Parallel processes in clinical supervision: Implications for coaching mental health practitioners

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Abstract

This paper outlines the potential of parallel processes to enhance experiential learning opportunities in coaching for mental health practitioners. Traditional views of parallel processes in clinical supervision are examined in relation to how they can be applied to enhance coaching mental health practitioners. For example, parallel relationship patterns refer to repetitive interpersonal relationship patterns that are transferred from client interactions with mental health practitioners into the coaching sessions for these mental health practitioners. In addition, experiential learning strategies that utilize parallel process concepts might include the use of equivalent protocols for staff development coaching as are used by mental health practitioners in their work with clients experiencing mental health problems. Two coaching approaches (skills acquisition and transformational coaching) to support the implementation and use of a practice model for mental health staff and clients are presented to exemplify the potential advantages of purposeful use of parallel processing in coaching mental health practitioners.

Key words: parallel process, mental health, transformational, interpersonal, supervision

Introduction

This conceptual paper argues that the benefits of staff coaching could be enhanced with more purposeful use of parallel processing. The first aim of the paper is to describe how parallel processing as used in clinical supervision might be transferred into the coaching arena to enhance mental health practitioners' personal and professional development alongside clinical skills development. Secondly, the paper proposes expanding the conceptualisation of parallel processing to include experiential learning protocols in coaching for mental health practitioners that have been used with mental health clients. This proposal is based on the premise that the concept of parallel process involves actual enactment of processes that are transferred from one interpersonal context to be re-enacted in another. The paper argues that the greater the number of parallels being engaged consciously (i.e., the exploration of interpersonal relationship patterns as well as the personal use of parallel change facilitation protocols by mental health practitioners) the greater the normalising and empathy building functions mental health practitioner coaching will serve. These aims will be explored in relation to different coaching approaches.

Parallel processes in clinical supervision

Typically "parallel process" has been described within clinical supervision relationships where the dynamics of the relationship between a mental health professional (supervisee) and a client are re-enacted with the supervisor. Hence, parallel process is an extension of the concept

of transference that originated in psychodynamic therapy. Transference referred to the re-enactment by the client of his/her unresolved relational needs with the mental health practitioner. In the context of supervision this is subsequently re-enacted by the mental health practitioner with her/his supervisor (Luborsky & Crits-Christoph, 1998; Book, 1998).

Searles argued that, "the parallel process behaviour of both the supervisor and supervisee rests upon 'transitory unconscious identification occurring as a function of the relationship with the client'" (Searles, 1955, p. 161). Morrissey and Tribe (2001) refer to this as the mental health practitioner having "the experience briefly of being like a client whom s/he does not actually resemble" (p. 104). It is argued that parallel process is a way of learning (Ekstein & Wallerstein, cited in Morrissey & Tribe, 2001) and is described plainly as "if the supervisee does to the supervisor what the client has done to them, in turn the supervisee can then hopefully learn how to deal with the situation" (Morrissey & Tribe, 2001, p. 105). Accordingly, parallel process is not only the repetition of a relationship dynamic travelling 'up the line' from the clinical relationship to the supervisory relationship, but the dynamic also travels 'down the line' from the supervisory relationship to the clinical relationship (Mothersole, 1999; Doehrman, 1976). This idea has been extended by the suggestion that when supervisors use more empowerment focused practices (e.g., being supportive, less directive, etc) during supervision it is likely these practices would transfer to the therapeutic relationship with clients (Lombardo, Greer, Estadt & Cheston, 1998).

Such processes highlight the importance of attending to and understanding the specific relationship dynamics that occur in the therapeutic relationships with clients, and how they may be presenting as part of the supervisory relationship. Recognising how they may present in supervision allows these dynamics to be worked through to the benefit of the supervisee (mental health practitioner) and ultimately the client. That is, as a result of this more explicit understanding of what is happening in the relationship between supervisee and supervisor, the supervisee may be better able to manage the relationship issues with his/her client(s). This could result in downward directed learning from the supervisor through the experiential learning of the supervisee in order to support the relationship between mental health practitioner (supervisee) and client.

The challenge for supervisors is to notice when such (unconscious) re-enactments might be occurring and their own reactions to the presenting relational dynamics (i.e., potential counter-transference) (Book, 1998; Hayes, Gelso, Van Wagoner & Diemer, 1991). If the supervisor fails to notice re-enactments (which often represent stuck points the mental health practitioner may be experiencing with the client) s/he may respond to the mental health practitioner in a similar way as the mental health practitioner did with the client. This contributes further to the continuation of an often frustrating, unresolved dynamic that may threaten or rupture the supervisory alliance in a manner that reflects the working alliance between the mental health practitioner and his/her client (Mothersole, 1999; Grenyer, 2002). As a result, the supervisor might be corralled into a reciprocal role of either trying to advise or fix the situation for the mental health practitioner, or become frustrated by the mental health practitioner's apparent dependence, lack of motivation or resistance, that mirrors the mental health practitioner's assessment of his/her client's motivation (Mothersole, 1999; Cassoni, 2007).

Ruptures in the supervisory alliance (Safran, Crocker, McMain, & Murray, 1990) are likely to result in a halting of forward progress with the relationship and mental health practitioner's goals. Consequently, the mental health practitioner may revert to previous habits or clinical practices rather than progress with new behaviours. This again can mirror how clients who experience ruptures with the mental health practitioner may disengage from the clinical process and retreat to more familiar and unhelpful ways of interacting with the world.

Supervisors require sufficient alliance rupture management skills to: 1) resolve counter-productive tensions in the relationship, 2) understand how the dynamic might be worked through by the mental health practitioner with the client, and 3) help the mental health practitioner feel empowered enough to move forward (Safran & Muran, 2000). Therefore, the supervisor needs to be able to understand and work with the mental health practitioner's motivational tensions (e.g., wanting to confront the client but also wanting to keep the peace; wanting to challenge the supervisor but being afraid of conflict). Supervisors also need to be able to clarify pathways to move forward, as well as manage their own reactions to these relationship dynamics. The current paper translates and describes these structural, behavioural and interpersonal aspects of parallel process within a mental health coaching framework. This context involves coaching mental health service clients within their own recovery journeys, and simultaneously coaching mental health practitioners to support the adoption of these recovery coaching skills and in their own personal/professional development. Thus, there is a need to briefly clarify some of the similarities and differences between coaching and clinical practice and how adopting an empowerment and growth orientation for mental health practitioner coaching can parallel the personal recovery journeys of mental health service clients.

Coaching and clinical practice

The traditional view of distinctness between coaching and clinical practice is examined here in terms of the problems and knowledge sharing restrictedness resulting from a failure to recognise the significant overlap that exists between the two fields. If the overlap between coaching and clinical practice is acknowledged, the relevance of drawing upon specific clinical supervision practices to expand mental health staff coaching foci should be more apparent.

Differences between supervision and coaching contexts are to some extent able to be addressed by considering the differences between clinical practice (e.g. counselling) and coaching. Coaching has been described as being "essentially about helping individuals regulate and direct their interpersonal and intrapersonal resources to better attain their goals" (Grant, 2006, p. 153), and typically aims to assist coachees to increase performance through identifying goals that are consistent with their values and translating these goals into actions (Zeus & Skiffington, 2000). Therefore, coaching has clear motivational and behavioural activation functions (Ives, 2008; Stober & Grant, 2006). However, efforts to clearly separate coaching from clinical practice may restrict coaches from benefiting from the richness of knowledge and skills that are central to interpersonally focused clinical practice, theory and research.

Although there is debate regarding the distinctions between coaching and clinical practice, there is some agreement that they differ in several ways (see Ives, 2008 for review). First, the therapeutic relationship is likely to have a stronger relational focus and emotional bond than the coaching relationship (also see Passmore, 2007 re 'coaching partnership'). Second, coaching is future-oriented in contrast with the focus of clinical practice more often being on resolving past issues. Third, coaching is significantly more goal and action directed and structured with solutions rather than problems being the focus. Fourth, clinical practice has more of a 'healing' function than coaching which tends to be more performance focused. Fifth, coaching occurs with non-clinical populations. In addition, according to Ives (2008), the traditional view of the aim of clinical practice is to restore or gain stability, whereas coaching may encourage temporary instability to some degree in order to activate motivation for growth. However, although stabilisation is an important early stage of most clinical approaches, it is a generally held belief that once the client experiences some stability within his/her life and within the safety of the clinical relationship, the focus of therapy often shifts to one that challenges them to move towards positive growth.

The question becomes, is the goal of coaching simply to help the person clarify and strive to attain his/her goals and associated behaviour change, or is it more broadly to assist the person to grow as a human being, to be the person s/he wants to be? This may vary across the range of coaching approaches (Ives, 2008), from humanistic approaches (built around the principle of people's inherent tendency towards self-actualisation and growth) and behavioural approaches (that aim to facilitate behaviour change with associated psychological adjustments), to positive psychology approaches (that aim to build upon the person's strengths, hopes and wellbeing strivings). Even in amateur sports coaching contexts, coaches have indicated that coaching is about developing athletes personally as much as it is about skills acquisition and refinement (Vella, Oades, & Crowe, 2011). Therefore attitudinal and identity enhancement are as much the focus of coaching as skills acquisition and behavioural activation. This also calls into question whether clinical practice is purely about healing the past and about social adjustment, and the extent to which both clinical practice and coaching are about personal transformation (Joseph & Linley, 2006; Summerfield, 2006). Given that similar skills and approaches are used at different times in clinical practice and coaching, it would appear that the main differences are in the presenting needs of the person, the purpose and type of goals being pursued, and the degree to which the present centred relationship (i.e. relational dynamics) is explored.

Hawkins and Smith (2006; 2010) provide a continuum model in which coaching may occur across "skills" through "performance" to "development" to "transformational" coaching. They describe performance coaching as being focused on outcomes or outputs rather than specific skills within the person's existing role, more on capabilities than competence per se. Development coaching aims to use the person's current role as a strength upon which future roles, and the person as a whole, can be developed. However in contrast, "transformational coaching will be more involved with enabling the coachee to shift levels of 'action logics' and thereby make a transition from one level of functioning to a higher one" (Hawkins & Smith, 2010, p. 242). Shifting "action logics" refers to a type of existential re-orientation of one's learned or preferred ways of responding to situations particularly when under pressure, sometimes described in terms of reaction roles (e.g., rescuer, persecutor, martyr, individualist, tyrant etc, Hadikin, 2004) that reflect the decisions one makes when faced with complexity of choices (Rooke & Torbert, 2005).

Hawkins and Smith (2010, p.231) suggest that transformational coaching "enables coachees to create fundamental shifts in their capacity through transforming their way of thinking, feeling and behaving in relation to others." They further suggest that transformational coaching involves: 1) shifting the meaning scheme (i.e., changing specific beliefs, attitudes and emotional reactions); 2) working on multiple levels at the same time (i.e., physical, psychological, emotional and purposive elements) to the point that the coachee embodies these changes (i.e. thinks, feels and behaves differently); 3) shifting in the room (i.e., overcoming stuckness usually through enactment and integration – thus directing the parallel process); and 4) maximising engagement (i.e., working directly with motivational dynamics).

It is likely that there will be skills acquisition or performance elements regardless of where along the continuum a specific coaching contract may occur. However, development and transformation coaching require more personal investment by the coachee, and complementary coach relationship management skills, present centredness and personal commitment. For example, transformational questioning skills (i.e., aimed at bringing about deeper personal change) are required to encourage the coachee to move beyond his/her current mindsets (i.e., shift in action logics) in order to connect with the emotional experience of what it would be like to enact and live more consistently with his/her values (Hawkins & Smith, 2010).

Coaching and mental health services

Each of the different coaching approaches has something to offer to mental health services. These include improved support for mental health practitioners in terms of managing their own stress and wellbeing. They may provide structures that increase the likelihood that good coaching practices are transferred down the line from the mental health professional coaching situation into the client coaching situation. They may provide varying degrees of exploration of parallel patterns in interpersonal relationships which may assist the mental health practitioner to avoid repeating unhelpful relationship patterns with his/her clients.

Mental health staff report high levels of stress, burnout and reduced well being (Kipping, 2000). The performance of staff working under these conditions is likely to be reduced and their readiness to embrace change is also likely to be lower (Hobfoll & Freedy, 1993). They are also more likely to respond to the stress and complexity of supporting people with mental illness along old action logic lines and 'default' interpersonal roles (e.g., act as rescuers), rather than embrace the opportunities to practice new skills and knowledge and extend their response options. Stress and burnout are linked to decreased staff retention and subsequent loss of corporate memory (Lahaie, 2005) adding to client distress (Astroem, et al 1991) and organisational instability.

Although recovery in mental illness is a personal journey, it occurs within an often complex interactional field (Slade, Amering, & Oades, 2008; Deane & Crowe, 2007). Therefore, mental health practitioners require knowledge and skills to track and manage the many challenges present as part of the interpersonal/interactional processes of recovery. At a fundamental level this means the mental health professional needs to be able to establish and maintain a sufficient working alliance with the client, including the negotiation of recovery goals and tasks whilst maintaining a safe emotional and psychological space for both the client and the mental health worker (Deane & Crowe, 2007). Factors that influence working alliance include: 1) the beliefs, attitudes, and hopefulness/expectations of the mental health professional (Salgado, Deane, Crowe, & Oades, 2010; Beutler, Machado, & Neufeldt 1994); 2) the anxiety levels and well-being of the mental health practitioner (e.g. Hayes et al, 1991; Mothersole, 1999; Fox, 1998); 3) the culture of the organisation; 4) the client and mental health practitioner's readiness to adopt and work within a recovery/growth orientated framework; 5) the mental health practitioner's personal and professional identity and the quality of both current and past interpersonal relationships (Hersoug, Monsen, Havik, & Hoglend, 2002; Fox, 1998); and 6) the client's relating style (Klee, Abeles, & Muller, 1990). Therefore it is important that the mental health practitioner not only has relationship management skills but also develops his/her capacity to step back from the interaction enough to reflect on his/her own reactions and then decide on what might be a helpful way to proceed.

Reflective practice in mental health staff coaching

Reflective practice occurs when the mental health practitioner actively seeks to understand how contextual factors (e.g. social, cultural, personal experiences) influence current learning and practice, as well as practicing openness and creativity in assessing and challenging habitual responses where necessary (Miller, 2004; Wilkinson, 1996; 1999). Transformation of previous practices often involves dialectical thinking (Danielson, 2008), which is a deliberate reflection that changes meaning and actual behaviour. In coaching terms this corresponds with some of the aims of transformational coaching that empower the coachee to shift his/her action logics to reorient her/his responses to challenging or habitual situations (Hawkins & Smith, 2010).

An example of using parallel processing of interpersonal relationship patterns for reflective practice can be demonstrated in a context where a mental health practitioner is

experiencing interpersonal difficulties with a client. If a client's relating style is difficult, it is more likely to elicit negative responses from the mental health practitioner (Klee, Abeles, & Muller, 1990). However, the mental health practitioner's relationship style can also elicit positive or negative responses from the client. For example, if the mental health practitioner has a paternalistic relating style the response from the client might be one of submission or rebellion (i.e., role reciprocity or concordance, Mothersole, 1999). How the mental health practitioner addresses this is the critical issue here. If s/he is provided with coaching that encourages interpersonal reflection (Safran & Muran, 2000; Fox, 1998; Mothersole, 1999; Shulman, 2005) and intervention that explores the interpersonal dynamics and feelings of both the client and the worker, client outcomes are likely to be better (Foreman & Marmar, 1985).

At the interpersonal level, how mental health practitioners react to clients' relating styles, can reflect the mental health practitioners' own reciprocity or concordance tendencies, unresolved interpersonal issues, and/or anxiety issues (Fox, 1998; Shulman, 2005). Broadly speaking these reactions are types of countertransference. Interpersonal reflection in clinical supervision is helpful in regards to identifying and managing countertransference reactions (Gelso, Latts, Gomez & Fassinger, 2002; Hayes & Gelso, 2001). Strategies to manage countertransference reflect both the rupture resolution principles outlined above (Safran & Muran, 2000), good reflective practice, and when practiced in the moment reflect mindfulness principles, which have also been explored within coaching contexts (Passmore & Marianetti, 2007). It could be argued then that the broader the range of reflection activities engaged with by the mental health practitioner (e.g., exploring his/her own reactions and contributions to the interpersonal dynamics in clincial and supervision contexts, reflecting on what it might be like to be the client engaging with the mental health practitioner etc) the greater the normalising and empathy building functions mental health practitioner supervision or coaching will serve.

Coaching for mental health practitioners' development and skills acquisition
A current project of the authors is examining the implementation of two different mental health practitioner coaching conditions to support increased use of recovery support skills with mental health clients. Specifically the project examines the parallels between staff and client processes when working with the Collaborative Recovery Model (CRM - Oades et al., 2009). The CRM has a set of principles (recovery as an individual process and collaboration and autonomy support) and practices (supported by the use of Life Journey Enhancement Tools, LifeJET – Oades & Crowe, 2008). Adopting the CRM guiding principles requires the mental health practitioner to value the uniqueness of individuals' recovery journeys and to meet individuals where they are on their journey with the belief that they can make decisions about their life directions. Along with motivational enhancement strategies the CRM LifeJET protocols involve: 1) values and strengths clarification to help identify preferred life directions and a recovery/life vision, and resources and supports for change; 2) goal clarification, setting and planning; 3) specific action planning in order to reach goals; and 4) review and monitoring motivation and progress with these steps. Preliminary research has found such an approach is associated with more positive outcomes for clients with chronic and recurring mental illness (e.g., schizophrenia) (Clarke et al., 2009; Kelly & Deane, 2009).

Two staff coaching approaches are being compared to support the transfer of the CRM skills into practice, and to track mental health practitioner wellbeing and parallel processing. One staff coaching protocol is aimed at professional and/or personal development using transformative coaching strategies (e.g., an exploration of personal values and identity and mindsets), while the other aims to develop skills and confidence in the implementation of CRM practices (i.e. skills/performance acquisition coaching, mentoring). In the skills acquisition coaching condition, the emphasis is on exploring and mentoring mental health staff coachees'

applications of the CRM principles and LifeJET practices to support clients with their recovery from mental illness. This approach often takes a case review and problem solving structure. In contrast the transformational coaching condition focuses on the mental health practitioners' personal and/or professional life journeys and the applications of the LifeJET protocols in their own lives (i.e., less directly concerned with applications of CRM with mental health clients).

Therefore the skills acquisition coaching approach is an arm's length view of the mental health client's journey and clinical applications of a recovery coaching model. Transformational coaching involves a direct experiential contact between coach and the mental health practitioners (coachee). The mental health practitioner has a first-hand experience of coaching using the same LifeJET materials that they use with clients.

There are a number of parallel process elements potentially activated by having mental health practitioners engage in their own skills or transformational coaching. The more that coaching of the mental health practitioner reflects the development/transformational end of the coaching continuum, the more of these parallel process elements are likely to be observable. Both skills acquisition and transformational coaching conditions have personal accountability as a feature of being coached. This personal accountability is paralleled in the collaborative relationship with mental health clients. Other parallel processes may include personal resistances to working with various components of the CRM, which can be experienced by both the mental health practitioner and the mental health client. Coaching offers a forum to explore these resistances. Direct mapping of the mental health practitioner's resistance and perceived client resistance can also occur. For example, both clients and mental health workers have well documented attitudinal barriers to completing therapeutic homework (i.e., "action plans") (Kazantzis et al., 2005). A coach might note parallels between the mental health practitioner's refusal to complete "action plans" and clients' refusal to do "action plans". Poor or no attempts to implement action plans may be particularly directly observable in our transformational coaching condition where these are expected of mental health practitioners (coachees). The attitudinal barriers associated with such non-completion may be paralleled in the work between a client and the mental health practitioner.

Second, both coaching conditions provide an opportunity to explore power issues within the coaching relationships. Both mental health practitioner coaching conditions require the coach to attempt to give the responsibility for setting the coaching agenda and goals to the mental health practitioner so they may have a sense of self directedness and autonomy. However, the transformational coaching condition makes a point of using the immediacy of current mental health practitioner coaching relationship to explore the flow of the coaching alliance and possible alliance ruptures. This has direct parallels with clinical applications of CRM where mental health practitioners are encouraged to support client autonomy and empowerment, while actively working to provide a safe, empathic relationship that is responsive to fluctuations in the working alliance. The challenges of developing and maintaining the mental health practitioner coaching relationship includes the mental health practitioner trusting the coach with personally meaningful goals, fears, resistances, ambitions and so on. This provides the mental health practitioner with a direct experience of what some of her/his clients might experience while working on her/his own recovery.

Third, the mental health practitioners (particularly those engaged in transformational coaching) will likely be in touch with their own motivational and attitudinal conflicts that lead to resistance to change or drive change (i.e., with personal/professional growth, or with implementing CRM in practice with clients). Struggles with readiness and understanding one's

potential values conflicts are often very similar to those struggles that mental health clients experience when facing their own change and recovery prospects.

Finally, these experiential parallels provide a shared language of experience. That is, mental health practitioners may experience more empathy for the clients that they support and coach. They may have more personal experiences of going through their own change processes (e.g., personal resistances to writing down goals, or purposefully tracking their own progress with someone else) that they can share with clients in a way that normalises these experiences. In effect, both mental health practitioners and mental health clients are engaged in growth-oriented practices that reflect human change experiences, regardless of the presence or not of mental illness.

Each of these parallels also reflects meaning and personal identity development processes. Having mental health practitioners engage in their own values and strengths clarification, and using the coaching process to shape their preferred personal and/or professional identity, provides a direct experience of how coaching can assist clients with this part of their recovery journeys.

Conclusion

In this paper it has been argued that the practice of coaching can benefit from the well established clinical practice literature on parallel process. The various potential benefits of understanding parallel process in a coaching context have been outlined in the context of training mental health practitioners in new recovery oriented practices. Working with parallel processes that involve: 1) observational or awareness skills (mindful reflection), 2) interpersonal relationship management skills (parallel relationship patterns), and 3) change facilitation skills (parallel protocols), may increase mental health practitioners' empathy for clients and provide personal insight into mental health practitioners' own resistances, motivations, and personal growth experiences. This in turn may lead to higher rates of transfer of these structural coaching interventions into coaching practices with clients. Secondly, the more the coaching model reflects transformational coaching the greater the engagement of the self and personal growth of the mental health worker. Consequently, working directly with the immediacy of personal experience may increase the mental health practitioner's capacity to remain more present and mindful with clients, thus reducing the risk of being "hooked" into enacting reciprocating roles that contribute to alliance ruptures.

In conclusion, integrating purposeful parallel processing as used in clinical supervision into the coaching arena to enhance mental health practitioners' personal and professional development alongside clinical skills development is highly relevant for the advancement of coaching and mental health research. This integration can be further enhanced by expanding the conceptualisation of parallel processing as the interpersonal re-enactment of relationship dynamics to include the use of parallel change facilitation protocols in both coaching for mental health practitioners and with mental health clients. In this way, personal transformation appears to serve key normalising and empathy enhancement functions reflecting both the personal/professional development of the mental health practitioners and the recovery journeys of mental health clients. Currently the evidence of the personal and clinical advantages these parallel transformation journeys remains anecdotal, thus requiring further empirical investigation. It is anticipated that as the data from the current study becomes available for further analysis, this will inform future developments regarding parallel processing in mental health practitioner coaching.

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