for a layer of processing and reflection by the practitioner to occur before supervision. As some Ububele's clinicians are lay counselors with limited literacy, clinicians can elect to audio record their process notes instead.

Supervision sessions begin with an uninterrupted reading of the aforementioned transcript, after which the supervisor facilitates the sharing of responses to the presented material. A listening stance is adopted by the supervisor and supervisees, and participants are encouraged to free associate to the material. Through attentive listening, careful observation, and self-awareness (Tomlin et al., 2014), supervisor facilitation acts to ensure that multiple perspectives are voiced that self-reflection is deepened and that emotions evoked are attended to (Watson et al., 2014). Part of facilitating this for a multilingual team means ensuring that supervisees know that they are welcome to comment in their preferred language. This means that at times, the full supervision group may not all understand what has been shared. Translation is not insisted upon, as the focus is on facilitating the sharing, but is welcomed when spontaneously offered. Toward the end of a session, a treatment plan may be formulated, and case management issues may be discussed. In some cases, comments on technique may also be offered.

Also critical to the Ububele's supervision model is the development of a supervisor–supervisee learning alliance, which Watkins and Callahan (2016) describe as foundational to making supervision work. As Edwards (1997, p. 13) notes, the word supervisor "conflicts with the actual function of clinical supervisors." He goes on to suggest that terms such as "consultant, facilitator, or mentor" are more accurate descriptions. This is necessary for the goals of unencumbered sharing of diverse perspectives, personal self-reflection, and awareness of emotional responses, noted above, to be achieved. In addition, the supervisor is acknowledged as limited in their depth of understanding and knowledge of human experiences, and so the sharing of diverse perspectives is considered critical. In the context of a clinical team with varied educational backgrounds, in a country with a history of racial oppression, it is especially important to actively diminish unequal power dynamics in the supervision space. Thus, steps are taken to develop trust and safety in the supervisor–supervisee relationship, such as conveying respect for alternate perspectives, ensuring confidentiality, and the elevation of silenced voices or perspectives. This list of supervisor actions is similar to the findings on supervisory behaviors practiced internationally, as captured by Tomlin et al. (2014). Encouraging supervisees to share in their home language if they would like to and seeking alternate cultural and contextual perspectives form part of the specific efforts to facilitate a mentoring environment in a multicultural setting.

The core components of the Ububele's supervision model mentioned above (such as the regular meeting together to discuss cases, the reviewing of process notes, and the formulation of a treatment plan) are what Watkins and Callahan (2016) describe as supervision

rituals. These rituals, which form part of the frame of supervision, are considered to be the core components of the Ububele's supervision model, which create organizational benefits and opportunities for clinical growth and development, to be discussed further below.

Supervision in the Time of a Pandemic

At the time of writing, the world was in the midst of the COVID-19 pandemic. It is, thus, important to consider the impact of the pandemic on the Ububele's supervision model. As many community-based mental health organizations worked quickly to adjust their interventions to online platforms, Ububele did the same. While the delivery of many Ububele services was impacted, there was also an impact on the supervision model in significant ways. Ububele challenges included limited accessibility to internet access or suitable devices for many of our practitioners. Further, just as in the therapeutic relationship, where, due to COVID-19, these has been a shared experience and anxiety, so too was there a shared experience and anxiety in the supervisory space. Suddenly, the supervisor and supervisee faced the same vulnerabilities.

On a practical level, the ways in which supervision was conducted during the most vulnerable COVID-19 periods changed. Online platforms or telephonic connections were used and even though there was a physical distance, the essence of the supervision remained the same, and perhaps even, at times, deepened. Even though the move to remote supervisions meant that there was a more significant distance between practitioners, the sharing of the palpable anxieties about COVID-19 and the impact it had on the community were shared. Perhaps this highlighted once more the fact that the term supervisor is somewhat "misleading" (Edwards, 1997). The COVID-19 pandemic highlighted the togetherness which the clinical staff experienced and the importance of the relational aspect in reflective supervision. As stated by Rankine (2017, p. 1), "supervision is seen as a coconstructed partnership between the supervisor and supervisee."

Why Supervision Is a Nonnegotiable at Ububele

Ububele's intensive supervision model is an expensive endeavor for a community-based organization. Experienced psychologists, who can act as supervisors, are expensive. On some Ububele projects, supervision accounts for almost 40% of the project budgets. However, overall costs remain far lower than they would if experienced psychologists were the primary clinicians, and even then, supervision would still be important. And yet, despite how costly supervision is, it is considered a nonnegotiable by Ububele management. In this regard, advocacy efforts have been implemented to help secure funding for supervision, including the production of a short film on the value of supervision.

Heffron (2005) found that supervision leads to a better quality of service and better patient outcomes. This article asserts four potential reasons for this, which will now each be discussed in turn below, drawing on the literature which argues the same.

Ensuring Reflective Practice

Various authors have argued that reflective supervision is a central ingredient for good reflective practice and professional growth, with reflective supervision considered important for the development of the reflective capacities of the supervisee (Cox et al., 2011; Emde, 2009; Tomlin et al., 2014; Watson et al., 2014; Watson & Gatti, 2012). That is to say, supervision provides the practitioner with a much-needed space to think (Shipton, 1997), and thinking is critical for the formulation of treatment plans, and to ensure that diverse patient needs and varied treatment approaches are considered. Increased reflection is also important for the prevention of enactments or nontherapeutic engagements. A 2017 study found that practitioner reflexivity predicted practitioner effectiveness (Cologon et al., 2017), confirming assertions that the development of practitioner reflexivity is important.

Careful thought, while important in all contexts, is particularly important in communities such as Alexandra. The needs of Alexandra residents are often multifaceted, needing more than just a psychological holding and often calls for referrals to other networks for concrete needs to be looked after. This means that practitioners at all levels can often be pulled into acting in more concrete ways in the face of deprivation. Thus, in such contexts, it becomes increasingly important to continuously reflect on and in some ways normalize this as a shared experience. The frame of supervision mitigates this by being a space to think and not act (Yerushalmi, 2013).

Supervision provides a nonjudgmental, curious, and respectful relationship with another practitioner that can facilitate this thinking (Tomlin et al., 2014). That is to say, much like in therapy, thinking is easier in the presence of an other. The Ububele's supervision rituals and the presence of nonjudgmental, respecting other is understood to create a space safe enough for free association (unencumbered thinking), to facilitate the clinician's own internal grappling, and to tune into occurrences of what is called "parallel processes." Parallel processes have been defined as "the tendency for the dynamics of the patient and nature of the treatment interaction to be unconsciously transported by the supervisee into the supervisory relationship and reenacted there" (Watkins, 2013, p. 263). That is to say, when noticed, parallel processes can provide the practitioner with information about the experiences of the patient that can assist with thinking about what is needed for intervention. Free associations and awareness of one's own experience can also assist with this. For example, in infant mental health interventions in particular, reflective supervision is considered critical for encouraging thinking about the often-forgotten experience of the baby (Cox et al., 2011; Watson et al., 2014).

Increasing Practitioner Self-Awareness

Supervision has been proposed as both a space for learning therapeutic techniques, as well as for learning about one's own feelings (Edwards, 1997). Thus, another important function of reflection supervision is the facilitation of self-reflection for the mental health practitioner. In psychotherapy, the clinician's own emotional responses and relational model are central to the therapeutic process. The clinician's emotional response to their patient is often referred to as the clinician's countertransference to the patient (Hayes et al., 2011). The clinician uses this emotional response, or countertransference, to inform their intervention but also actively works to contain their emotional response in order to be a containing presence to the patient. A lack of self-awareness about one's own emotional response, as well as a lack of containment of this response, is understood to contribute to acting out or avoidance

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of the work, negatively impacting on service delivery (Hayes et al., 2011; O'Rourke, 2011).

With awareness of one's own emotional experience so central to mental health intervention, it is important that space is provided to become aware of these emotions. Supervision allows such space, allowing for "thought about the feelings that arise from the work, and the impact those feelings have on the work" (Lanyado & Horne, 1999, p. 172). Thus, supervision provides a space where one's own personal histories, evoked by the work, can be safely explored and enactments prevented (Tomlin et al., 2014; Weatherston & Barron, 2009).

Preventing Practitioner Burnout

Additionally, due to the high levels of distress that are presented in therapeutic work across all health care settings, organizations must be alerted to the potential for burnout and despondency within their team of practitioners. Ububele's supervision model takes this into account. This may be particularly true for work with infants, as Heffron et al. (2016) state that the parent–infant space is often charged with high levels of distress and anxiety. They go on to say that if practitioners offering such interventions are not aware of their own triggers and distress, it could present as avoidance or denial which may negatively impact the work. The authors go on to emphasize the need for reflective supervision to be an integral part of service delivery to prevent burnout. The shared spaces of supervision can provide social support and alternate perspectives which can offer hope.

Spaces of hope and support may be particularly important for practitioner who live in the context of intervention, as is the case at Ububele. While the diversity, local knowledge, and representation of local residents on staff is an organizational strength, it also means that a substantial portion of Ububele's staff body have been and continue to be directly impacted by the harsh realities of living in Alexandra. It is therefore critical to engage with this and offer holding and containment on an ongoing basis.

Culturally Sensitive Practice

Importantly for Ububele's multicultural context, reflective supervision allows for open engagement with the topics of culture, diversity, race relations, and power dynamics. Watkins and Callahan (2016) assert that these often-neglected topics are critical issues to engage in supervision to ensure culturally sensitive interventions. Group supervision, with mutual respect, has been put forward as particularly helpful for engaging with such issues, through the presence of diverse perspectives (Heffron et al., 2016). Reflective group supervision is argued to provide a space where often-avoided and difficult topics such as "race, class, context, and difference" can be explored (Heffron et al., 2016, p. 636). A diverse representation of individuals in a group supervision space allows for practitioners to challenge one another to be culturally sensitive in their interventions and interactions and helps create awareness about cultural blind spots.

A Case Example: Traumatic Grief and Loss of Baby L

In an attempt to convey the above-described value of supervision for promoting thinking, self-awareness, and ethically sound practice, this article will now provide a case example. Starting with a short case vignette, the article will move to an excerpt from an anonymized transcript presented in supervision and is followed by a brief summary of the events of the supervision session. This example is from the work occurring in the hospital setting and offers insight into the types of cases that are typically seen there. Due to strained health care systems, infant loss presents on a somewhat regular basis. While excerpts from the vignette are an accurate representation, some details have been changed in order to anonymize the family and protect their identity. Following the vignette, the ways supervision is used to ensure ethical practice, ensure effective intervention, and ensure culturally sensitive practice will be highlighted.

> In a recent infant mental health group supervision at Ububele, a psychologist presented a consultation carried out at a local hospital. She presented the case of "L", a fourth time mother, and her baby boy "Y". The psychologist shared her detailed written up transcript and described the interaction she had had with L, five hours after the birth of her baby. Baby Y had been carried full term and weighed 2.9 kilograms at birth.
>
> L had had a traumatic birth, which was due to a slow reaction to her prolonged labour and waiting hours at the over stretched public hospital to have an emergency cesarean section. It was reported that baby Y did not cry after birth and was rushed off to the Neonatal Intensive Care Unit, with his mother L, unable to see him or hold him after his birth. During the consultation with L, the psychologist reposted that she was almost immediately tearful as she held out her hands, exposing empty palms, stating repeatedly that she had not gotten to hold her baby.
>
> She began to cry, and she said that she wanted to hold her baby, that she had not seen that baby Y was ok. The other women in the room reminded her that they would go together in a few minutes to feed the babies and they tried to comfort her saying that baby Y was going to be ok.
>
> —transcript excerpt.
>
> The psychologist shared how she spent some time with L exploring her anxiety and fear about the wellbeing of baby Y. The psychologist then went on to share that due to the third wave of COVID-19 and increased hospital restrictions, a follow up call was made with L, instead of a face-to-face consultation. When the psychologist phoned L, baby Y's grandmother answered the call. Sadly, she shared that baby Y had died and expressed her rage about the neglect her daughter and baby experienced which resulted in the death of her grandchild. She informed the psychologist that baby Y was to be buried the following day. Additionally, she willed the psychologist to assist them in laying a formal complaint towards with hospital.
>
> After the transcript was shared, a silence filled the room for a few minutes. "There are so many dead babies. I feel so angry.", someone in the group said. This was not a lone voice as others in the group expressed their rage at the broken system and the loss of a full-bodied baby. The anger was soon followed by many questions, "When did he die? Why did he die? What was explained? Who is to blame? Did she ever get to hold her baby?". Then, more silence fell upon the room, and then a heavy, heavy sadness. Another practitioner spoke of how this case had reminded her about a mother and baby she had consulted with. Baby had also died a few days later.

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> One of the practitioners then spoke about mother's empty hands and her repeated cry at not having held her baby yet and how her hands will remain empty and her breasts full; with no baby to hold. This opened up a powerful parallel process for the group about how often our own hands feel empty; how often we are left with empty exposed palms and feelings of helplessness, heartbroken at the deaths of babies and constantly feeling disempowered alongside our clients in a system that fails families and babies like Y. Rage filled the room again and then a painful silence.

> One of the supervisees then spoke about the other women encouraging L—with the promise that she would get to feed her baby and then get to hold him. This was linked to the need for a supervisory "feed" in moments when we are faced with our own empty hands in the reality of the limitations of our psychic holding and the need and wish to impact not only the families that we serve, but also the systems that they are part of. The team then spoke about the holding of the group of mothers for L and how the supervision group often holds the same function so that the work can continue. The group was then able to reach a place of thinking and wondering. "What is the task ahead and what intervention can be offered to this grieving family?". The group was able to think in a sensitive way and offer ideas about how to hold both the clinical part of the work by offering a bereavement therapy for the family, as well as how to assist the family with a referral to take up the failure by the hospital.

> A cultural aspect also arose within the supervision where the meaning of the name given to baby Y was shared ("do good things"). This allowed the group to think about what it means to "do good things" within the organisation's community and context and how often the system doesn't "do good things".

The above case example illustrates a number of above-described functions of reflective supervision for practitioners working in a community-based organization. First, the supervision provided an opportunity for the holding and containment of intense emotions evoked by the work in the practitioner but also evoked by similar experiences for other practitioners. The case also highlights, through the parallel process, how this function of the supervision helps to prevent burnout through the experience of social support and shared experiences. Further, the case highlights how space for thinking is created, and how the group and thinking space can aid in the development of a comprehensive treatment plan.

Conclusion

In closing, this article has attempted to outline the value of clinical supervision for practitioners providing therapeutic support across all contexts, but especially in public service settings, such as community-based and nonprofit organizations. In financially strapped settings such as those, but also across health care contexts, management is regularly required to engage with cost-saving measures. However, this article asserts that supervision should be protected and prioritized. In addition to providing an overview of the supervision model used in a community-based organization in South Africa, this article has argued, using literature and a case example, that clinical supervision, regardless of context, years of experience, or professional background, is important for promoting practitioner reflexivity, promoting practitioner self-awareness, preventing practitioner burnout, and promoting culturally sensitive practice—all critical ingredients for quality and ethical clinical practice.

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