

Journal of Social Intervention: Theory and Practice –
2011 – Volume 20, Issue 1, pp. 5–22
URN:NBN:NL:UI:10-1-101306

ISSN: 1876-8830

URL: <http://www.journalsi.org>

Publisher: Igitur publishing

Services in cooperation with Utrecht University of
Applied Sciences, Faculty of Society and Law

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Received: 9 September 2010

Accepted: 30 December 2010

Review Category: Research

HOW SOCIAL WORKERS EXPERIENCE SUPERVISION: RESULTS OF AN EMPIRICAL STUDY IN THE HEALTHCARE SECTOR

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ABSTRACT

How social workers experience supervision: results of an empirical study in the healthcare sector

Very few studies provide insights into how social workers experience supervision as a means of supporting their professional working relations with medical doctors and nurses. The research findings presented in this paper are based on an extensive quantitative survey on "Knowledge and Expertise" in everyday work settings, and guided interviews conducted with selected respondents throughout Germany. They show how supervision is perceived by different groups of social workers. The social workers interviewed had an ambivalent view of supervision. They hold supervision in high regard and believe that it has positive effects, yet they do not perceive it to have any sustained impact on their everyday work. Supervision in multi-professional teams is frequently

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experienced as a continuation of the hierarchical relations that characterize the healthcare system: the interviews revealed situations in which the respondents were passive or experienced an inability to address conflicts in the presence of other professional groups, or to offer social-work-specific perspectives on particular cases. Despite this, social workers continue to value supervision. The article reflects on why this is the case, and what kinds of supervision social workers need in order to be effective in a changing global setting.

Keywords

Quantitative research, qualitative research, social work, healthcare sector, supervision, multi-professional working contexts

SAMENVATTING

De ervaringen van social workers met supervisie: resultaten van een empirische studie in de gezondheidszorg

Er zijn slechts weinig studies die inzicht geven in de waardering voor supervisie, van sociaal werkers in de (para-)medische sector. In dit artikel worden (delen) van onderzoeksresultaten gepubliceerd, gebaseerd op een uitvoerige survey over "Kennis en Expertise" in alledaagse praktijken en gestructureerde interviews met Duitse respondenten. Deze resultaten laten zien hoe supervisie gewaardeerd wordt door verschillende groepen sociaal werkers. De geïnterviewde respondenten hebben een ambivalente houding jegens supervisie. Enerzijds hebben zij een positieve waardering voor supervisie en zijn zij overtuigd van de positieve effecten ervan, anderzijds zijn zij van mening dat supervisie geen steun is in hun eigen dagelijkse werkzaamheden. In een multidisciplinair team wordt supervisie ervaren als een verlengstuk van het hiërarchisch georganiseerde systeem van gezondheidszorg: in de interviews komen situaties aan bod waarin de respondent niet in staat was of in de gelegenheid werd gesteld om, in de aanwezigheid van andere professies, problemen bespreekbaar te maken of een "sociaal werk-geluid" te laten horen. Desondanks continueren de sociaal werkers de supervisie. In dit artikel wordt gereflecteerd op de vraag hoe dat komt, en wat voor soort interventie het sociaal werk behoeft om in een veranderende mondiale context succesvol te kunnen zijn.

Trefwoorden

Kwalitatief onderzoek, kwantitatief onderzoek, social werk, gezondheidszorg, supervisie, multidisciplinaire werkomgeving

SUPERVISION

Supervision has long been a well-known method for training and supporting social workers. The conceptualization and use of supervision has been shaped by many international influences and historical developments. For this reason, in order to understand the models of supervision that are referred to in this research on supervision in the healthcare system, it is useful to first briefly consider the roots of the supervision system. In Germany, supervision developed along different lines in the fields of medicine and social work. In the psychoanalytical profession, supervision developed into a method of self-awareness within a professional framework. First, those learning the profession would conduct analyses in the presence of an experienced analyst/supervisor, which would include paying attention to the evaluation and assessment of the learning process (Klinkhammer, 2009, p. 81). This more normative function of supervision can still be found in some parts of the medical profession, especially in psychiatry.

In the field of social work, supervision developed in conjunction with the method of social casework practiced in the United States, which was introduced in Germany immediately after the Second World War. Supervision was offered as part of the training of inexperienced workers in institutions, which eventually resulted in the current system of team supervision. Over time, the initially normative function of supervision shifted and another function emerged: that of support for the worker (Van Hees, 2010, p. 32). The concept of the "professional self" (Robinson, 1936) conceived of the worker as his or her own instrument in the helping process. Supervisees had to be enabled to reflect on themselves, as well as on the demands of the organization and their professional work. Through systematic reflection alongside complex and dynamic working processes, supervision has become a tool for safeguarding relations between professionals, their roles in organizations and their interaction with clients.

In view of the history and frequent use of supervision, it is remarkable how little research has been carried out into this counselling process and the professional expertise that has been built up around it. Conventional instruments are not generally suitable for testing the effectiveness of helping processes, especially those that involve helping sick people in desperate situations. For many years, supervision has been an appropriate and effective quality assurance instrument. A central topic of supervision is reflection on a professional's role in their organization, on everyday work, interaction with clients and colleagues, and how to control one's own perceptions and affective experience and action. Associated with this is the equally important subject of how to achieve a balance between private life and work, between closeness and distance. The specific

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tasks that are associated with working with sick people often lead to emotional exhaustion among social workers, which can be put down to the constant tension between the desire to help and feelings of powerlessness. How to prevent burnout is therefore a further topic of supervision.

For these purposes, supervision has had an established place in the professional lives of social workers, nursing staff and medical professionals in the German healthcare sector for decades. Most supervision in medical settings takes place in groups, usually in multi-professional teams, which reflect on the work with clients and on joint work. Team supervisions often alternate with case supervisions, in which the team discusses patients and reflects on their interactions, as well as interventions. The supervisors who are selected and contracted are usually trained and licensed professionals. Unlike in other countries, the common understanding of supervision in Germany is that it is "external"; that is, supervision is not associated with the organization concerned. Furthermore, supervision is commonly understood to be a supportive counselling process (cf. Kadushin & Harkness, 2002, p. 217).

Since supervision in the medical setting has its own specific features, various supervision formats exist side by side (Klinkhammer, 2009, p. 81). These differ in terms of their theoretical frameworks, supervisory attitudes and supervision methods. In medical contexts, supervisors may also be participants' superiors. The following textbox presents the prevailing supervision formats and provides a short overview of their historical backgrounds.

1. The clinical-medical setting is based on a tradition of internal supervision, the understanding of which is based on depth psychology (Hille, 1998, p. 57). As early as 1920, the therapeutic work that accompanied psychotherapy training in Berlin also included supervision by experienced therapists, who supervised novices to the profession. The emphasis is on attitudes and feelings in the relationship with individual patients.
2. The social-science-oriented method of supervision originated in social work in the US in the early 20th century (Belardi, 2000). In Germany, its development was initially influenced by depth psychology in the 1920s, before this method fell into disuse under National Socialism. In the 1950s and 1960s, supervision was introduced to West Germany (Geißler-Piltz, Mühlum & Pauls, 2005, p. 140). It developed in conjunction with the method of social casework, which was practiced in the US and introduced in Germany immediately after the Second World War by exiled social workers. Supervision was offered in the training of inexperienced workers in social work institutions, resulting in the current system of team or case supervision. Supervision in social work, which was initially a more

normative and controlling method that monitored work performance, became a supportive method founded on reflection (Kadushin & Harkness, 2002). During the following decades, supervision was increasingly recognized by other helping professions (Van Hees & Geißler-Piltz, 2010, p. 80). Nowadays, one can find a wide range of supervision concepts. As a result, approaches to supervision have grown more diverse, and it has become an accepted counselling process in various professional fields. One factor that is commonly found across the broad methodological spectrum, however, is a shared understanding of supervision as a counselling process that favours external supervisors who are well-trained and licensed.

The following research findings focus on the role played by social workers in the multi-professional healthcare sector, as reflected by their perceptions and evaluation of team and case supervisions. The research asked how they experienced the well-known and frequently-used method of reflection, and whether they thought it helped them to manage their professional roles and their daily work, as well as their psychic hygiene.¹

RESEARCH METHODS AND SAMPLE

Before turning to the results of the research, let us first look briefly at the way in which the research methods were developed. The research project was originally planned as a comparison of social work in Finland and Germany. The questionnaire on "Knowledge and Expertise in Social Work" upon which the study is based was developed at the University of Helsinki by a group of Ph.D. students, who had various questions and intentions. The questionnaire, which originally comprised 98 questions, was translated into German and shortened to 69 questions. These focused on three aspects of social work. One of these was supervision, which was regarded as an instrument for practical reflection; there were 20 questions in this area. Only in the course of initial evaluations did it become clear that it would be necessary to design a supplementary qualitative survey in the form of guided interviews, so as to be able to interpret the quantitative results and answer new questions arising from these. Moreover, the theoretical construction of the Finnish questionnaire was neither consistent nor transferable, which meant that from a methodological perspective, the questionnaire could only be regarded as a preliminary study for subsequent qualitative research.

The quantitative survey was conducted nationwide. In order to reach as many social workers in the healthcare sector as possible, every member of the German Association of Social Work in Healthcare (DVSG) was contacted and asked to complete the 69-question questionnaire.

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Of the 645 questionnaires that were sent out, 307 were returned. 241 women and 66 men took part in the survey, resulting in a gender breakdown of 78.5% versus 21.5%. The average age of respondents was 46, with the majority (78.9%) aged between 36 and 55. Nearly all respondents (98.0%) were graduates and licensed social workers. At the time of the survey, the respondents' average duration of employment was slightly more than ten years. One third of the social workers interviewed were employed by independent organizations, followed by municipalities and other employers. Almost all of the social workers were working in inter-professional settings, primarily in the in-patient clinical area. The evaluation of the data was computer-aided (SPSS).

The qualitative survey was also carried out nationwide. To collect as many subjective assessments of social workers' everyday work in the healthcare sector as possible, heterogeneous groups were formed in a theoretical sampling (female/male, East/West, different German states, professional and supervision experience). To supplement the quantitative study, we specifically sought interview subjects who were employed in the area of outpatient healthcare. A total of eight interviews (individual and group interviews) were conducted with 16 social workers; two of these social workers were not employed in healthcare (control group). Although the social workers who were interviewed came from different parts of Germany, the sample is not considered to be representative.

I. No.	f/m	East/West	Field of Work / Place of Interview
1	f	West	Outpatient care (Psychiatry), Berlin
2	f	East	Youth welfare service, Berlin
3	m	East	Outpatient care (Psychiatry), Potsdam
4	3m	West	2 x SW Hospital and 1 x SW Post-rehab-support (Psychiatry), Heidelberg
5	m	West	Probation service, Berlin
6	4f	West	2 x SW Day hospital (Psychiatry), 2 x SW In-patient care (Psychiatry), Lörrach/Aschaffenburg
7	3f	East	1 SW Day hospital (Psychiatry) 1 x SW Rehab clinic, 1 x SW Hospital, Erfurt
8	2f	West/East	2 x SW In-patient care (Psychiatry) Berlin/Madgeburg

All of the interviews took the form of problem-centred guided interviews, in accordance with the method set out by Witzel (1982). Given time limitations, the four interviews that took place outside Berlin were conducted as group interviews. The method used promotes the development of the interviewee's own ideas through listening (cf. Bortz & Döring, 2002, p. 318). However, the

interview participants were recorded separately so that statements could be attributed to specific individuals. The guided interviews were conducted in a narrative way: the social workers were asked to describe their experiences with supervision and supervisors, reflect on how supervision helped to improve their daily work and their roles in multi-professional teams, reflect on what they got out of team supervisions, what they thought supervision should accomplish, and so forth. The interviews were evaluated with the aid of qualitative content analysis (cf. Mayring, 1993); categorization was both deductive (based on the guidelines) and inductive (the result of the material). The interviews were evaluated using ATLAS.ti software.

RESULTS OF THE QUANTITATIVE SURVEY

This section briefly outlines the data that were gleaned from the questionnaires on supervision. Respondents were asked to relate their experiences with various supervision formats, and to describe what they associated with supervision in their everyday work in medical-clinical contexts.

An evaluation of the 20 questions devoted to supervision clearly revealed that team supervision is the dominant form of supervision (roughly 60%), ahead of team and case supervision (approximately 30%). As supervision takes place in the healthcare sector, in which multidisciplinary teams predominate, more than half of the respondents reported participating in meetings that also involved other occupational groups. These included doctors, nurses, psychologists or occupational therapists – all professionals with a biological-medical approach to health and/or a ranking above that of social workers in the professional hierarchy. It thus appeared all the more important to find out whether supervision could yield a true practice-related grasp of the biological-psychosocial approach to health that is representative of the field of social work. This was only the case for around one supervisor in three; most of them were from other professions, mainly psychologists (71.2%) or doctors (15.5%).

Only roughly half of the respondents reported that they were familiar with the theoretical framework underlying the supervision that they had experienced. One reason for this could be that for many respondents, it was not clear that supervision had been based on different theoretical concepts. It may also be the case that supervisors themselves do not make these different theoretical backgrounds sufficiently transparent. Given the professional context, it is also conceivable that the supervisors' methodological tools are secondary to other criteria, such as personal sympathy or professional proximity to social work. When respondents were able to identify an approach, systemic/solution-oriented approaches took precedence over conversation- and Gestalt-therapeutic approaches.

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When asked about the usefulness of the supervision, two thirds of respondents indicated they were satisfied and thought that supervision should continue. Only about one third of them, however, had the impression that supervision provided the necessary relief from the strain of their daily work, or had met their expectations. Social workers seem to find supervision important and believe that it has a positive effect on their professional work, yet they also seem to lack clear experience of this in their day-to-day work.

In the view of the social workers who responded, the most common supervision topics in the healthcare sector include: the search for methods of resolution and action in work with clients; reflection on proximity and distance in interactions with clients; reflection on their own behaviour; and general improvements in the quality of their work. When the focus was on an individual's professional situation, more than half of the social workers indicated that they were satisfied with the supervision. When the issue in question was how to prevent stress and burnout, however, only some 20% were satisfied with their supervision. Even fewer social workers' expectations had been met with regard to the provision of support in the area of organization and work effectiveness – areas of particular significance for modern social work. Complaints were also heard with regard to the supervisors' lack of relevance to research findings and a lack of integration of theory.

RESULTS OF THE GUIDED INTERVIEWS

As shown, the evaluation of the questionnaires yielded valuable findings, but also some inconsistencies and contradictions. Further investigation in the form of semi-standardized interviews aimed to record the interviewees' subjective experiences of supervision as an informal instrument for further training in social work. In particular, the interviews looked at the question of whether supervision conducted in multi-professional teams can strengthen the professional behaviour and identity of social workers.

Even from the written survey, it had been clear that the majority of supervision groups are multi-professional. This type of team supervision was therefore a topic that was addressed in the interviews.

Social placement in team supervision

In the interviews, the question of who participates in team supervision played a key role in reflections on team and case supervision carried out at a group level: which colleagues from which

professional groups are members of the team, and is the boss among the participants? These were the central questions that the interviewees asked themselves.

Team supervision is particularly charged if the boss, in most cases a psychiatrist, also serves as the supervisor. The social workers interviewed also seem to have difficulties when their superior takes part in team supervision sessions, because having a hierarchical structure affects the patterns of interaction. Two social workers reported that the superior is someone “who can fire me, too,” (I 7:1234),² and who can return from the supervision session asking themselves, “Hmm, did I choose the right person for the job?” (I 7:1239). However, the respondents were also aware of the opportunities that are presented by team supervision that involves the management. They described the “kind-hearted boss” who, with his “supervision ear” (I 7:1237), learns that a social worker is no longer able to cope with certain tasks “due to strong feelings” (I 7:1236). One question that remains central, however, is how to behave in order to avoid having to fear sanctions. It is clear that there are individual and group problems that one can “hardly thrash out in the presence of [my] boss” (I 7:1245).

When a supervisor plays a dual role, in the sense that they also hold a position of authority in a clinic or ward, this has an influence on the supervision process. For the most part, the relationships between “in-house” supervisors and social workers are unaffected by the process of reflection. However, professional work relationships can become overshadowed by supervision that is perceived to be controlling. Despite their obligation of confidentiality, an employee who is dependent upon a supervisor/boss will not reveal professional concerns, or even conflicts, out of a sense of the need to protect themselves.

Even the presence of a superior as a participant in a team supervision would appear to give rise to multiple difficulties:

Well, my boss, my bosses take part, too. That's a good thing. It gives me an opportunity to see them in a slightly different light. They see me differently, too. But I think for me, I'd say that's a situation where there's also a little caution: how much of myself do I really want to reveal? How much do I want to admit as regards excessive demands and stress? (I 7:1242:1247)

In the interviewees' experience, there is little difference between case-based and institution-based team supervision; both are seen to contain elements of “social division.” Case-based supervision involves all of the professional groups who have to work together on a particular ward. One young social worker noted that it was usually the doctors who introduced their patients during a session.

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For her, this has created a disparity “that the doctors don’t want to recognize as such.” She suspects that, given this practice “sometimes things that need to be said aren’t. And that’s where I could use a little extra supervision.” (I 8:1424–25)

The multi-professional team in psychiatry

From a social worker’s standpoint, multi-professional teams in psychiatric settings differ from teams in hospitals more generally. The team is viewed as a major factor in the therapeutic process. At the same time, just as in other medical settings, there are also contradictory lines of responsibility: on the one hand, it is desirable to have multiple perspectives, with each of the occupational groups independently putting forward its own professional approach; while on the other hand, the doctors remain responsible for all of the professions involved (cf. Bauer, 2004, p. 36). Interaction in therapeutic teams is not only made difficult by ambiguities related to authority, however. Usually, several people from different professional groups are involved in treating individual patients. Each has a different status, a different type of expertise, and different informal and formal powers. The result is increased competition – something that is further aggravated by the fact that personnel policies become more stringent in periods of economic difficulty. Working in a multi-professional team thus brings considerable potential for conflict; conflict that could be worked through in a supervisory setting. Addressing conflict, however, requires having a great deal of courage and self-confidence, particularly when those who need to make themselves heard have little power. One social worker described their experience of conflict in forceful terms: “the topic was suicide in the psychiatric setting, and there’s always a certain tension: how do you put it? Because there are certain colleagues sitting there where I’m afraid [...], they end up making fun of it” (I 6:2001–2004).

The fear of making a fool of him- or herself leads the social worker to become withdrawn. One presumes that there are also other topics that can lead to feelings of shame and embarrassment governing the interaction. To circumvent these feelings and tensions, there is an awkward silence.

But I already had supervision sessions in the wards involving casework, and the actual problems weren’t discussed at all [...]. You noticed that the case was the subject of a huge conflict because people have different views and ways of approaching it. But the supervisor [...] failed to pick up on any of that. Instead, he just abandoned the problem more and more. And that’s when there was this awkward silence. (I 6:2271–2277)

What supervisor is not familiar with this awkward silence, which can hide so much? The interviewees suggested that everyday conflicts among colleagues are concealed. The social workers also indicated quite clearly that while supervision theoretically treats all participants as equals, strong distinctions are in fact made with respect to status. The quotes presented here indicate a central problem: representing one's own point of view requires professional confidence, especially when faced by more dominant professions. To investigate this phenomenon further requires that we take a general look at the situation of social workers in the healthcare sector.

Explanatory approaches to social work and supervision

At the outset, it should be noted that the healthcare sector is based on a strict hierarchy. One profession – medical practice – is clearly dominant, while other professional groups are subordinate to it. The hierarchy is supported by the doctors' habitus. Early in their careers, students of medicine and medical assistants working in hospitals internalize their membership of the medical profession. They demonstrate specialized knowledge and expertise, and orient themselves hierarchically by representing a value system that is typical of their profession. Belonging to the dominant profession, which is evident from their work attire, allows them to assert themselves and to distinguish themselves from other groups (cf. Bourdieu, 1985, p. 17; Kraus & Gebauer, 2002, p. 43). Without a doubt, an objective and a subjectively-experienced distance separates social workers from the medical profession within multi-professional work contexts. Social workers have a lower social ranking in the educational system and do not have a (full) university education. Given their status as graduates of colleges of higher education, their work does not involve the manipulation of scientific and independent knowledge, and they instead respond to practical needs for action with solution-oriented knowledge. It appears that social workers' own superiors are rarely experts from the same field, which only perpetuates this historical problem (Gerull, 2009). Social workers perceive themselves to be dependent on professional administrators, to whom their social scientific background is just as suspect as it is to members of other medical professions. As they cannot be clearly positioned within the system of patient care, they are symbolically relegated to a lower rank. This, in turn, affects social workers' self-confidence. Although they receive personal recognition as all-rounders, in their everyday work setting, they tend to lose sight of their professional mission, which is to navigate between the various systems of expertise in a preventative, advisory and networking capacity.

This brief overview would not be complete without a gender-sensitive look at the social position of the social worker. The literature describes the social construction of gender in processes of professionalization. In other words, social occupational fields are distinguished by tasks that

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correspond to tasks that involve relationships and feelings, which have traditionally been thought of as female responsibilities (Gildemeister, 1998, p. 255). Even if this gender-specific division of labour were to be delegitimized, this would not mean that the pattern of gender categories that shapes everyday activities would be eliminated along with it. Indeed, patterns of action run counter to those viewed as constitutive in the structural logic of professional behaviour. Social workers devalue themselves by internalizing the existing hierarchical structure, and frequently see doctors as overpowering interlocutors. This vision of their own powerlessness compromises their own capabilities, as clearly demonstrated by the perceptions of supervision situations and the climate in multi-professional teams described in the interviews.

The situations that were described by social workers in the interviews correspond to the analyses made by supervisors who work in medical clinics. Adam (1998) and Scobel (2002), for instance, paint a picture of supervision in a hospital context that has to contend with a host of adversities. In addition to the individual factors identified by Scobel, a series of problems is also identified that influence interaction in the inter-professional group, with fear and the prevention of shame being predominant among them: the “fear of voicing criticism, the fear of expressing one’s own fears, the fear of showing oneself, the shame of admitting to oneself and others that one has swallowed so much without having said anything” (2002, p. 76). This underscores the strong hierarchical culture of healthcare institutions; a prevailing culture of power and powerlessness, which often creeps into supervision.

Social workers’ expectations

This serves to lend even greater weight to the hopes and expectations vested in the supervision process or in the supervisor as an individual. Social workers have unrealistic conceptions of individual post holders, and high expectations of them. The goals that an organization needs to accomplish, the things that teams or individuals do not want to or cannot change – all these expectations are projected onto supervisors. They become projection screens for unfulfilled professional longings for success, recognition, intimacy, trust and security. The search for security and trust comes to the fore. Social workers look for a supervisor “whom I can trust,” someone with a “caring” approach (I 8:1633). For some, the ideal supervisor is someone from outside the specific setting, an individual who is held in esteem and who can really understand and appreciate a social worker’s professional situation in a multi-professional work context. For others, “caring” means acceptance: “You should have the feeling that he or she is concerned about your needs. So a genuine personal relationship can then take shape, which is very important, particularly where this topic is concerned – supervision” (I 3:271–273). Behind this statement, one suspects, lies a

desire to be on the same level in the hierarchy as the supervisor, to upgrade one's status as a social worker, and to gain faith (through others) in one's own skills. Another social worker paints an ideal picture of a supervisor: he can only "tell everything" to a supervisor whom he can really trust. This supervisor would assume the position of an instructor and explain psychodynamic processes to him.

I think it's very important that I can tell a supervisor everything, that things are good on a personal level, that I have real trust and that the supervisor [...] can maybe let me know what he thinks, why I react in such and such a way in a particular situation, why I'm so emotionally charged, or what the possible reasons are as to why I am the way I am at the moment. (I 4:1466–1468)

While opinions and expectations may vary with regard to the supervisor's personal qualities or qualifications – whether it is an individual with a focus on depth psychology, someone who takes a systemic approach or who has some other focus – there is widespread agreement that the supervisor should not be the medical director, the assistant medical director or any other person from the institution. Trust, a highly-valued quality that we found throughout the responses collected on the topic of supervision, is strongly linked to an individual's external status (I 1:999–1001; I 3:1908; I 7:1486; I 8:432–434). Supervisors should also take responsibility for ensuring that all professions participate equally in the supervision. In terms of practical benefits and having an ethical grounding, the distinction between responsibility for the process and responsibility for the substance of the process would seem to be an important one. A supervisor who acts responsibly in this sense does not take substantive decisions, but does commit him- or herself to shaping the process in a way that all professional groups can participate on an equal footing. It is essential for the supervisor to take a non-biased professional stance if social workers are also to benefit from team supervision.

For all the preferences that are expressed for supervisors who are not linked to institutions, some reservations are heard as well (Vollmöller, 1998; Berker, 2002). Some doubt whether individuals who are external to a situation can feel responsible for the social inequalities within a group. After all, social workers complain that they are not held in sufficiently high esteem, or that their silence is interpreted "hierarchically." Scobel also puts forward this view of multi-professional supervision in his analysis, in which he articulates the tasks of supervisors in the healthcare sector: "In a hospital ...supervision must mediate between the various professional groups. The aim is to enable communication that makes allowances for the diversity and differences of the 'languages' involved" (2002, p. 25). All those interviewed would agree with this statement, in the hope

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that “their supervisor” would act in the same manner. The question remains, however whether supervisors can accomplish this. External supervisors – particularly self-employed supervisors – are financially dependent on those who provide supervision contracts, who are very rarely social workers. In response to our question about who had selected the supervisor or the form of supervision, the reply was: “It was a recommendation by my boss, who knew him from previous supervisions. And then it was a decision by the team as to how it works” (I 7:1263–1264).

When social workers are asked what kinds of competence a supervisor should have, a variety of opinions were expressed. What social workers in fact want is a supervisor from their own ranks; someone who is familiar with their work from experience and does not come across as “narcissistic” or “schoolmasterly” (I 2: 1125 and 1138). That is, not someone who offers solutions on the basis of their knowledge and who considers this to be superior to the participants’ own expertise. Others express a wish for university-trained supervisors who have a good command of supervision methods. This could include the desire that the supervisor guide them to think beyond their day-to-day work. In this, however, they also subject themselves to hierarchy of the healthcare sector, in which respect and esteem are traditionally linked to specialized expertise. Supervisors from within their own ranks are often viewed with scepticism; social workers tend to have as much (or as little) faith in them as they have in themselves. “Well, I don’t think it absolutely has to be a social worker. I think someone from the field of psychology would be better in my view” (I 7:1452:1461).

These observations clearly show just how little the social work profession appreciates its own expertise, in the form of knowledge that has been gained from experience. Supervision can be used to identify areas of competence and to confidently present them to the outside world. As early as 1987, in his concept of the “reflective practitioner,” Schön pointed out that viewed as a professional practice, social work is creating new models and methods all the time. The creation of innovative approaches to changing practice is integral to the experience of social work. This experience feeds into social workers’ practical knowledge and constitutes new expertise, which exists with or alongside traditional expertise and scientific knowledge (Böhle, 2009). Supervision can be viewed as a forum for critical reflection on and development of this expertise, with social workers being encouraged to construct their own perspectives and, on the basis of their experiences, generate theories that relate to their own professional behaviour. Viewed this way, the emphasis is on understanding the social interventions that constitute social work and the complexity of the issues involved. Critical reflection on this shared expertise, and the theoretical views of social workers and other professional groups in the context of their respective areas of work, results in innovative

processes. "If we are in a position to develop a learning profession that can systematize and renew the knowledge derived from its experience, then supervision will become a 'learning lung' that supports the professional body in developing a professional self-identity" (Salonen, 2005, p. 64).

CONCLUSION

This study on supervision in the healthcare system reveals the difficulties that confront social workers and supervisors in their everyday work. The results clearly show the hierarchy within medical-dominated institutions, the effects of which even extend into the area of supervision. The social workers interviewed have an ambivalent view of supervision. The idea of supervision is initially accepted as part of the process of professional socialization, in the form of training or practical supervision, where it stands for trust and understanding (Van Hees & Geißler-Piltz, 2010). It is evident that these experiences and perceptions are carried over into a social worker's professional life, whereupon they are either confirmed or challenged. Damage occurs when individuals' expectations regarding supervision are disappointed.

It must be assumed that, despite the many criticisms that were expressed, participation in team supervision also means recognition. Social workers often view themselves as lone fighters who work on a large number of wards, and in many areas, they are the only representatives of their profession. This is why a team should act as a place where people can be "among their own kind," a place where they can recoup their energy. The fact that these expectations of teams or of team supervision in multi-professional work contexts are not always fulfilled only serves to heighten the sense of disappointment. The issue here is not primarily a person's individual experience, nor their self-awareness nor the clarification of professional responsibilities, but rather that person's professional role in the overall structure of a hospital ward or group.

Social workers often experience supervision as a continuation of a hierarchically ordered healthcare system, in which their tasks within an inter-professional team are diverse and yet unclear. The resulting lack of recognition triggers various reactions – a sense of powerlessness, helplessness, annoyance, and dissatisfaction – for which social workers often blame others or their own behaviour, but more rarely, the organization of the multi-professional work context. The interviews revealed situations in which the respondents were passive or experienced an inability to address conflicts in the presence of other professional groups, or to offer a specific social work perspective on a particular case. Yet social workers continue to value the idea of supervision; and not without reason, as it presents an opportunity to reflect on one's own actions and to create new models and

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methods. The experience of working in a multi-professional work context is particularly conducive to the creation of innovative approaches for bringing about practical change.

Taking recent forecasts by health economists into consideration, there is widespread agreement that future multi-disciplinary cooperation will be necessary for hospitals and other healthcare institutions to be able to survive (Becker-Kontio, Kimmig-Pfeiffer & Schwennbeck, 2004, p. 45). For the field of social work, cooperation with other professional groups thus lies at the heart of new learning processes (Ovretveit, Mathias & Thompson, 2002); processes in which supervision could play a role. The key question is thus: is supervision valued enough? Or, as Salonen (2005) puts it: can supervision help social workers to tackle the challenges that face them, and to develop and strengthen their own independent role within the multi-professional team? As the findings of this study suggest, this is barely succeeding precisely where it is most important: in the multi-professional work context.

NOTE

- 1 The research findings are based on an extensive quantitative and follow-up qualitative survey on "The Knowledge and Expertise of Social Workers in the Healthcare Sector" (Geißler-Piltz & Gerull, 2009).
- 2 Abbreviation in parentheses: I for Interview, followed by number of the interview, followed by the line in the transcription of the interview.

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