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The Case for Supervision in Homœopathy

Our embryonic profession of homœopathy is developing form and structure. With accreditation and therefore the redevelopment of curriculum on the agendas of many of our colleges and state registration occupying the dreams of many in the Society, the question of supervision arises. In any profession where the relationship between client and practitioner involves intimacy, vulnerability and the see-sawing inequalities of power, a code of ethics and regulatory practice goes without saying. They tend to be rather dry documents that we pay scant attention to until we have need of them which is hopefully not very often. What we need as well is support and guidance through the grey, difficult, challenging and growing experiences of daily practice. We need time and space to reflect, integrate and change practice. The full richness of a daily clinic schedule is lost to many of us a lot of the time through simple pressure of time and necessity. This is where supervision comes in. It is the structured down-time we each need to recover. Like a true relaxation or a meditation, it is time out to do 'nothing very much' in a very focused way and like these its benefits are truly amazing. It is the aim of this paper to define the role of supervision. I will show how it can play a crucial role in defining what homœopathy is, how it helps us to keep the faith with that ideal and in so doing ensures our safe and ethical practice of homœopathy so that we and our patients are free to do our work. I will discuss both what supervision is and what it is not, how we can go about incorporating it into our training of students and how we might encourage and prepare homœopaths to do supervision for each other.

WHAT IS SUPERVISION?

Supervision means literally 'Oversight'. The Latin 'super' means over and 'visio' sight. It is the overview. It equates with Hahnemann's 'Unprejudiced observer'. This is the place within each of us from which we perceive what is to be cured. The homœopath perceives what is to be cured in the patient. The supervising homœopath perceives what is to be cured in the supervisee in relation to their practice of homœopathy. This may mean in their relationship with a patient or patients in general, in relation to belief systems or prejudices which constitute either an obstacle to perception or a bottom line, or it may mean in relation to their understanding of what constitutes a homœopathic response etc.

Supervision means the practice of awareness. It enables us to develop an understanding of ourselves as object with an objective reality having both effect and consequence. We do this by exploring our subjective reality, our emotional responses, beliefs and prejudices within the boundaries of the supervisor-supervisee relationship. In short, supervision is a perception of the overview and an understanding of one's position in the whole enabling one to take responsibility for oneself and one's actions (ability to respond) and this is a very liberating place to be. It is not the practice of homœopathy, therapy, counselling, mentoring or teaching. Supervision will contain elements of each of these as appropriate but it is not defined by any of them. It is maintaining the boundaries between these different disciplines that is a primary task for the supervisor. Supervision is there to provide another layer of containment for the patient and to protect them from the homœopath's own issues. Through good supervision the patient is ensured a safe and ethical environment in which to heal and grow. The homœopath is empowered and supported to develop a practice which also nourishes them. By being encouraged to practise as themselves and not as an idea of how a practitioner should look and behave then a personally liberating and creative practice of homœopathy is developed. Students are always saying to me in this context, "Once I've got myself sorted out then I'll be able to practise" as if that day ever comes and as if they have not already arrived!

Supervision is about clarifying intention. Whether it focuses on the practitioner or the patient in any particular instance, then its motive is to find out what the true intention is, rather than the 'should' or 'would' of the matter. Many difficult cases are solved in the discovery of true intention. For example it may be the homœopath's true intention to be liked or admired by a patient, preferring to stay on mutually comforting ground rather than risk finding out what the matter is and it may be the patient's true intention to please the homœopath in order to be considered a good patient while at the same time feeling they are not really being themselves. It is obvious that both will beaver away without progress until the true nature of this relationship is understood.

Supervision is all about relationship. The patient – practitioner relationship mirrored in the supervisor-supervisee relationship. It is all about power and the dynamic nature of that slippery object. Good supervision reveals the true nature of the relationship and in so doing frees us from its constraints on us to react in particular ways. It puts 'response' where 'reaction' was. It is because supervision is about relationship that it is a nonsense to me to talk of 'case supervision'. Supervision as it tends to be practised at

the moment involves a student/homœopath taking a paper case to another homœopath and getting that practitioner's response to the case that is a second opinion. This may or may not be useful in solving the case in terms of the simillimum but it does nothing to empower, support or illuminate the trainee/homœopath's own process. A case is always a dynamic process. Two different homœopaths may both give different but curative prescriptions to the same patient. This is a philosophical discussion we continue to have of course. What does it mean? There may be one simillimum for everyone given optimum timing and conditions but the reality most of us know is the 'good enough' prescribing dependent upon the relationship between patient and practitioner in daily life. The case is always mediated through the personality of the prescriber. This is why I consider so-called 'practitioner development' and 'case supervision' to be properly undertaken by an integrated approach which focuses on the case via the practitioner's perception throughout, raising both personal issues and those of case management as appropriate.

Supervision is at the heart of the therapeutic relationship. It is the keeper of the highest ideal. 'Supervisor' is a place within ourselves as well as a role we both give to others and undertake for others. When practitioners say, as some do, "I don't need supervision" I feel they are sometimes not recognising that they are doing this work for themselves. A training in supervision, whether for supervisors, practitioners or students makes explicit the nature of this process, articulates it and makes it more accessible to us. The aims and objectives of supervision are therefore no less than the development of the practitioner as themselves.

WHAT IS HOMŒOPATHIC SUPERVISION?

The perception of what is to be cured in the trainee/homœopath in relation to their practice is for the purpose of analysis divided into two parts: the practitioner development part, that is awareness of prejudice and the casework; and the clinical training part, that is paper case and live case work. Whatever the relationship in which supervision is being done; tutor – student or external case supervisor – student for example. It is the job of supervision to locate and focus on the appropriate area, make the space to work on it, delegate or refer it, take appropriate action and finally to assess the effectiveness of the supervision. Some people engaged in supervision may be better at exploring the psychodynamic nature of the relationship while others may be more able in the technical application of homœopathy. Some lucky souls will be good at both. Everyone can develop intention and focus with the aid of structure and purpose. This is why we need to explore supervision as a discipline separate from teaching and prescribing etc. Recognising when and what to delegate is part of the art of supervision. With trainees, gaps in teaching are highlighted for example. Sometimes you need to suggest that a personal issue is worked on with a counsellor or therapist in order that patients are protected from a counter transference. It is obvious that to be an effective safeguard for patients there needs to be feed-back between colleges, regulatory bodies and supervisors.

On the whole supervision is a mutual process. On occasion the supervisor must be prepared to take on a regulatory role if she understands patients are at risk from a practitioner.

WHO UNDERTAKES SUPERVISION?

At the moment, training homœopaths are supervised by tutors and sometimes by teachers as well as by supervising homœopaths external to the college. Post graduate supervision is carried out by colleagues practised in the art of supervision as well as by therapists, peer groups etc. The point is that supervision can be carried on in a variety of relationships; one to one, in groups and within oneself. Supervision is an aspect of consciousness we each need to develop. It is a matter of locating the patient, practitioner, teacher, student and supervisor, as well as counsellor, friend, mentor etc. within us and to recognise where we are coming from and to note its appropriateness to any particular case. Because the more you put into a relationship the more you get out, it is my contention that supervision is most effectively carried out professionally within the security and intimacy of a stable relationship developed for the purpose. I think that we will discover as a profession, as psychotherapists and counsellors have before us, that when it comes to practising with ease, avoiding 'burn-out' and protecting patients, then supervision is the shortest route: It takes us from the centre to the particulars. A system of supervision which focuses on the case and not on the relationship in which the case was received is like a prescription being made on particulars without reference to the centre of the case. It reinforces separation, the case as separate from the prescriber, whereas a wholistic approach to training and supervision mirrors the integrated and processual nature of the healing relationship.

WHAT SKILLS DOES A SUPERVISOR NEED?

A supervising homœopath needs to be skilled in homœopathy in the sense of being willing to engage in the process with an enquiring mind, with a willing heart and with the intention of understanding without prejudice. It follows that a supervising homœopath needs to have experience of practice. If not then the tendency to separate out practitioner development from case work is reinforced. Some of the tools of psychotherapy are useful to the understanding of the patient-practitioner relationship and the obstacles to its being a curative relationship, for example concepts of projection, transference and counter transference. However, I think that the case-taking skills of the homœopath and the principles of homœopathic philosophy are enough of themselves to guide the supervisor-supervisee relationship through to ethical and liberating practice once they are properly understood.

It is my contention that we do not need to train supervising homœopaths in psychotherapy in order to provide a whole training in homœopathy.

WHAT METHODS ARE APPROPRIATE TO SUPERVISION?

To be most effective the supervisor-supervisee

relationship needs to mirror that of the patient-practitioner. The phenomenon of parallel process is one in which the patient's material is acted out unconsciously by the practitioner with their supervisor. For example, a patient may be angry with a practitioner for not being available enough. The prescriber in turn may feel their supervisor is not available enough to support them. For this unconscious material to be made explicit and thereby defused, a parallel power relationship needs to be set up for the purpose. The most appropriate method remains the same in both relationships, and that is case-taking. Role play and other techniques of psychodrama are useful especially in group work, but essentially all that is required is a grasp of the simple art of case-taking. What does this mean exactly? It means a return to paragraph one of the Organon: "The physicians high and only mission is to restore the sick to health, to heal as it is termed". If this is our only intention, to focus all our efforts in this direction of curing the sick, within ourselves that is as well as in others, then our practice will always tend to return to an ethical and personally transforming purpose. How will it do this? Because if this is the focus of all our efforts then we will be asking what is sick and what is healthy in any particular case and how is health to be restored? By returning to this purpose in daily practice we reinforce our intention. And what is this asking? This is case-taking. This is the purpose of case-taking, to find out what the matter is. Whatever else we do with it, this is the singular purpose of taking the case. If we do this solely with the intention of finding out what is to be cured then we are able to practice and to supervise without prejudice and with intention to cure.

The main method to be used in supervision is the case-taking method. By this method the supervising homœopaths agenda, to get the training practitioner to practice according to the supervisor's style for example, is replaced by the training homœopath's agenda. The supervisor's prejudices are exposed and the training homœopath's prejudices explored. How do we take a case like that? Suffice to say here that if the intention is to find out what the matter is with the training homœopath then the less the supervisor puts in the better. What we need for this method to be effective is a structure for supervision that reinforces its purpose so that supervision doesn't replicate teaching, therapy or prescribing. I use a cyclical model which sets up the supervisor-supervisee relationship to parallel that of the patient-practitioner. It takes each aspect of the process in turn, locating issues before moving on to the next area. Basically, we move from ground rules to focusing on an issue to making the space for that work before we then with a renewed awareness, make a response to the case. Having done that we review the work and finally remake the ground rules. Full circle. This structure was developed within person-centred counselling by Steve Page and Val Wosket and I have simply adapted it to our needs.

WHAT GOALS NEED TO BE REACHED IN SUPERVISION?

The aim of supervising the training homœopath to licensed standard must be to ensure they are able to:

a) take a homœopathic case
b) take steps to understand and analyse a homœopathic case
c) make a homœopathic response.

By the time registration is sought they need to be able to demonstrate the ability to manage and take responsibility for every aspect of the homœopathic case by having a portfolio of cases representative of their individual learning process of the art and science of homœopathy, and/or having completed a certain number of clinic hours under supervision. These hours, begun before licensed membership, would cover every aspect of clinical work from 'sitting-in' observation through case-taking and recording to full responsibility as prescriber and manager of cases. Nothing new in that except that at the moment many students have to get this lot together in a very hit and miss sort of way and no one relationship is necessarily developed in which the student feels known or understood as a becoming practitioner. Here we need to look at the system as a whole, for example, there could be a large number of tutors, supervisors as well as practitioners providing 'sitting-in' hours, each of whom are required to fill in confidential reports on the students progress. But the question raised is, who for? Are these reports just 'receipts' for work done or are they actually for the benefit of the student, there to assist them in their development?

If we take 'practitioner development' work/modules, case work and external clinical training, so-called 'sitting-in', and integrate them into core curriculum, then we intend to understand the quality of the relationships between the trainee, her homœopathy, patients, teachers and supervisors. We do not just intend to follow form, to demonstrate to others that we undertake a proper training. This participatory approach to training is followed through with an open, mutual, critical approach to assessment.

CONCLUSION

What I wish to develop is an integrated training of homœopaths which incorporates and transforms the understanding of other disciplines into the homœopathic context so that it becomes our own. This is an important development for us in that it will enable us to be positive in our assertions about what homœopathy is. It is not homœopathy plus a bit of psychotherapy and a little Buddhism, for example. It is another whole and particular expression of the truth in the same way as these other disciplines are.

I see our reliance on counsellors and psychotherapists for example to provide us with much that would qualify as 'practitioner development' as a temporary state of affairs as a profession, while also asserting the right for individual homœopaths to seek the help and guidance they need from whomever and in whatever manner they choose. This is a different vision to the prevailing situation in which a training homœopath undertakes a college training and then adds to it some clinical hours and case supervision, the nature and quality of which depends upon ringing round and hitting lucky with a helpful homœopath. This is what needs to be integrated into the homœo-

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