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Reflective insights on group clinical supervision; understanding transference in the nursing context

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Reflecting on group theory within clinical supervision offers useful vantage points from which to engage nursing and the helping professions in the task of supervisory practice. This paper presents reflective experiences of group clinical supervision training and practice through a critique of Hawkins and Shohet's process centred model. The underlying premise of transference hypothesis is that experiences and memories from the past inform present behaviours. Little has been written about the hypothesis in relation to clinical supervision in nursing and the helping professions. However, the hypothesis was criticised by John M. Shlien in the 1980s and remains pertinent today due to expansion into social and healthcare practice. Reflective autobiographical diary entries focus on the model's two latter stages which propose the use of Sigmund Freud's transference hypothesis. The work of Freud, Foulkes, Heidegger and Hawkins and Shohet are synthesised and conclude with a phenomenological suggestion that immediacy and openness are necessary ontological conditions for group clinical supervision. Valuing empathic attunement to better understand group clinical supervision may be more important than theoretical distractions for non-therapeutic clinical supervision practice

Keywords: Freud; transference; nursing; helping professions; group clinical supervision

Introduction

An ability to attune ourselves to other people's feelings and intentions is central to human nature and our need for survival, prediction of risk from others, and social competition (Flinn, 1997). These empathic skills are especially valuable in nursing and the helping professions attempts to facilitate learning for supervisee practice (Hawkins & Shohet, 2006). Sigmund Freud (1915, p. 194) addressed the issue of shared human empathy as a '... remarkable thing ... (where the) unconscious of one human can react upon the other without passing through consciousness ...'. One person's unconscious reaction communicates itself to other people in the room (Totton, 2005) and we instinctively take notice in order to understand the intentions and perceptions of the other (Damasio, 1994). In doing so, man's existential terror is lessened because '... a store of ideas is created, born from a man's need to make his helplessness tolerable ...' (Freud, 1961a, p. 23). Taken from the Latin word

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reflectere, the word reflection means to ‘bend back’ and recollect, consider and deliberate in an attempt to search for fresh meaning (Lovitt, in Heidegger, 1977, p. 155). A contemporary definition suggests reflective practice is a specific type of thinking within a ‘given set of characteristics’ enabling a range of new perspectives to emerge (Kahn *et al.*, 2006, p. 15). In nursing and the helping professions reflective practice is considered to be an effective method when developed in a sustained group activity called group clinical supervision (Bondas, 2010).

The purpose of this paper

Previous experiences of professional development as a supervisee and supervisor have been developed by the author through interpretive methodology to inform reflective practice (Regan, 2007; Regan, 2008). This process was particularly useful due to aspects of intuitive and empathic practice and a need to make sense of uncertainty and experience (Baker, 2008). In this paper, experiences of a group clinical supervision training and practice are developed through Hawkins and Shohet’s (2006) process centred supervision model for the helping professions, including nursing. The model’s latter stages are informed by Freudian transference hypothesis as an interpretive mirroring process to capture empathic responses between the supervisor and supervisee. Little has been written of transference hypothesis and clinical supervision in nursing (in particular) and the helping professions due to the theory largely being used in psychotherapy (Yegdich, 1998). This paper therefore de-constructs the hypothesis in an attempt first to understand what it refers to and second, to apply it where necessary within clinical supervision, in particular when it becomes known (and shown) to be an issue.

Group clinical supervision

Group clinical supervision is a formal support mechanism referring to when one or more practitioners join together to learn and develop their critical reflective abilities (Bransford, 2009). It is a process facilitated by a clinical supervisor with specific responsibility for cognitive movement in the form of participants sharing practice issues, promoting new learning and developing new perspectives (Bondas, 2010). Group clinical supervision has been identified as an effective way of meeting the quality agenda of healthcare organisations but it remains largely underdeveloped, overlooked and under-resourced in the United Kingdom (UK) National Health Service across multi-disciplinary teams (Bishop, 2008; Milne, Sheikh, Pattison, & Wilkinson, 2011).

With financial constraints dominating contemporary healthcare provision, group clinical supervision is considered to be a cost-effective alternative to individual supervision, requiring the supervisor to develop group facilitation skills (Bondas, 2010). In nursing, group clinical supervision has been found to incorporate an eclectic mix of nursing orientated models and applied theories, for example, managerial, safeguarding, transformative theories, reflection, cognitive theory, psychoanalysis and psychodynamic theory, to name but a few (Bondas, 2010). Due to a variety of roles and contexts, this eclectic mix is typical of nursing practice with no one model dominating (Bondas, 2010).

Clinical supervision in healthcare

A variety of interrelated issues appear to be relevant: the quality and access of supervision, what model is in use, and threats to its use (HSC, 2011; Regan, 2012). First, the quality of clinical supervision and access to it has been questioned, for example, in specialist community public health nurses (health visitors) therapeutic work with mothers suffering from peri-natal depression (National Institute for Health and Clinical Excellence [NICE], 2007; Regan, 2012). This therapeutic work consists of increased support and offering non-directive listening visits to mothers (NICE, 2007). In short, the quality of this intervention is affected due to a lack of training in psychotherapeutic methods by the health visitors (Regan, 2012). This is compounded when accessing clinical supervision if the supervisor (often a health visitor) has not had psychotherapeutic training to interpret interrelational process issues (Regan, 2012). The result means that these process issues are rarely discussed in clinical supervision (Regan, 2012).

Research identifies poor access to clinical supervision by community practitioners (Regan, 2012) and hospital nurses (Koivu, Hyrkäs, & Saarinen, 2011). In a UK study, only one-third of nurses received clinical supervision early on in their careers (Bishop, 2008). In another study, 18% of practice nurses in one UK Trust received a form of clinical supervision compared to 85.9% of mental health nurses (Butterworth, Bell, Jackson, & Pajnikihar, 2008). The inconsistencies are evident and yet the ability and confidence to challenge existing social, political and cultural conditions (Yip, 2006) remains pertinent due to high profile cases of organisational failures leading to neglect of patients (HSC, 2011).

Second, the developmental benefits of clinical supervision are threatened by organisational policies which specify the need to quantify practice through action plans, learning outcomes, documented session content that can be accessed in case of a disciplinary procedure (Yip, 2006). It becomes a managed event (Yip, 2006). This supervisory model parallels the tension in a healthcare environment, favouring empirical dominance over more tacit knowing and promoting a more nuanced approach to applying evidence into nursing practice (Evans, Pereira, & Parker 2009; Regan, 2008). However, this contractual and administrative model carries a disciplinary risk if learning outcomes are not met and maybe a factor in its inconsistent access (Yip, 2006).

Third, clinical supervision can promote supervisee insight, efficacy, knowledge and skills, but when located within poorly performing healthcare organisations the conflicting tensions appear to negate its positive effect on the quality of care given (White & Winstanley, 2010). In part this is due to poor understanding of what clinical supervision is and how it works (Milne *et al.*, 2011) and healthcare organisations' resistance to practitioner-led innovation and empowerment (Murray, 2007). Hence, the result is a systemic failure to understand the potential for reflective practice through an empowering form of clinical supervision and practitioners consistently lacking protected time for sustained reflection on practice (Bishop, 2008).

Hawkins and Shohet's process-centred model

Hawkins and Shohet's book entitled *Supervision in the helping professions*, first published in 1989, promotes a process-centred model with supervisees maintaining control and autonomy. Supervisees voluntarily choose their own clinical supervisor

in order to identify process issues themselves that are relevant to their clinical work, and are guided by an experienced supervisor unrelated to hierarchical structures (Hawkins & Shohet, 2006). Hawkins and Shohet's model promotes supervision in a collegial, adult professional relationship with the clear focus of bringing to the timed session the supervisees' own practice agenda (Hawkins & Shohet, 2006). Their six-stage model suggests each supervisor should: reflect on the content of a session, be able to explore strategies, any interventions used and have the knowledge and skills to explore the process further. During these stages any issues presented are explored with an aim to develop new insights, new possibilities and new learning through regular time-out to offload. This enables opportunities to be critical, develop autonomy and self-awareness as a reflective practitioner (Bishop, 2008). Hawkins and Shohet's last three categories focus on the supervisory relationship and the supervisee's counter-transference using the here-and-now process as a mirror or parallel to the there-and-then process (Hawkins & Shohet, 2006). Finally, the latter stage focuses on the supervisor's own counter-transference (Hawkins & Shohet, 2006). Hawkins and Shohet's model therefore has the capacity to empower and engage nursing and the helping professions to reflect on a deeper cognitive level by allowing the process of learning to occur, time to reflect on beliefs, prejudices and assumptions that may otherwise remain unchanged (Bishop, 2008).

Clinical supervision training

The clinical supervision training provided an opportunity to develop group clinical supervision skills for supervisory practice. Training was held over two semesters in a higher education institution and we were encouraged to use a (reflective) autobiographical diary in order to make sense of subjective experiences. My first entry identified a key theme which this paper develops further. I wrote:

As the first couple of weeks went on I wondered why the group facilitator neither agreed nor disagreed with what was being said. This issue evoked a degree of frustration at being in a group with non-directive group facilitation. Because it was unfamiliar to me I was unaware of the interpretive theory behind the facilitation style, which I later realised was informed by Freud's transference hypothesis. Hence, I wondered about the evidence base of Hawkins and Shohet's model when proposing its use within clinical supervision.

Central to Freud's transference hypothesis is that psychoanalytic therapy evokes reactions in a person as a necessary step to remembering affect-laden past experiences based on the premise that what cannot be remembered is destined to be repeated (Bransford, 2009). Defining it in relation to what a phenomenon is, transference hypothesis appears to be a phenomenon that 'shows itself' just as it is encountered and in its 'appearance' it is made manifest (Heidegger, 2003, p. 54). The process of the supervisee projecting a phenomenon results in the supervisor identifying the projective (identification of) feelings and actions and recurrent patterns of interaction (Bransford, 2009). What may have been forgotten is not the supervisee's memory of the past event but the affective memory and feelings that accompanied it, feelings re-enacted, identified, analysed and then re-interpreted back to the supervisee (Bransford, 2009). Hence, the cycle needs to be objectified in order to reduce the cyclical repetitions and assumption of evoked memory that would be counter-productive to a supervisor maintaining an emotional distance

(Bransford, 2009). In supervision that may result in a parallel process (Totten, 2005; Yegdich, 1998). This may be defined as ‘... an unconscious replication of the therapeutic (*or helping*) relationship in the supervisory situation ...’ (Morrissey & Traibe, 2001, p. 103). With its roots in the transference hypothesis, parallel process is an interrelational dynamic referring to when words cannot adequately relay the meaning of experienced phenomena. This may result in unconscious issues being re-enacted in the supervisory relationship (Bransford, 2009). Despite clinical supervision not being considered therapy, the conditions and processes may be similar, requiring awareness of contextual boundaries (Yegdich, 1998). I wrote in my diary:

As this transference hypothesis became known (and shown to me in its appearance) I was asked to facilitate a group. During the session I realised the hypothesis could be of use to understand the unfolding events. One person was on time and the rest of the group were late, leading to a heated exchange by the early group participant telling the group off for being late again. She said it was bad form to be late especially due to the fact that we were all in training to improve our facilitation skills. I was taken aback by the speed of events and had a glimpse as a non-directive facilitator of observing and maintaining an “emotional distance” within the group. I momentarily wished for the perceived safety of this approach and by remaining an observer I wouldn’t feel obliged to interject and expose my anxiety ...

This reinforced that group clinical supervision needs to develop a degree of emotional and intellectual distance from the group otherwise a supervisor risks reacting unproductively, or being stuck as events unfold (Foulkes, 1984).

Leadership

The group clinical supervisor needs to pay attention to their own changing feelings (Foulkes, 1984). This is not only because those feelings will be obvious to the group by their posture, tone and demeanour but because feelings are a human’s most sensitive indicators to what is going on in the interpersonal situation (Searles, 1978). Although the individual is the *reason* for the group, the group phenomenon reflects back onto the individual by acknowledging the first basic problem of social interactions, the reciprocal relationships experienced between individuals and how other people relate back to the group as a whole (Foulkes, 1984). The facilitator knowingly accepts this responsibility to avoid a power play, encouraging a decrescendo move from leader *of* the group to leader *in* the group, replacing the authority of the *leader* by the *authority* of the *group* (Foulkes, 1984). This acknowledges the facilitator’s aim to maintain the focus of putting *words to feelings* as a first stage of gaining insight and making *explicit* any unconscious infantile reactions, called transferences (Foulkes, 1984). The resulting insights may link present relationships with past events with transference hypothesis proposed as a powerful tool for interpretation (Foulkes, 1984). It is this interrelational complexity that underpins the issue of leadership, being an important characteristic of non-directive facilitation to avoid being a trigger for the transference process and through an emotional distance being open when it occurs (Foulkes, 1984). Therefore the facilitator functions completely in the interest of the group and tries to reduce their effect on triggering evoked reactions (Foulkes, 1984). Reflecting on the group situation allowed me to challenge this hypothetical practice (Greatrex, 2002).

I wrote in my journal entry:

This phenomenon may have been demonstrated by my focus on the style of facilitation at the beginning of supervisory training and feeling unprotected, frustrated and reactive due to the perceived lack of direction and feedback in the group and with each other. By remaining silent for long periods of time, I felt the facilitator colluded with group members' superficiality ... statements were left unchallenged, including my own. As a result I felt many learning opportunities were missed. It was a real perception as interesting learning issues faded away from view rather than being challenged. At the time I had little idea why I felt this way but the style was working in one sense, in that it took me out of my comfort zone and inspired me to reflect on my reactions ... what I failed to appreciate as a supervisor-in-training was that my search for ideas was a way of coping with my own anxiety, paralleling the underlying dynamics of transference hypothesis that inspires reflection on clinical uncertainty.

It has been suggested that nursing is a fervent testing ground to understand the effects of transference hypothesis due to the context of often unacknowledged feelings and empathic understanding (Evans *et al.*, 2009). Out of this professional uncertainty, the phenomenon of anxiety emerges to drive a need to understand and apply psychoanalytic theory into supervision for nursing and the helping professions (Evans *et al.*, 2009; Hawkins & Shohet, 2006). However, due to the narrow lens of interpretation when applied into non-therapeutic group clinical supervision its application requires caution (Evans *et al.*, 2009). One may also question the moral implications of invoking a degree of anxiety in an attempt to better understand the interpretive processes (Evans *et al.*, 2009; Geller & Foley, 2009).

Transference hypothesis and interpretation

Freud's transference hypothesis has been reconstructed and applied into a number of contemporary non-psychoanalytic practice (Jones, 2005). Freud himself suggested it was a universal phenomenon dominating each person's relationship to his environment (Freud, 1961b) and paralleled the intra psychic feelings from one person to another (Greatrex, 2002). It has therefore been adopted as an interpretive tool for supervision practice (Hawkins & Shohet, 2006), cognitive behavioural therapy (Swan & Hull, 2007), communicative psychoanalysis (Smith, 1999), existential psychotherapy (Handley, 1995), social work practice (Bennett, 2008), speech and language pathology (Geller & Foley, 2009) and nursing (Jones, 2005). Its importance is to make what is latent (phenomenon) to become manifest, revealed and shown to interpret its meaning (Foulkes, 1984).

Contemporary views of transference hypothesis appear to have changed little since the 1970s, with the hypothesis being defined as the repetitive experience of feelings, drives, attitudes, fantasies and defences towards a person in the *present* that are unconsciously displaced from the past (Swan & Hull, 2007). This unconscious relocation of experiences from one interpersonal situation to another accepts *past* childhood patterns of behaviour being repeatedly displaced and transferred onto *any* person in the *present* (Freud, 1959; Jones, 2005; Swan & Hull, 2007). For supervision, an open window analogy indicates the clinical supervisor is searching for a phenomenological glimmer of what is hidden behind discourse (Westen, 1988). What may be unconsciously revealed through a person's own language may be the use of a metaphor identifying inner belief systems that become symbolised in the language-in-use (Ricoeur, 1976, 1977; Westen, 1988). Understanding *through*

interpretation therefore underpins the primary clinical task (Handley, 1995) and focus of clinical supervision for nursing and the helping professions (Yegdich, 1998). The *act* of interpretation enables humans to establish meaning and its significance to our *own* individual situation (Ricoeur, 1977). It therefore has a place in the larger epistemology of phenomenology (Ricoeur, 1977).

The conditions for clinical supervision and psychotherapy are similar, with discourse evoking memories, feelings and parent-child dynamics explored for educational and developmental reasons instead of therapeutic change (Schamess, 2006a). Irrespective of whether a non-therapist supervisor is aware or unaware of repetitive pre-determined behaviours, they occur nonetheless as both supervisee and supervisor may enact transference hypothesis as a parallel process (Hawkins & Shohet, 2006; Schamess, 2006a; Yegdich, 1998). Therefore it is up to the supervisor to decide whether to ignore or accept the phenomenon if the transference implications are revealed to them (Schamess, 2006b).

Counter-transference

Freud (1959) later suggested that any reactions, whether conscious or unconscious (to a supervisee or supervisor), may be in response to transferences and may distort perception and judgement if left unidentified (Hawkins & Shohet, 2006; Jones, 2005). The intimacy involved within interrelational situations may result in transference reactions and irrational feelings applying to *either* the supervisor or the supervisee (Jones, 2005). However, the concept of counter-transference can be confused with feelings which are *actually* reality based (Spinelli, 1995). Everyday stressors such as a flat tyre, hearing bad news on the radio or having an argument all contribute to what humans bring to a situation by way of neuro-biological responses (Shlien, 1984). The reaction to a group member's transference and the supervisor's own counter-transference responses become almost indistinguishable, but acknowledging this benefits the supervisor and the group (Foulkes, 1984). Counter-transference may therefore explain why a group member or supervisor reacts in certain ways, for example, feeling stuck, uncertain, a need to intellectualise, being avoidant, defensive, exercising poor judgement or distorted thinking (Hayes *et al.*, 1998). On these occasions the supervisor needs to ask *whose* transference or counter-transferences are being initiated and who is reacting to whom? I wrote in my diary:

Referring back to experiences as a facilitator frustrated by the unfolding events in the group of late students (anger, lateness, me feeling stuck and exposed) triggered a counter-transference response.

Hayes *et al.* (1998) suggested there are five components from which to make sense of group process issues. They are: origins, triggers, manifestations, effects and management factors. The identified areas of unresolved conflict result in identification, understanding or defensiveness and distorted reactions when exposed to the group processes (Hayes *et al.*, 1998). Conscious awareness of group friction may evoke a *response* in behaviour and feelings (*manifestations*). This may lead to the potential for three forms of internal response: misperceptions of topic frequency, feelings of liking or disliking phenomenon, withdrawal and avoidance from the group (Hayes *et al.*, 1998). Therefore the risk of over-involvement and not recognising misinterpreted non-verbal cues reinforce counter-transference behaviour (Jones, 2005) and

reflecting on the phenomena can be useful for effective group awareness in the future (*management*). In effect, counter-transference may be a defensive irrational reaction to unresolved needs, distorting perception of the group members and leading to poor facilitator judgement (Hayes *et al.*, 1998) but once it is recognised (appears) then it can be overcome (Freud, 1959).

A flawed concept

The critical literature on transference hypothesis is lacking in volume and consensus, evident by the age of some cited work here, adding uncertainty as to its validity and application into group clinical supervision for nursing and the helping professions. The most significant critic appears to be John M. Shlien (1918–2002) from Harvard University in the mid-1980s with his *Counter theory of transference* (1984). Shlien (1984) suggested a flaw in the transference hypothesis occurred when Freud (1959) first introduced the concept of counter-transference, referred to as *all reactions* to a person whether conscious or unconscious defensive reactions. His views are partly supported and de-constructed by other academic literature (Handley, 1995; Jones, 2005; Spinelli, 1995). Counter-transference reactions occur in response to transference or other phenomena occurring within the group when reviving a series of psychological experiences by substituting them as *one* and the *same* (Jones, 2005). In this sense *all* human relationships contain transference elements but the false group situations, metaphorically speaking, add the necessary fuel to fire unresolved issues in the facilitator (Shlien, 1984).

Shlien (1984) recommended a counter theory to the traditional repetitive compulsion theory. He suggested the transference hypothesis is just that, a *hypothesis* and as such it remains ‘... a fiction, invented and maintained to protect the therapist from the consequences of his own behaviour ...’ (p. 1). The interpretation of transference feelings distract and are counter-productive to the facilitator. If left unchecked the facilitator may dismiss their real human reactions when dealing with multi-directional dependency within the group (Shlien, 1984). When people feel *understood*, not transference awareness, then this human empathy in itself allows them to understand themselves and promotes their own self-healing (Shlien, 1984). If humans can better understand how they think, act and connect with other people (as in supervisory practice) then reflexive understanding can be promoted (Boss, 1987).

Therefore, the transference hypothesis has become an obstacle, lacking in evidence of its effectiveness (Shlien, 1984). It is a therapeutically reinforced smoke-screen, diverting therapy away from new theory and practice for over 50 years, rather than a useful explanatory interpretive framework (Shlien, 1984). At the expense of other alternative realities the theory in its traditional form appears to restrict interpretive possibilities (Spinelli, 1995). However, one of the errors of transference is assuming that *any* response duplicates a prior similar response, which is then replicated (Shlien, 1984), an overvalued idea that confuses two phenomenon (Midgeley, 2006). Shlien asked what if every second instant were the first? An analogy he made related to the sour taste of a lemon at 30 being similar when tried at aged three; however, the lemon is always sour. *Similar* responses are not *always* repetitions; the love for a newborn baby is not due to previous experience of the baby because there was no earlier instance (Shlien, 1984). Provide these conditions again and they will produce, not reproduce, the similar feelings of love again and again (Shlien, 1984). The produced experience therefore mixes with

memories and associations, memories only reproducing the conditions, not the memory accounting for the response itself (Shlien, 1984).

Neuro-biology and perception

The question whether any response duplicates a prior similar response is supported in olfactory sensory research. Pincus, Freeman, and Modell (2007) re-constructed the transference hypothesis from Freeman's (1991) studies. When mammals (rabbits) smell a chemical (through olfactory sensation) receptor cells in the nose respond to the inhaled air, with the neurones in the brain responding independently to organise patterns of activity. Despite being wiped clean in transmissions from a rabbit's brain neurones, in humans perception is said to occur due to a construction of stimuli elicited from previous experience (Pincus *et al.*, 2007). Perception then occurs 'behind' the receptor cells and beyond the level of the olfactory bulb, and it is here that the brain begins to construct its meaning (Pincus *et al.*, 2007).

Pincus *et al.* (2007) conceded that olfaction is unique to sensory modalities by its emotional responses (direct access to the cerebral cortex) in contrast to auditory and visual sensations (p. 631). However, olfactory stimuli and the construction of meaning are made evident in memory and learning, such as when experiencing the smell of coffee, burning wood, the seaside or baby clothes. Memory can be re-constructed and once pleasing smells can be transformed to repulsion, such as in pregnancy due to hormonal changes and nausea (Pincus *et al.*, 2007). This perceptual phenomenon is 'always changing' depending on 'exposure to different odorants and their meaning with every new experience alters all others with no fixed stores of representations' (Pincus *et al.*, 2007, p. 632). This continual feedback process is the basis for perception and transference hypothesis involving intentional dynamics where previous emotional experiences (historical attachments) both inform and shape current perceptions (Pincus *et al.*, 2007). The transference hypothesis may be considered a high ordered phenomenon experienced the same way as other neuro-biological sensory modalities and learning theories, but it goes beyond memory and learning (shaping, neural pruning) and humans finding (creating/ attuning) themselves through and to other people (Pincus *et al.*, 2007). Therefore, in order for real transference to occur it must be part of a 'precept of another person' (p. 636). Pincus *et al.* therefore suggested transference phenomenon goes beyond the simplicity of gustatory and olfactory senses and more empirical studies are needed to better understand the processes of high ordered transference phenomenon.

Phenomenology

Handley's (1995) critique of the history of transference hypothesis talks about the hypothesis re-formulation into a more phenomenological perspective as facilitator and participant inevitably become intertwined in each other's experiences. In response to his critical analysis of Freudian hypothesis, Handley (1995) suggested it is an abstraction to a more ontological analysis of what happens when humans meet each other. Ontology and the study of being in its modern sense is a study of objects and what is understood by phenomenology (Heidegger, 2008). Medard Boss's re-conceptualisation of transference hypothesis suggests the participant's

openness is *distorted* by viewing the world in a narrow and closed way with their projections clouding their interrelational capacity for authentic engagement (Handley, 1995). Hence, future relationships are distorted and immature due to a person's inability to be open (Handley, 1995).

Boss's work in the *Zollikon seminars* (1987) reinforced the essential human engagement of transference hypothesis in a psychological sense as a curious ontological (existential) disposition. An attunement always ready in a sense beforehand (Boss, 1987). Critically, Boss concluded that transference hypothesis has 'no meaning at all' because *nothing* needs to be transferred. Carl Rogers said something to the same effect. The 'respective attunement' for which a phenomenon shows-itself is already present and disclosed, in other words it is there already in the moment (Boss, 1987). The facilitator merely has to present a favourable environment for the other person's openness to be disclosed (Boss, 1987).

On a more general level, Heidegger suggested Freud's 'erroneous theories' fail on two main grounds. First, by inventing the unconscious mind his theories failed on scientific grounds against pre-suppositions that were generally unverifiable (Boss, 1987, p. 311) and remain so today (Jones, 2005). This is surprising, first, because Freud had been a medical physician and had toyed with the idea of a career in neuro-science before his psychoanalytical work developed (Midgeley, 2006). Second, and most importantly, Freud failed to see the ontological characteristics of being human, instead reducing man's potentiality to a series of categorised conceptions (Boss, 1987). However, what has been referred to as a reductive characteristic is what allowed Freud to conceptualise man in the first place, reducing people to a series of wishes, desires, instincts and impulses in relation to his libido theory (Boss, 1987). Similarly, transference hypothesis continues to restrict human understanding predicated on the subject-object duality which fails to take into consideration the realities of life and real reactions (Boss, 1987). For Boss the emphasis is always on the relationship, and by authentically knowing oneself the individual and group are free to open up to whatever may present itself in the here and now (Boss, 1987).

Conclusion

Experiences of group clinical supervision facilitation have been discussed to analyse the use of transference hypothesis for nursing and the helping professions. There is a lack of critical literature on transference hypothesis in clinical supervision, requiring a synthesis of Freudian theory in order to make sense of its purpose and scope (Jones, 2005). This paper clarifies the hypothesis and offers criticism from various sources, with suggestions that real feelings when evoked should be acknowledged as being individual, valued and discussed in the moment of its realisation (Shlien, 1984). This appearance, when it is shown, identifies a re-conceptualisation of transference hypothesis and a need for openness and authenticity attuned to phenomenological thought (Boss, 1987; Handley, 1995). However, the reflective processes discussed in this paper are ironic because new insights have been developed from the very thoughts, feelings and reactions to conditions in group clinical supervision evoked by non-directive facilitation and the transference hypothesis (Geller & Foley, 2009). In that respect it appears to have lived up well to its interpretive and analytical function.

Notes on contributor

Paul Regan is a senior lecturer in adult nursing, School of Health, University of Central Lancashire. He is interested in community public health nursing research and the effects of policy, politics on patient care. He has a developing interest in action research for pedagogical practice and as a postgraduate student he is interested in hermeneutic phenomenology applied into understanding people and nursing practice.

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