Journal of Genetic Counseling, Vol. 16, No. 2, April 2007 (© 2007)
DOI: 10.1007/s10897-006-9065-0

Professional Issues

Report from the UK and Eire Association of Genetic Nurses and Counsellors (AGNC) Supervision Working Group on Genetic Counselling Supervision

Group Authorship: AGNC Supervision Working Group

Membership of the AGNC Supervision Working Group:
Alison Clarke,[1] Anna Middleton,[2,5] Lorraine Cowley,[3] Penny Guilbert,[4] Rhona Macleod,[1] Angus Clarke,[2] and Van Tran[4]

Published Online: 17 February 2007

The Association of Genetic Nurses and Counsellors (AGNC) is the professional organisation which represents genetic counsellors and genetic nurses in the United Kingdom (UK) and Eire. The AGNC recognises that genetic counselling supervision is instrumental to the practice, training and registration of genetic counsellors in the UK. The AGNC formed a Supervision Working Group, whose terms of reference were to collate information on supervision and create a list of 'best practice' recommendations for its genetic counsellor members. This report delivers the findings from the Supervision Working Group and has been peer reviewed by the AGNC membership in the UK and Eire and ratified by the AGNC Committee. It offers a working definition of genetic counselling supervision, gives an overview of some of the literature on supervision and concludes with practice recommendations.

KEY WORDS: genetic counseling; practice; supervision; recommendations; supervisor.

INTRODUCTION

THIS document was produced as the result of work undertaken by the UK and Eire Association of Genetic Nurses and Counsellors (AGNC) Supervision Working Group. The AGNC is the professional organisation which represents genetic counsellors and genetic nurses in the UK and Eire. The remit of this group was to make evidence-based recommendations to the membership of the AGNC, to support the needs of genetic counsellors from any professional background for supervision.

It is a registration and training requirement for genetic counsellors to receive counselling supervision and it is recommended that all genetic centres have arrangements for supervision in place by 2008. Non-compliance may affect the ability of genetic counsellors to obtain registration and may also affect the ability of clinical genetics departments to act as training centres for genetic counsellors. Registration is the formal process that genetic counsellors in the UK complete in order to obtain professional recognition (see www.agnc.org.uk for more details).

[1]Northwest Regional Genetics Service, St. Mary's Hospital, Manchester, UK.
[2]Institute of Medical Genetics, University Hospital of Wales, Cardiff, UK.
[3]Northern Genetics Service, Institute of Human Genetics, Newcastle Upon Tyne, UK.
[4]Nottingham Department of Clinical Genetics, City Hospital, Nottingham, UK.
[5]Correspondence should be directed to Dr. Anna Middleton, Consultant Research Genetic Counsellor at Institute of Medical Genetics, University Hospital of Wales, Cardiff, UK; e-mail: middletona1@cardiff.ac.uk.

1059-7700/07/0400-0127/0 © 2007 National Society of Genetic Counselors, Inc.

Throughout the document reference will be made to 'genetic counsellors' and 'clients' for the purposes of consistency. The authors, however, wish to acknowledge the diversity of the AGNC membership and to reflect the different relationships that we have with the people for whom we provide a service. Therefore these terms may equally be substituted with 'genetic nurse specialist,' 'genetic associate' and 'patient' respectively. Furthermore, genetic counselling is provided by clinical geneticists in that they too provide emotional support and encourage client reflection. Much of what follows about the benefits of skilled supervision will therefore apply to clinical geneticists too.

The terms 'clinical,' 'counselling' and 'psychological' supervision are often used interchangeably. In order to define this more carefully and in order to avoid confusion, we have adopted the term 'genetic counselling supervision' and will refer to this throughout the document. The following headings will be used to guide the reader:

1. Defining Genetic Counselling Supervision
2. Supervision within a Governance Framework
3. Context of Practice
4. Potential Benefits of Supervision in Genetic Counselling Practice
5. Theoretical Framework and use of Reflection
6. A Model and Framework for Supervision in Genetic Counselling
7. Modes of Supervision
8. Documentation
9. Resource Implications
10. Recommendations for Genetic Counselling Supervision

DEFINING GENETIC COUNSELLING SUPERVISION

Following a review of the literature surrounding clinical and counselling supervision, the Supervision Working Group agreed that within the context of clinical genetics and the role of the genetic counsellor, certain key phrases were considered pertinent to formulating a definition of genetic counselling supervision. These phrases are illustrated below:

Supervision . . . .

> 'Involves reflecting on practice in order to learn from experience and improve competence' (Kohner, 1994).

> 'Is a practice focused professional relationship involving a practitioner reflecting on practice guided by a skilled supervisor' (UKCC, 1996).

> Is 'a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations' (NHS Management Executive, 1993).

> 'Is a designated interaction between two or more practitioners, within a safe/supportive environment, which enables a continuum of reflective, critical analysis of care, to ensure quality patient services' (Bishop, 1998).

> 'Is an exchange between practising professionals to enable the development of professional skills' (Butterworth, 1992).

The Supervision Working Group considered each of these phrases and reached a consensus on the definition of genetic counselling supervision.

Definition of Genetic Counselling Supervision
Genetic counselling supervision is a formal and contractual arrangement, whereby genetic counsellors meet with a suitably trained and experienced supervisor to engage in purposeful, guided reflection of their work. Focusing on the dynamics between client and genetic counsellor, the aim of this process is to explore the interaction between the counsellor and their client, and the impact of external factors on this, enabling counsellors to learn from experience, improve their practice and maintain competence. The overall intention is to enhance the quality and safety of client care and to promote the ongoing professional development of the genetic counsellor.

SUPERVISION WITHIN A GOVERNANCE FRAMEWORK

There is understandable confusion between what is meant by supervision in different contexts. In clinical professional contexts, it is usually taken to mean a form of overseeing by someone in authority (line manager or someone with more experience or more knowledge). This is very different from the ethos underpinning counselling supervision for therapeutic counsellors. Such counsellors are required to have regular, ongoing supervision independent of any managerial relationship by their professional body, e.g. British Association for Counselling and Psychotherapy (BACP). Genetic counselling

supervision draws on the ideas behind supervision for therapeutic counselling. It is not a line management appraisal nor usually offered by someone within the direct working hierarchy.

In the genetic counselling arena there is the need to distinguish genetic counselling supervision from the clinical/medical supervision/case review that is normally undertaken, whether formally or informally, with medical colleagues within the team. Such clinically-focused case review discussions are not a substitute for genetic counselling supervision for those using counselling skills in managing clients.

Within the NHS, supervision can be seen as an integral part of quality assurance by providing challenge, reflection, support and development for those undertaking counselling roles. Such practitioners will have issues arising from their client work, from their membership of teams and from organisational pressures and constraints. McSherry *et al.* (2002) considers the provision of supervision to be an organisational issue requiring resources and management support if governance structures are to be strengthened. This echoes earlier work (Darley, 1996) which identifies clinical supervision (in nursing) as a factor in the reduction of complaints, litigation and sickness with organisations and therefore important in risk management. It is also reinforced by the BACP in their Ethical Framework, giving supervisors and managers a responsibility for maintaining and enhancing good practice to protect clients (BACP, 2002).

Bond (1993) and Copeland (2000) review aspects of individual and organisational accountability in this context and provide some ideas on appropriate division and co-ordination of tasks between supervisors and managers. It may be of value to apply this model to the genetic counselling context.

Within health care generally and in the National Health Service there is a push towards the widespread introduction of clinical supervision (which parallels genetic counselling supervision in our context) as a means of supporting lifelong learning and continuing professional development, thereby improving the quality and standards of care. All health care professionals are working in a rapidly changing environment with the consequent need for continuing professional development. This is particularly the case in genetic counselling practice, which is increasingly complex and rapidly evolving in nature. As a consequence there is no end point to learning about practice, no matter how senior or experienced the practitioner and supervision provides a useful arena for ongoing learning and development.

In a health service with a limited budget managers are likely to want to see demonstrable benefits from supervision and the successful implementation and continuation of supervision in genetic counselling is likely to rely on measurable outcomes regarding its effectiveness and its impact on the delivery of client care. As a consequence it is important that the process of supervision is explored and evaluated in this field to discover the most appropriate, effective and beneficial approaches in a practice setting.

CONTEXT OF PRACTICE

In the UK, genetic counsellors work predominantly in, or are associated with, Regional Genetic Centres within the NHS. As such, they work within organisational frameworks as well as within the AGNC Code of Ethics and the codes of conduct of any other professional group to which they may belong e.g. nursing. They have a complementary role to clinical geneticists, with whom they often work in close partnership offering joint counselling or combined management. Increasingly, a proportion of work is counsellor–led. This usually involves the management of cases with a well-defined diagnosis where the main requirement is counselling and clinical and psychological information giving around the implications of the diagnosis for family members and pre- and post-test counselling for presymptomatic testing. Genetic counsellors also work with many other professionals in pathway approaches e.g. multidisciplinary cancer services.

Families may be seen at home or in a clinic setting. Interactions may involve individuals, couples or family groups. Most referred families will have experienced ill health, disability or loss due to the presence of an inherited condition. The counsellor will therefore need to interact with people who are upset, angry, confused, in denial, etc. As Kennedy (2000a) remarks: ‘Genetic counsellors do not provide psychotherapy . . . (However, they do) engage with their patients around a variety of psychosocial issues: family dynamics, cross cultural concerns, decision making, loss, grief, depression and anxiety.’

Genetic counsellors need to create and maintain helping relationships in these circumstances, working through the clinical information, exploring and supporting the needs of their clients to achieve an

optimal outcome. The clinical situation is often unpredictable and requires a range of counselling skills as well as an adequate genetic knowledge base. Kessler (1997a, 1997b) and Sarangi *et al.* (2004) draw attention to the tension between the information giving and counselling skills required of a genetic counsellor and see this as a challenge that needs actively addressing. Supervision provides a way to explore and manage such tensions whilst developing strategies for practice.

The mixed (multi-task) context of genetic counselling and the tensions incumbent within practice require adequate risk management and support mechanisms to be in place to assure a safe and effective practitioner in the delivery of a quality service to clients. Assuring that all genetic counsellors can access appropriate supervision is a means of managing this situation and is strongly advocated here for the wellbeing of the counsellors and their clients.

Potential Benefits of Supervision in Genetic Counselling Practice

Supervision has an extremely poor research base and there is a lack of empirical evidence to demonstrate its effectiveness. Reviews of the supervision literature draw negative conclusions about research in this area and indicate that studies are flawed methodologically (Ellis *et al.*, 1996; Binder, 1993; Perris, 1993; Alberts and Edelstein, 1990). As yet there is a lack of evidence to support claims regarding the benefits of supervision, or to show that it improves client outcomes. Literature and research specifically about genetic counselling supervision is extremely limited. Of the literature found, none reported an overall negative outcome of having supervision, either on the individual, organisation or client. The studies that were reported indicated that the overall experience and outcome of supervision was generally positive.

Clarke (2001) used a previously validated tool developed by Bowles and Young (1999), and based on Proctor's Interactive model of supervision, to examine the perceived benefits of supervision amongst genetic counsellors in the UK. This indicated that genetic counsellors who are in receipt of supervision agree that it has benefits in the formative, normative and restorative domains outlined by Proctor in her interactive functions of supervision model (Proctor, 1986), see later. They agreed most strongly with the view that supervision helps them to cope with difficult practice situations. It was the formative or reflective learning and educational benefits about which there was most agreement as to the beneficial effects of supervision. These benefits involve learning new ideas and approaches to practice, thinking through situations more critically and increased self awareness. In addition genetic counsellors agreed that supervision helps them to feel that their practice is of an acceptable standard. This supports the view that genetic counsellors value supervision as a means of analysing, improving and validating practice.

Clarke also found that the most common theme mentioned as recurring in supervision by respondents was the discussion of approaches and strategies to practice, which adds further weight to the idea of supervision as a means of exploring practice. The other issues respondents most frequently reported as being discussed in supervision include difficult ethical dilemmas, family dynamics, the counsellor's own strong and powerful feelings and angry, hostile and 'difficult' clients. Themes identified as being common in sessions have parallels with those listed by Middleton *et al.* (2004, 2007) who documented the experiences of genetic counsellor's responses to supervision in Cambridge, UK as well as Kennedy (2000b) who looked at case presentations and discussions in a leader led supervision group in Boston, US. Many of the themes concern difficult practice issues that have the potential to provoke uncomfortable feelings in the practitioner, or that cause dilemmas and uncertainties regarding practice interventions. By discussing these issues, practitioners may be seeking reassurance and verification regarding the appropriateness of their case management, and requesting advice about the possibility of alternative approaches.

Some literature suggests that the increasingly complex nature of genetic counselling and the kinds of problems and challenges that are now being faced require alternative, innovative and more active counselling approaches (Kenen and Smith, 1995; Eunpu, 1997; Elwyn *et al.*, 2000). These approaches remove the emotional distance between the client and the counsellor and engage the client on a deeper more interactive level (Kessler, 1997a, 1997b; Kenen and Smith, 1995). This may leave the counsellor more exposed on an emotional and psychological level. Without adequate support mechanisms this could be damaging to the counsellor and may interfere with the provision of effective genetic counselling. The

provision of supervision may help to prevent such problems from arising and ensure that practitioners have access to the support and restorative mechanisms that will enable them to cope with the emotional impact of their work.

Studies concerning the process of genetic counselling have shown inadequacies in the counselling skills of practitioners (Kessler, 1979, 1981; Kessler and Jacopini, 1982; Michie *et al.*, 1997). A study by the AGNC indicated that only a minority of genetic nurses/counsellors have undertaken specific training in counselling skills on a dedicated course (Skirton *et al.*, 1997). It is often difficult to find the time or funding to attend formal counselling courses. The course content within general counselling may not seem applicable to a lot of genetic counselling situations that may, for example, mainly focus on clinical information giving. However, we would argue that the use of counselling skills would be relevant to all interactions with clients. Specialist counselling courses specifically aimed at genetic counselling practitioners are few and far between and are often expensive and located at venues requiring additional expenses for travel and accommodation. As a result it can be difficult for genetic counsellors to continue educating themselves in terms of the counselling aspects of their role. Generic counselling courses that are not specifically aimed at genetic counsellors may be of great value since working with a client group that is outside one's usual remit offers a learning opportunity about universal themes underlying all human situations. Supervision provides a forum in which to continually refine and develop counselling skills and improve practice.

Gaining insight into the process of what genetic counselling actually constitutes has proved difficult utilising traditional approaches and modes of research. Genetic counselling is a practice-based profession and proponents of reflective practice and reflective learning maintain that knowledge can be generated from the practice setting (Schon, 1983; Benner, 1984; Rolfe, 1996, 1998; Johns, 1996). Advocates of reflection maintain that by purposefully reflecting on practice and applying a process of critical thinking and analysis, learning takes place and thereby the creation of knowledge and improved future practice. The application of supervision as a vehicle for reflection and the careful evaluation of this process may provide a means of examining and exploring what actually happens in genetic counselling and engendering knowledge.

THEORETICAL FRAMEWORK AND USE OF REFLECTION

The process of genetic counselling supervision should be grounded within a theoretical framework. The exact basis of this can vary depending on the supervisor's experience and training. A registered genetic counsellor would be expected to use supervision to develop an 'internal supervisor' (Casement, 1985), which refers to an ability to conduct a simultaneous process of reflection, while at the same time, working with clients. The ability to internalise this self-reflection process enables genetic counsellors to critically analyse how they are working and to adapt and focus on the client's needs in an appropriate manner. The development of this process can be guided by counselling theory and techniques, for example, application of Roger's person centred counselling or consideration of transference and counter transference, projection, identification etc. The genetic counselling registration process requires genetic counsellors to consider such counselling theory and therefore supervision can be used as a focus for this.

The following sections give details of some of the theory behind reflective learning and practice with a model and framework for genetic counselling supervision.

REFLECTIVE PRACTICE AND LEARNING

The New Shorter Oxford English Dictionary (1993) defines 'reflect' as to 'turn one's thoughts (back), fix the mind or attention: ponder, meditate: employ reflection'.

One of the forefathers of reflective practice, John Dewey (1929), states:

> 'We do not learn by doing.... We learn by doing and realising what came of what we did.'

According to Andrews (1996) reflection should not be confused with thinking about practice as this may only involve recalling what has occurred rather than learning from it. The process of reflection is focused and involves a willingness to learn from personal experience by purposefully going through and reviewing events. It also involves some follow up action whereby this learning is utilised to bring about change. The overall aim is to enhance practice and the effectiveness of the work we do with clients.

> Johns (1995) feels 'The essential purpose of reflective practice is to enable the practitioner to access, understand and learn through his or her lived experiences and as a consequence to take congruent action towards developing increasing effectiveness within the context of what is understood as desirable practice' (Johns, 1995, p. 226).

THEORIES UNDERPINNING THE CONCEPTS OF REFLECTIVE LEARNING AND REFLECTIVE PRACTICE

The works of Schon (1983, 1987 and 1991a, 1991b) on reflection are amongst the most frequently cited in the literature. Schon's book, The Reflective Practitioner (1983), is considered to be a seminal work. Schon introduced the idea of two types of reflection, 'reflection on action' and 'reflection in action.'

Reflection on action is retrospective contemplation of practice. This is the approach adopted in supervision where the supervisee looks back at a past event with a supervisor. Reflecting on action means noticing what one has been doing, and how well it works, and on the basis of these observations adjusting practice in the future. This process turns experience into knowledge. According to Schon reflection on action is a way of generating knowledge from the messy and unpredictable practice setting by actively processing experiences away from the situation in which they were acquired.

Reflection in action occurs when the practitioner has to think about a situation or problem while they are dealing with it, drawing on prior knowledge and experience. Schon also refers to reflection in action as 'experimenting in action' or 'thinking on your feet.' In counselling practice this correlates with having an awareness and understanding of process which is one of the most useful skills of counselling and probably the most difficult to achieve. It involves responsiveness to what is happening inside the counsellor and imagining or guessing what is happening in the client and between the counsellor and client. Casement (1985) describes this as internal supervision and as a process of 'self review in the session.'

L'Aguille (1994) points out that reflection is a skill and is not perfected instantly. Practitioners may need help in order to acquire the skills necessary for effective reflective practice. Dolley *et al.* (1998) suggests that the role of the supervisor is to offer a framework of process and skills that can be a vehicle for a reflective journey. Supervision can thus help practitioners develop the skills necessary to reflect on practice in a purposeful and effective way. The acquisition of these skills helps to develop practitioners who are able to reflect not simply after the event but while they are actively engaged in practice or what Schon termed reflection in action.

MODELS OF REFLECTION

Within the literature there are a number of reflective models to choose from (Benner, 1984; Driscoll, 1994; Ghaye and Lillyman, 1997; Johns, 1997). Detailed reviews of reflective practice include Palmer *et al.* (1994), Goff (1995a, 1995b), Clarke *et al.* (1996) and Tseng (1998). It is not possible within this report to look in any detail at these models. All reflective models are based on the premise that intentionally reflecting on practice leads to awareness, better understanding and learning thereby enhancing future practice. Reflection has been conceptualised into varying stages depending on the author (Meizrow, 1981; Schon, 1987; Powell, 1989; Johns, 1992). Each stage involves an increasing level of awareness. Richardson and Maltby (1995) describe six levels of reflectivity and these are descriptive, affective, discriminative, judgmental, conceptual and theoretical. A registered genetic counsellor would be expected to reflect at a theoretical level and supervision can be used as a vehicle for this. In addition to this, reflection at an emotional level is also paramount. It takes honesty, emotional maturity and training to be able to use the internal experience to inform the integration of theoretical concepts.

A MODEL AND FRAMEWORK FOR SUPERVISION IN GENETIC COUNSELLING

Proctor's Interactive Model of Supervision

The work of Proctor (1986) has been extremely influential and led to a proliferation of publications specifically on counselling supervision. Within the nursing literature Proctor's interactive model of supervision (Proctor, 1986) is referred to in major references as a way of approaching supervision (Butterworth *et al.*, 1998; Bishop, 1998; Bond and Holland, 1998; Dolley *et al.*, 1998; Fowler, 1998; Power, 1999; Driscoll, 2000).

This model is an integrated system with three interactive functions: formative, restorative and

normative that could provide a useful framework for supervision within the field of genetic counselling.

- *The formative*, or educational function provides a framework and process for reflective learning. It is about developing the skills, understanding and abilities of the supervisee. It enables the supervisee to recognise strengths and weaknesses in his/her work to gain knowledge and to relate theory to practice in a critical way.
- *The restorative* or supportive function is concerned with how practitioners respond emotionally to the stresses of their work. It offers an opportunity to explore feelings and to develop insights into the way work impacts on the practitioner emotionally. It is about de-stressing, re-charging and devising coping strategies.
- *The normative* or managerial function highlights the importance of professional and organisational standards and the need for competence and accountability. It is concerned with safe practice and developing and maintaining standards of practice. It is about ensuring that the work of the supervisee is appropriate and in accordance with professional codes of ethics and guidelines for practice.

Proctor's model is helpful in isolating different dimensions of supervision, which is seen as a dynamic process, moving between the three functions and starting with whichever is most appropriate at the time. It provides a flexible framework which Bond and Holland (1998) suggest is useful in diverse health care situations with differing requirements. The balance may be affected by the location and nature of service provision. The practitioner's experience or stage in their career may also affect the balance between functions. The role of the supervisor does not equate with any one of the functions but draws on each of them with the aim of helping practitioners to improve their individual professional practice. As a result a key challenge for the supervisor is maintaining balance between the three functions.

MODES OF SUPERVISION

Supervision can take place in a number of different formats. The two most common methods are explored in more detail here: one-to-one and group supervision, variations of these approaches also exist. Each mode of supervision has advantages and disadvantages and the most suitable method will depend on a number of factors including the practice setting and the individual personalities of those involved. Some individuals may opt to receive supervision in different formats at different times, depending on their needs at that particular point. Other individuals may use a variety of supervision approaches in combination in an effort to extract the advantageous aspects of each one and maximise the overall benefit.

One-To-One Supervision

This method can involve an individual practitioner having supervision with a more experienced supervisor from the same discipline and area of practice. Alternatively the practitioner may attend sessions with a supervisor whose experience is in a different area of practice, external to the department where the supervisee works. Peer supervision on a one-to-one basis with an individual of a similar grade and experience is another option (Dolley *et al.*, 1998).

The advantages and disadvantages of individual supervision have been outlined by Carroll (1996).

Advantages

- Private and highly personalised with the supervisor's interventions geared specifically to the needs of the individual supervisee.
- The individual attention given to the supervisee provides a forum that is systematic, ongoing and highly educational.

Disadvantages

- Expensive in terms of time and economics.
- Feedback is given from only one perspective.
- There is a risk that the relationship can become collusive with very little challenge.
- This approach can also create dependency in the supervisee.

GROUP SUPERVISION

The group approach to supervision can be divided into group supervision with a designated supervisor or supervision in a group context but with no

designated facilitator and where the members share the responsibility for providing each other's supervision. The group may consist of peers from the same discipline or alternatively may be from a variety of professional backgrounds. The latter form of supervision is sometimes referred to as network supervision. Additionally group supervision may occur within a team of staff that works together on a regular basis.

Clarke (2001) found that the most usual format for genetic counselling supervision in the UK was via a multi-disciplinary group approach. However, when asked what sort of supervision these people preferred most said they would like to have access to both one-to-one and group supervision. The sort of group supervisions available in the UK are often led by a facilitator from an outside discipline and resemble the type of leader-led supervision group described by Kennedy (2000a, 2000b) and Middleton *et al.* (2004, 2007).

Little is known about team group supervision, although it is postulated that it may be more vulnerable to the detrimental influences of the group process, team dynamics and the politics of the working group (Carroll, 1996; Hawkins and Shohet, 1989).

Hawkins and Shohet (1989) explore the advantages and disadvantages of group supervision.

Advantages

- Economical in terms of time, finance and expertise.
- Provides a greater range of input and perspectives. This may be a particularly useful format in genetic counselling where standards of professionalism are emerging providing a useful arena to explore practice, discuss the appropriateness of interventions, seek possible alternatives, and obtain the validation and support of colleagues (Clarke, 2001).

Disadvantages

- The interference of group dynamics with the supervision process, which may be destructive and distracting.
- There is also less time for each individual to receive supervision.
- Confidentiality may be difficult to maintain in a group context (Dolley *et al.*, 1998).
- This setting may be more anxiety provoking and overwhelming for some participants limiting their ability to benefit and learn in a group environment (Platzer *et al.*, 2000; Miller *et al.*, 1994; Newell, 1992).
- Some individuals may find it more difficult to speak freely in a group setting (Clarke, 2001; Webb, 2000).

The literature suggests a number of key areas that should be taken into consideration when group supervision is being organised to increase the effectiveness of the supervisory process. For example, the utilisation of a group facilitator with not only supervisory but also excellent group skills (Dolley *et al.*, 1998) is paramount. This is stressed in the literature as being of particular importance with staff team groups (Dolley *et al.*, 1998; Carroll, 1996).

Where a group leader is not utilised, Hawkins and Shohet (1989) emphasise the value of incorporating structures into the group supervisory process to enable group participants to share in the responsibility for focusing on the group's needs. These structures include making a clear group contract and setting ground rules regarding:

- The commitment of group participants.
- The frequency, duration and location of meetings.
- How time will be allocated between group members.
- The expectations of group members about the purpose of sessions.

Middleton *et al.* (2004, 2007) have documented the experiences of one-to-one and group supervision for the team of genetic counsellors in Cambridge. They showed that prior to having group supervision the team were all concerned about sharing within a group setting, mostly this related to fear of being able to discuss issues freely, fears of being judged by colleagues and worries about not being able to contribute to the sessions. Such issues have been identified in other work looking at group supervision (e.g. Kennedy, 2000b; Hiller and Rosenfield, 2000). However, after having group supervision in place for a year the team from Cambridge did not feel these issues were so relevant anymore and reported the positive benefit of having access to group supervision on their practice as genetic counsellors. The team also reported the benefits of having access to both one-to-one and group supervision and found that each type of session met different needs and enabled a

more holistic approach to working—more so than when there was access to just one-to-one supervision alone. The literature recommends the supplementation of group supervision with additional one-to-one supervision and suggests that ideally the use of group supervision should come from a positive choice rather than a compromise (Carroll, 1996; Webb, 2000).

The Multidisciplinary Group Supervision Session

One issue to consider, and on which genetic counsellors in different units may reach different decisions, is the extent to which they wish their group supervision to include clinical geneticists as well as genetic counsellors. There is less professional expectation that clinical geneticists will engage in supervision but no less need for it—on behalf both of the clinical geneticists themselves and of their clients. Indeed, the Joint Committee on Higher Medical Training (JCHMT), representing the Federation of the Royal Colleges of Physicians of the United Kingdom (the executive body responsible for the supervision of higher medical training) recommends that all Specialist Registrars in Clinical Genetics must have counselling supervision implemented into their training: 'supervision by a psychologist or experienced counsellor should be available locally and the trainee should make regular use of this' (JCHMT, 1999).

The role of the genetic counsellor is broadening and it is now not unusual for a genetic counsellor specialising in research or education to also be part of the team. Being able to access genetic counselling supervision is a requirement for all registered genetic counsellors in order to maintain their registration, whether they work clinically in research or in education.

The sharing of different roles and encounters within a group setting can be beneficial to all concerned, irrespective of their role in the department. The contribution that other disciplines such as academic genetic counsellors or clinical geneticists can make to this should not be underestimated.

In general, we would encourage colleagues to support multidisciplinary genetic counselling supervision alongside our clinical genetics colleagues and academic genetic counsellor colleagues, even if this is not the only type of supervision made available within a unit. Such openness to joint supervision may enhance mutual respect and the quality of multi-professional working, to the benefit of professionals and all of our clients. We would also encourage, where appropriate, that genetic counsellors should also be able to choose to have single profession (i.e. clinical genetic counsellor only) group supervision as well.

DOCUMENTATION

It is a widely established practice in clinical supervision and counselling supervision that contracts are drawn between the supervisor and supervisee (BACP, 2002). These contracts may facilitate the negotiation of ground rules for the supervision sessions.

Aspects that are usually covered by a contract include practical considerations such as when to meet, how often and what can be discussed. The ground rules should also incorporate statements regarding confidentiality and the circumstances under which this rule may be broken, see Appendix A for a sample group contract.

Some UK NHS Trusts may have operational policies or guidelines for exemptions to confidentiality. Within the context of genetic counselling supervision it would be relevant to adopt the practice of mutual contracts. Given the disparate nature of NHS Hospital Trusts, the content of the contracts should be agreed locally, taking into consideration any local policies regarding supervision. An example of a supervisor contract is given in Appendix B.

In addition to contracts, there would, within the practice of genetic counselling supervision, be an expectation that records were kept by the genetic counsellor in line with recommendations by BACP for standards of good practice. The benefits of record keeping are manifold. The genetic counsellor will be able to review events and identify possible recurring themes that may highlight a training need or an area of developing expertise. Equally, if themes are shared within a department, then possible service development issues or departmental issues may be addressed. In the main however, the benefits of record keeping must be for the genetic counsellor and will provide an auditable trail of their reflection on practice, their personal and their professional development.

As for contracts, standards for record keeping should be agreed at a departmental level, taking into account the requirements of Local Trust policies. Some issues that need to be addressed may include anonymity of information, storage of

information and when (if ever) it might be necessary or desirable to share information with a third party.

Other Practicalities

Supervision sessions, whether on a one-to-one or group basis, should be available within a uninterruptible and quiet, private environment. This may be in a room used for counselling clients or may be inside or outside the main working department. There are particular benefits to using a room off-site; having a physical detachment from the work place may help the genetic counsellor, metaphorically speaking, to unravel themselves psychologically from the departmental structure, so that they can focus and engage in the supervision. Having paid time away from work also assigns a credibility and importance to the process. This demonstrates that the genetic counsellor is valued enough to be given focused time on their needs and is allowed the time away from everyday tasks (Middleton *et al.*, 2004, 2007).

One-to-one supervision is usually an hour long and group sessions may vary between one to two hours (the latter including a break half way through). The size of groups may vary from between 4–8 members. The same supervisor may supervise both one-to-one and group sessions or alternatively a different supervisor for these may be used. One-to-one sessions usually happen on a monthly basis with group work available anything from fortnightly to every two months.

With respect to the number of hours of supervision required, the BACP (2004) have been consulted together with consideration of the current practices of clinical genetics departments already providing a high standard of genetic counselling supervision. The BACP (2004) recommends a minimum of 1.30 h per month of individual supervision per month independent of client numbers. A full time counsellor (defined as 20 client contact hours) is expected to have 3–4 h of individual supervision per month. In the case of group supervision, if the group consists of 4 members or fewer, participants can count half the time. In a group of 5 or more the time is divided between group members.

A supervisor with specific training in counselling and supervision may be chosen to undertake the work. He/she should have a recognised professional counselling training to at least Diploma level. In addition to this he/she should be a member of either the British Association for Counselling and Psychotherapy (BACP), or have accreditation as a Counsellor or British Psychological Society (BPS) Chartership as a Counselling Psychologist. He/she should also have a recognised Counsellor Supervisor training to at least Certificate level (a sample job description is included in Appendix C). He/she is also expected to undergo and fund their own supervision.

There are sound reasons why a supervisor employed on an external consultancy basis might be the preferred recommendation. This reduces role boundary and dual relationship issues. Whilst it is not necessary for a supervisor to have knowledge of genetics itself it is an advantage to have someone used to working with NHS issues and who has a grasp of ethical concerns surrounding the subject. An external genetic counselling supervisor would also not incur any overhead costs to a department.

RESOURCE IMPLICATIONS

Resource implications in support of supervision will depend upon the decision regarding one-to-one versus group supervision and should not be the primary factor in making that decision. For individual issues to be discussed fully within a group setting there might be a need to meet more often, thereby increasing the costs of an apparently more economical (cheaper) arrangement. Individual supervision in counselling situations is usually arranged on a monthly basis. Such a system would mean that only one practitioner at a time was involved rather than a whole group on a regular basis. Supervision costs range from 35–70 per hour on a one to one basis and may cost more for group supervision.

For a department of 10 clinical staff having individual supervision on a monthly basis for 9 months of the year, the cost may be around 4000 pounds sterling (i.e. 400 pounds sterling per person). This should be compared with the cost of a practitioner needing to take sick leave for stress/burnout for a period of two weeks at a cost of around 1200 pounds sterling to the service.

If individuals wanting supervision are funded from different sources to the majority (e.g. via an academic rather than an NHS source) then the organisers of supervision may want to pursue funding from both. This means that adequate provision needs to be made within academic budgets to fund the supervision, for example, this should be considered within grant proposals. If the academic genetic counsellor has a different line manager to their NHS colleagues then the supervisor needs to be made aware of this so that clear lines of reporting are in place should there be cause for concern about practice.

RECOMMENDATIONS FOR PRACTICE

A thorough review of the literature surrounding supervision has been completed for the compilation of this document. This, together with consideration of the BACP (2004) recommendations for supervision for therapeutic counsellors, has led us to create an evidence based list of recommendations for genetic counselling supervision.

Recommendations for Practice

- Genetic counsellors should have access to both one-to-one and group supervision.
- Group supervision can consist of genetic counsellor only groups and/or multi-disciplinary groups (e.g. involving clinical geneticists, academic genetic counsellors or other health professionals within the team).
- The supervisor should be a psychological therapist trained specifically in supervision, working external to the department (i.e. outside the internal line management structure).
- The supervisor should not be a direct line manager.
- Supervision sessions should be conducted within work time, with the option of having sessions off-site, if appropriate.
- Genetic counselling supervision should be funded from within the departmental budget.
- Access to supervision (whether one-to-one, group or both) should be available on at least a monthly basis.
- IDEALLY, each genetic counsellor should have 1 h of one-to-one supervision every month and also participate in a 2 h group session every 4–6 weeks involving up to 8 members of the group.
- AS A MINIMUM, each genetic counsellor should have access to at least 1 h of supervision per month (this is equivalent to 1 h of one-to-one supervision or 2 h of group supervision involving 4 members or less. If only group supervision is available and groups involve 4 + members then 3 h of group work per month is required). It is anticipated that departments currently complying with the minimum requirements for supervision will aim to increase supervision availability over time to meet with the 'ideal' requirements.

APPENDIX A: SAMPLE GROUP SUPERVISION CONTRACT

It is envisaged that each group will develop it's own contract and may be different from the sample contract below. The terms of the contract are usually developed in the first session and are personal to each group.

1. The supervisor will establish the issues to be discussed each session by asking each supervisee at the beginning to list the areas they want to cover. Time will then be allocated accordingly to create a structure for the session.
2. Topics for the agenda can be brought up by individual members as well as the supervisor.
3. Issues raised at group supervision cannot be discussed with any other members of the department who are not group supervision members.
4. Any group members who are unable to attend can be informed of what was discussed at the session they missed and the group can discuss issues that have been raised within the groupwork, outside of the session.
5. Each group member will make all reasonable efforts to attend every session, where this is not possible, at least 24 h notice will be given.
6. The supervisor will not raise issues within the group setting that have been raised within individual one-to-one work. However, individuals within the group may choose to raise issues themselves that they have discussed within on-to-one sessions.
7. Personal issues can only be brought to group supervision when they are impacting on work life. It is envisaged that most group sessions will cover case discussion and team group dynamics, but this will vary.
8. The supervisor can keep notes if they choose; all written documentation will be completely anonymous and will maintain client and other group member's confidentiality.
9. Notes will be taken by the supervisor, these are for her/his use only. These remain confidential and no direct access will be given to anyone within the Clinical Genetics Department. These will be kept by the supervisor at her/his premises and not within the Clinical Genetics Department. However, they may be used as a prompt if the supervisor is needed to make specific comment in relation to a disciplinary issue.
10. If the supervisor has any doubts about an individual's competence, she will raise it with the individual in the first instance and then after discussion with the supervisee, with their line manager.
11. Everybody within the group is responsible for only bringing issues that they feel comfortable with and everyone is also expected to contribute issues for discussion.

APPENDIX B: SAMPLE CONTRACT FOR THE GENETIC COUNSELLING SUPERVISOR

This contract is to cover counselling supervision between the genetic counselling (clinical and academic) and geneticist staff at the Clinical Genetics Department of . . . . Hospital and . . . . (name of supervisor).

Contracted sessions will be offered on a one-to-one and group basis. The one-to-one sessions being an hour long and the group sessions being 2 h long.

The one-to-one work will happen on a monthly basis for each genetics professional and the group work will also happen on a monthly basis. This will start from . . . . . . and will continue until either party terminates the contract (giving at least 3 months notice).

The contract will be on a trial basis for the first 3 months then, if both parties are happy to continue this will, do so on a permanent basis.

Payment for the contracted hours will be . . . . . . per hour and this will be based on number of hours worked.

Currently approximately . . . hours per month are required for counselling supervision, this will be flexible and will increase as funding is obtained for other members of staff.

We have arranged for a room to be made available at . . . . (place).. on . . . . (date and time) . . . for each session. We have chosen to have our supervision outside the Clinical Genetics department. Staff who are not available on this day are able to book one-to-one sessions on an individual basis at other times in the week.

Due to the nature of our work, it is possible that we may need to cancel previously booked appointments for supervision, and this may happen at very short notice. We will, however, endeavour to give at least 24 h notice if cancellation is necessary. If a member of staff has to cancel an appointment they will also endeavour to find a replacement for that session. If no replacement can be found and the session is empty then the session will not be funded.

As you, . . . (name of supervisor) . . . are self-employed you will be responsible for arranging and paying for your own supervision.

You, ... (name of supervisor) . . . . will be responsible for arranging professional indemnity insurance, and paying the necessary premium in connection with work undertaken for the Service.

You, ... (name of supervisor) . . . will invoice . . . (name of contact person) . . . . periodically for work undertaken.

If you . . . . . (name of supervisor) . . . . are sufficiently concerned about issues shared by one of our staff within supervision, you will discuss this first with the supervisee, if the issues do not resolve then you will inform . . . . (genetic counsellor's line manager's name) . . . . of these. Otherwise issues discussed within one-to-one and group supervision are confidential between you and the supervisee/group. You, ... (name of supervisor) . . . . may take notes for your own reminder and will store these externally to the Clinical Genetics Department. We do not have access to these notes, but they may be used as your own prompt if we need information in relation to a disciplinary issue.

Annual leave will be unpaid and at your discretion, although if you choose to take more than 2 months continuous leave you will arrange for interim cover.

You will work according to the British Association for Counselling and Psychotherapy 'Ethical Framework For Good Practice In Counselling And Psychotherapy.'

It is envisaged that as part of normal working arrangements, the supervision programme will be reviewed after 1 year.

I agree to the above conditions:

Signature: . . . . . .(Supervisor)

Signature: . . . . . .(Senior Genetic Counsellor)

Date:

APPENDIX C: SAMPLE SUPERVISOR'S JOB DESCRIPTION

Job Title: Genetic Counsellor Supervisor

Role Purpose: To provide both Individual and Group supervision for a group of approximately X NHS genetic counsellors, clinical geneticists and X academic genetic counsellors in a professional, competent and ethical manner in line with the agreed service description.

Role Context: The role of supervisor requires a professionally trained and accredited (BACP or equivalent) counsellor or counselling psychologist who is also a trained and experienced counselling supervisor. There is a requirement for the supervisor to be clear about the tensions within and the boundaries between issues of Supervision, Line Management and Counselling. The supervisor is to discuss any concerns about counsellors' safety to practice (e.g. potential and actual complaints against the counsellor/service, issues of concern within the practice setting or any other issues which are deemed to fall outwith the remit of the supervisory relationship) with the supervisee first. If this does not resolve the relevant issues then, this will be discussed with the supervisee's line manager, as a last resort, the supervisor can report any concerns, with the full knowledge of the supervisee, to the Head of Specialty.

KEY ACCOUNTABILITIES

Clinical Practice or Work Practice

1. To be responsible for the Individual and Group Supervision for the genetic counsellors and clinical geneticists.
2. To be accountable to the Head of Department for ensuring that the team receive an appropriate level of genetic counselling supervision.
3. To mentor and assist genetic counsellors in their application for Registration/Accreditation and in their ongoing Continuing Professional Development (CPD).
4. To work within Child protection Guidelines.
5. To monitor and ensure that the genetic counsellors and clinical geneticists provide a professional and ethical practice.
6. To maintain and enhance good practice by practitioners, to protect clients from poor practice and to assist genetic counsellors and clinical geneticists in acquiring the attitudes, skills and knowledge required by their role.

Health and Safety

1. To work within the provisions of Trust Health and Safety policy

Education and Development

A. Self

1. To demonstrate continuing professional development, through development of knowledge, skills and keeping up to date with professional practice to maintain Accredited/Registered professional status.
2. To keep up to date with developments in counselling theory and practice and to keep abreast of research in the fields of counselling and supervision.

B. Others

1. To be able to convey a range of theoretical concepts and ideas to a group of experienced genetic counsellors and clinical geneticists.

Policies and Procedures

1. The duties and responsibilities of the post will be undertaken in accordance with the policies, procedures and practices of X Healthcare NHS Trust. It is the post holder's responsibility to ensure they keep up to date with these policies and other policy documents.

Professional Conduct

1. The post holder is required to maintain their professional registration with the British Association for Counselling and Psychotherapy (or equivalent) and to work within the BACP Ethical framework for Good Practice in Counselling and Psychotherapy.

Communication

1. To maintain effective communication with the genetic counsellors and clinical geneticists as individuals and as a group.
2. To maintain effective communication with the Head of Specialty. To participate in Specialty meetings and other professional meetings as required.

Service Development

1. To contribute to the planning and development of any service developments that are agreed.

DIMENSIONS

1. Directly responsible for providing guidance to a group of up to X professionally qualified NHS genetic counsellors and clinical geneticists and X academic genetic counsellors, enabling them in their provision of professional and ethical practice. This is achieved by *fortnightly/monthly/bi-monthly* genetic counsellor only group sessions and *fortnightly/monthly/bi-monthly* multi-disciplinary genetic counsellor and clinical geneticists (and others if appropriate) group sessions. As well as monthly one-to-one sessions
2. Monitoring and overseeing the counselling work of X NHS genetic counsellor and clinical geneticist staff

SKILLS, KNOWLEDGE AND EXPERIENCE

1. **Professional Qualification:** A recognised professional counsellor training to at least Diploma level.
2. **Further specialised training:** British Association for Counselling and Psychotherapy (BACP) Accreditation as a Counsellor or British Psychological Society (BPS) Chartership as a Counselling Psychologist.
3. **Further specialised training:** A recognised Counsellor Supervisor training to at least Certificate level.
4. Experience of providing supervision to counsellors working elsewhere in the NHS.
5. Extensive experience of at least 2 years working as a supervisor with individuals and groups.
6. Extensive experience of working as a counsellor with a wide range of clients.
7. Extensive (at least 4 years post qualification) experience of supervised practice as a counsellor.
8. Knowledge and understanding of the role of the genetic health professional.
9. Extensive knowledge of counselling research kept up-to-date through CPD and reading.
10. Highly developed knowledge of the main counselling theoretical approaches underpinned by theoretical knowledge and relevant practical experience. Kept up-to-date with CPD and reading.
11. Evidence of continuing clinical practice as a counsellor.
12. Ability to organise own time effectively and to plan and prioritise own workload to ensure all genetic counsellors and clinical geneticists receive the required level of supervision whilst being able to respond to supervisee's individual supervision needs.
13. Good written and verbal communication skills.
14. Ability to keep careful records and contribute to audit.
15. Ability to supervise within a variety of counselling models, enabling supervisee to work within their own model.
16. Ability to work co-operatively with others as part of a team.
17. Highly developed ability to make judgements regarding highly complex facts or situations, balancing the need to maintain supervision confidentiality, and recognise when issues should be taken to his/her Line Manager.
18. Ability to make judgements during case presentations which often involve highly complex facts or situations which require the analysis, and interpretation and comparison of a range of options which must then be communicated tactfully to the genetic counsellor or clinical geneticist presenting the case.
19. Knowledge of group dynamics gained through extensive experience of providing Group Supervision, training as a Clinical Supervisor and through CPD.
20. Ability to work with complex and challenging group dynamics in Case Discussion Groups where counsellors' professional opinions may be in conflict with one another.
21. Ability to be highly effective under stress.
22. Ability to be tactful and diplomatic in facilitating a group of experienced professionals and when offering constructive criticism or when ensuring that counsellors adhere to the protocols and Service Description of the Clinical Genetics Service.
23. Ability to use Microsoft Word Processing packages, Outlook (Email-sending and receiving documents; Calendar functions), and to use the Internet for research.

COMMUNICATION & RELATIONSHIP SKILLS

1. To be able to manage the group dynamics within Case Discussion Group. Communication concerns highly complex/sensitive information requiring empathy and reassurance skills. To be able to facilitate a Case Discussion Group where the participants' theoretical approaches may vary considerably and whose views and formulations may be at odds.
2. To respect individual supervisee confidentiality in the group setting (for example when issues have been disclosed by the supervisee within an individual session).
3. To negotiate and maintain the complex boundaries of confidentiality between the dimensions of counselling, management and supervision.
4. To be able to both receive and provide complex and sensitive information concerning case material being discussed by genetic counsellors and clinical geneticists (in both Individual Clinical Supervision and Group Case Discussion).
5. To be able to assert appropriate authority over a group of experienced genetic health professionals. In line with the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy.
6. To be able to convey a range of theoretical concepts and ideas to a group of experienced professional genetic counsellors and clinical geneticists.
7. Maintaining good working relationships with administrative staff in Clinical Genetics.

PHYSICAL EFFORT

1. Sitting still giving full attention and maintaining eye contact for prolonged periods. Each period of supervision being no shorter than 1 h. On some working days this physical effort must be sustained for 6.5 h.
2. Sitting in constrained periods in meetings or when working with computers.

EMOTIONAL EFFORT

1. Demanding of emotional energy. Frequently dealing with genetic counsellors and clinical geneticists under a great deal of stress.
2. Dealing with their occasional distress. Continually being exposed through the genetic counsellors and clinical geneticists to distressing client material.

3. Helping genetic counsellors and clinical geneticists cope with working with distressed and disturbed individuals and in difficult and varied circumstances.
4. Frequent use of empathy, reassurance and skills in challenging.

WORKING CONDITIONS
1. Available to be contacted by telephone out of hours.
2. Willingness to engage with genetic counsellors and clinical geneticists who need out of hours guidance, support and to be prepared to take decisions on their behalf concerning clinical work.
3. Frequent need to move furniture (heavy chairs and small tables) to provide an appropriate environment for Group Case Discussion

SIGNATURES
After reviewing the questionnaire please sign to confirm agreement
Post holder:

REFERENCES

Alberts, G., & Edelstein, B. (1990). The therapist training: A critical review of skill training studies. *Clin Psychol Rev*, *10,* 497–511.

Andrews, M. (1996). Using reflection to develop to develop clinical expertise. *Br J Nurs*, *5*(8), 503–513.

BACP (2002). British Association of Counselling and Psychotherapy. Ethical framework for Good Practice in Counselling and Psychotherapy. In-house publication Code 384, www.bacp.co.uk

BACP (2004). British Association of Counselling and Psychotherapy. How much supervision should you have? In-house publication Code S1, www.bacp.co.uk

Benner, P. (1984). From novice to expert. Menlo Park, California: Addison-Wesley.

Binder, J. L. (1993). Is it time to improve psychotherapy training? *Clin Psychol Rev*, *13,* 301–318.

Bishop, V. (1998). *Clinical supervision in practice: some questions, answers and guidelines*. London: Macmillan /Nursing Times Research Publications.

Bond, T. (1993). *Standards and ethics for counselling in action*. London: Sage.

Bond, M., & Holland, S. (1998). *Skills of clinical supervision for nurses*. Buckingham: Open University Press.

Bowles, N., & Young, C. (1999). An evaluative study of clinical supervision based on proctor's three function interactive model. *J Adv Nurs*, *30*(4), 958–964.

Butterworth, T. (1992). Clinical supervision is an emerging idea in nursing. In T. Butterworth, J. Faugier, & P. Burnard (Eds.), (1998) Clinical Supervision and Mentorship in Nursing (second edn.). Cheltenham: Stanley Thornes.

Carroll, M. (1996). Counselling Supervision. Theory, Skills and Practice. Cassell.

Casement, P. (1985). *On learning from the patient*. London: Tavistock.

Clarke, B., James, C., & Kelly, J. (1996). Reflective practice: Reviewing the issues and refocusing the debate. *Int J Nurs Stud*, *33*(2), 171–180.

Clarke, A. (2001). *A Descriptive and exploratory study regarding the provision of clinical supervision in genetic counselling in the United Kingdom and Ireland*. MSc thesis. Manchester University.

Copeland, S. (2000). New Challenges for supervising in organisational contexts. In B. Lawton & C. Feltham (Eds.), *Taking supervision forward* (pp. 162–173). London: Sage.

Darley, M. (1996). Clinical supervision: it relevance to managers. *Nursing Times*, Feb, p 5.

Dewey, J. (1929). *Experience and nature*. New York: Grave Press.

Dolley, J., Davies, C., & Murray, P. (1998). *Clinical Supervision: A development pack for nurses (K509)*. London: Open University Press.

Driscoll, J. (1994). Reflective practice for practice-a framework of structured reflection for clinical areas. *Senior Nurse*, *14*(1), 47–50.

Driscoll, J. (2000). Practising Clinical Supervision. A Reflective Approach. Balliere Tindall in Association with the RCN.

Ellis, M. V., Ladanay, N., Krengel, M., & Schult, D. (1996). Clinical supervision research from 1981 to 1993: A methodological critique. *J Counsel Psychol*, *43,* 35–50.

Elwyn, G., Gray, J., & Clarke, A. (2000). Shared decision making and non-directiveness in genetic counselling. *J Med Genet*, *37,* 135–138.

Eunpu, D. L. (1997). Systematically-based psychotherapeutic techniques in genetic counseling. *J Genet Counsel 6*(1), 1–20.

Fowler, J. (Ed.) (1998). *The handbook of clinical supervision — your questions answered*. Salisbury: Quay Books.

Ghaye, T., & Lillyman, S. (1997). *Learning journals and critical incidents: Reflective practice for health care professionals*. Salisbury: Quay Books

Goff, A. (1995a). Reflection—What is it? A literature review. *Assignment*, *1*(1), 7–14.

Goff, A. (1995b). Reflection—What is it? A literature review. *Assignment*, *1*(2), 24–28.

Hawkins, P., & Shohet, R. (1989). *Supervision in the helping professions*. Buckingham: Open University Press.

Hiller, E., & Rosenfield, J. M. (2000). The Experience of Leader-Led Supervision: Genetic Counselors' Perspectives. *J Genet Counsel*, *9*(5), 399–410.

JCHMT (1999). Curriculum: Clinical Genetics November 1999 (www.jchmt.org.uk/clingen)

Johns, C. (1992). Reflective practice and nursing. *Nurse Educ Today*, (12), 174–181.

Johns, C. (1995). Framing learning through reflection within Carper's fundamental ways of knowing in nursing. *J Adv Nurs*, *22,* 226–234.

Johns, C. (1996). Visualising and realising caring in practice through guided reflection. *Adv J Nurs*, *24,* 1135–1143.

Johns, C. (1997). *Becoming a reflective practitioner*. PhD thesis. Open University, Milton Keynes.

Kenen, R. H., & Smith, A. C. M. (1995). Genetic counselling for the next 25 years: Models for the future. *J Genet Counsel*, *4*(2), 115–124.

Kennedy, A. L. (2000a). Supervision for practising genetic counselors: An overview of models. *J Genet Counsel*, *9*(5), 379–390.

Kennedy, A. L. (2000b). A leader-led supervision group as a model for practicing genetic counselors. *J Genet Counsel*, *9*(5), 391–398.

Kessler, S. (1979). The genetic counsellor as psychotherapist. *Birth Defects: Original Articles Series. The National Foundation*, *25,* 187–200.
Kessler, S. (1981). Psychological aspects of genetic counselling: Analysis of a transcript. *Am J Genet Med*, *8,* 137–153.
Kessler, S., & Jacopini, A. G. (1982). Psychological aspects of genetic counselling. 11. Quantitative analysis of a trancript of a genetic counseling session. *Am J Med Genet*, *12,* 421–435.
Kessler, S. (1997a). Psychological aspects of genetic counseling. 1X. Teaching and Counseling. *J Genet Counsel*, *6*(3), 287–295.
Kessler, S. (1997b). Psychological aspects of genetic counseling. X1. Nondirectiveness Revisited. *Am J Med Genet*, *72,* 164–171.
Kohner, N. (1994). *Clinical supervision in practice*. London: King's Fund Centre.
L'Aiguille, Y. (1994). Pushing back the boundaries of personal experience. In A. M. Palmer, S. Burns, & C. Bulman (Eds.), *Reflective practice in nursing*. Oxford: Blackwell Scientific.
McSherry, R. (2002). Clinical supervision and clinical governance. *Nursing Times*, *23*(98), 30–32.
Meizrow, J. (1981). A critical theory of adult learning and education. *Adult Educ*, *32*(1), 3–24.
Middleton, A., Wiles, V., Downing, S., Everest, S., Kershaw, A., Robathan, S., Burton, H., & Landy, A. (2004). Counselling supervision for a team of genetic counsellors from the UK. European Psychosocial Aspects of Genetics Conference, Munich, 12–15 June. Plenary presentation EL21. *European Journal Human Genetics*, *12*(Suppl 1), 355.
Middleton, A., Wiles, V., Kershaw, A., Everest, S., Downing, S., Burton, H., Robathan, S., & Landy, A. (2007). Reflections on the experience of counselling supervision by a team of genetic counsellors from the UK. *J Genet Couns*, *16*.
Michie, S., Bron, F., Bobrow, M., & Marteau, T. (1997). Nondirectiveness in genetic counseling: An empirical study. *Am J Hum Genet*, *60,* 40–47.
Miller, C., Tomlinson, A., & Jones, M. (1994). Researching professional education: Learning styles and facilitating reflection. English National Board for Nurses Midwives and Health Visitors, London.
Newell, R. (1992). Anxiety, accuracy and reflection: The limits of professional development. *J Adv Nurs*, *17,* 1326–1333.
NHS Management Executive (1993). *A vision for the future: The nursing, midwifery and health visiting contribution to health and health care*. London: Department of Health.
Palmer, A., Burns, S., & Bulman, C. (1994). *Reflective practice in nursing-the growth of the reflective practitioner*. Oxford: Blackwell Scientific.
Perris, C. (1993). Stumbling blocks in the supervision of cognitive psychotherapy. *Clin Psychol Psychother*, *1,* 29–43.
Platzer, H. L., Blake, D., & Ashford, D. (2000). Barriers to learning from reflection: A study of the use of groupwork with post-registration nurses. *J Adv Nurs*, *31*(5), 1001–1008.
Powell, J. H. (1989). The reflective practitioner in nursing. *J Adv Nurs*, *14,* 824–832.
Power, S. (1999). *Nursing Supervision: A guide for clinical practice* (Chapter 2 pp. 17–32). London: Sage.
Proctor, B. (1986). Supervision: A co-operative exercise in accountability. In M. Marken & M. Payne (Eds.), *Enabling and ensuring-supervision in practice* (pp. 21–34). Leicester: National Youth Bureau, Council for Training in Youth and Community Work.
Richardson, G., & Maltby, H. (1995). Reflection-on-practice: Enhancing student learning. *J Adv Nurs*, *22,* 235–242.
Rolfe, G. (1996). *Closing the theory-practice gap*. Oxford: Butterworth Heinmann.
Rolfe, G. (1998). Beyond Expertise: Reflective and Reflexive Nursing Practice. In C. Johns & D. Freshwater (Eds.), *Transforming nursing through reflective practice*. Blackwell Science.
Sarangi, S., Bennet, K., Howell, L., Clarke, A., Harper, P., & Gray, J. (2004). Initiation of reflective frames in counseling for HD predictive testing. *J Genet Counsel*, *13*(2), 135–155.
Schon, D. (1983). *The reflective practitioner*. New York: Basic Books.
Schon, D. (1987). *Educating the reflective practitioner*. San Francisco: Jossey Bass.
Schon, D. (1991a). *The reflective practitioner* (Second Edn.). San Francisco: Jossey Bass.
Schon, D. (1991b). *The reflective practitioner-how professionals think in action*. Aldershot: Avebury.
Shorter Oxford English Dictionary (1993). Oxford University Press.
Skirton, H., Barnes, C., Curtis, G., & Walford-Moore, J. (1997). The role and practice of the genetic nurse: Report of the AGNC Working Party. *J Med Genet*, *34,* 141–147.
Tseng, N. M. (1998). Re-examining reflection-a common issue of professional concern in social work, teacher and nursing education. *J Interprof Care*, *12*(1), 21–31.
UKCC (1996). Position statement on clinical supervision for nursing and health visiting. United Kingdom Central Counsel for Nursing, Midwifery and Health Visiting.
Webb, A. (2000). What makes it difficult for the supervisee to speak? In B. Lawton & C. Feltham (Eds.), *Taking supervision forward*. Enquiries and Trends in Counselling and Psychotherapy. SAGE Publications.