

Recommendations for establishing and maintaining PIT supervision

Introduction

These recommendations refer to the PIT-specific aspects of supervision, and should be read in conjunction with other relevant professional guidance (e.g., BPS, UKCP, HCPC) and local organisational policies. This document is intended to supplement rather than replace other guidance. PIT Special Interest Group UK (PIT SIG UK) are in the process of agreeing a set of competencies for PIT supervisors, which we hope will be available shortly.

In establishing any supervisory relationship all of the other aspects of good practice need to be in place, including an ethical framework for both the supervision and the clinical practice; clear boundaries; accountability (training and clinical); practical arrangements and appropriate consent and storage of audio- or video-recorded interviews; an agreed format (group or individual); and regular meeting time and frequency.

Different reporting arrangements will be in place when the supervision is of someone undertaking a formal training, and these should be explicit from the outset.

We envisage a continuum between supervision of absolute beginners with no experience of any therapy through to experienced practitioners of the model undertaking supervision as part of ongoing CPD. Basic therapeutic skills, adherence to the model, and identifying specific techniques characterise early supervision and with increasing expertise there will be greater focus on formulation and the strategy of therapy and eventually something more akin to reflective practice. We recommend that even experienced practitioners spend some supervision time reviewing adherence to basic skills, however.

The frequency and format of supervision will usually vary according to the context, for example the number and complexity of cases supervised, and level of experience of the therapist.

PIT supervision for inexperienced therapists

When establishing PIT supervision for novice therapists this will usually involve PIT training materials including audio-visual training materials, written guides and role plays.

Two tasks for supervisees which can be achieved outside supervision are (i) listening to and recognising PI skills, from their recordings (ii) practising PI skills eg with peers

A key aspect of PIT is identifying aspects of therapy that become counter-productive (see Meares and Hobson, 1977). Trainees need to identify unhelpful defensive patterns when faced by anxiety-provoking content in sessions. This may arise in review of actual sessions, but this is facilitated by training sessions using role play of therapeutic dilemmas, feelings evoked in the therapist, and ways of responding non-defensively.

The supervisor will need to ensure that appropriate equipment to make audio-recordings of PI sessions is available and that appropriate consent forms are used and readily available within an agreed framework for the organisation in which the therapy takes place.

Supervisees commonly feel apprehensive about the level of exposure they may experience on listening to tapes, and may avoid the experience. Our recommendations are that the expectation of tapings sessions is built into the clinical structure from the outset.

For trainees who are especially anxious, role plays using tapes and then experiencing listening as a reflective space rather than persecutory is helpful for trainees. It may be helpful to leave initial control of the material reflected upon in the hands of the therapist rather than the supervisor until the trainee feels confident.

Supervisees are expected to present session material verbally (typically with the aid of process notes) and present sections of audio-recordings.

Part of the focus of supervision will be on model adherence, principally determined by listening to audio-recordings. This will be led by the supervisor, but supervisees are expected to develop the ability to critically appraise their own (and others) model adherence over time. A formal model adherence rating scale is available for PIT, but it is not a requirement that this is used in every case seen. For trainees there may be specific requirements about demonstrating the ability to recognise, model in role-play and use in practice specific techniques that are important within PIT

Other foci of supervision will be on the development of the therapeutic relationship, identification of psychodynamic themes, and the therapist's responses to the patient. Supervisees are expected to attend supervision for the duration of therapies conducted.

The supervisor should have sufficient knowledge and experience of PIT to identify strengths and weaknesses of supervisees, we recommend that there is some oversight or supervision of the supervisory process whether formal supervision of the supervision or reflective practice groups. Supervisors should also be involved in sufficient review of their own practice to be confident that they are still adhering to the PIT model, and reflecting the knowledge, skills and attitudes in the supervisory practice.

Supervision of therapists of intermediate experience

The basic principles outlined above should still be in place but there will be less emphasis on identification and practice of specific techniques and more exploration of formulation, patterns in therapy, and more challenging therapeutic dilemmas.

Supervisions should still focus on recordings of sessions in at least a proportion of sessions.

The same structure, of having a formally designated, more experienced, supervisor who does not present cases in the group may continue into established independent practice depending on circumstances.

Peer group supervision

This is a common way of providing supervision for and between experienced therapists. It is possible to have supervision within an unstructured conversation about a case, but we recommend adopting a structure for the peer group that is agreed in advance. This may cover issues such as how to structure time (e.g one long discussion with space for another brief review, two cases discussed for equal time etc); who will co-ordinate the discussion and use of recorded material.

The overall goals for the supervision should be specified and may include any combination of professional skills development; skills maintenance in routine practice ; reflective practice using one case as an example of several similar cases; formal review of cases for professional validation; space to discuss challenging and complex clients. It is also common practice for the specific goals of a particular presentation of a case to be agreed at the outset so that other group members are clear what level of feedback is sought within a peer relationship.

One commonly used method is a structure of one key person discussing the material and managing time each week but on a rota basis. The format may be of that individual leading a conversation with designated time for the other group members to join the reflection, or a less formal structure. There is no clear research evidence about which is best as the aims may be different groups, but regular discussion in a supervisory framework is a requirement of practice of all professionals working therapeutically.

PIT training resources:

1. The generic, MUS and depression manuals (available on request from PIT SIG UK)
2. The University of Manchester training DVD (available from <http://www.medicine.manchester.ac.uk/psychiatrytrainingvideos/>)
3. Live role-play (peer-led and/or with supervisor)
4. Meares R & Hobson RF (1977) The persecutory therapist. *Br J Med Psychol* 50:349-359
5. Hobson, R.F. (1985) *Forms of feeling: The heart of psychotherapy*. London. Tavistock. Particularly chapters 11-15
6. Meares R (2012) *Borderline Personality Disorder and The Conversational Model: A Clinician's Manual*. Norton
7. Margison, F (1991) Teaching and Supervising Basic Psychotherapy Skills. In *Textbook of Psychotherapy in Clinical Practice*, Ed J. Holmes, London: Churchill Livingstone, pps 165-185
8. Margison, F (2002), Psychodynamic Interpersonal therapy. In *Integration in Psychotherapy: Models and methods*, Eds J Holmes and A. Bateman, Oxford: OUP, pps 107-124
9. Martin, J, and Margison F (2000) The Conversational Model. In S Palmer and R Woolfe, *Integrative and Eclectic Counselling and Psychotherapy*, London: Sage, pps, 57-73
10. Meares, R (2006) The Conversational Model. In S. Bloch, *An Introduction to the Psychotherapies* (4th Edn.) (2006), Oxford: OUP, pps 287-308
11. Margison, F (1995) Psychoanalytic Psychotherapy. In: *Charlie : An unwanted child* [Series: In Search of a Therapist], Ed. M. Jacobs, Buckingham: OUP pps 68-87
12. Adherence rating scale
13. Conversational model roleplay cards (copyright held by Frank Margison; available on request from PIT SIG UK)

There is already an evidence base for some of these resources (e.g., the MRC and counselling studies, and feedback from existing PIT courses)

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