**PROFSUPV700: Written Assignment One**

1. With support from the literature, identify what you consider to be the purpose and function of professional supervision.
2. Identify the policies and practice standards/codes (both organisational and professional) which mandate supervision in your work context and your profession. Provide examples and reference to policy an other material as required.
3. With reference to relevant literature describe the organisational culture(s) which are present in your organisation (or your supervisees’). Give examples.
4. Discuss with reference to literature how the organisational culture affects the practice of supervision, learning and professional development. What are the challenges or conflicts for supervisors in this context? Give examples.

**Introduction**

Hart Integrative Health (HIH) provides the practice context for my work as a supervisor. This scene is set in section one. Section two provides an account of how the purposes and functions of supervision are placed within this context. Sections three and four examine the cultureof HIH and discuss recent influences on the culture and role of supervision at HIH. The final section considers the means by which HIH is responding to existing professional mandates for supervision and the lack thereof by developing its own organisational mandates.

Davys & Beddoe (2010) discuss the tensions that can arise between the individual functions of supervision and between supervision and the organisation. Unless adequate attention is allocated to each function the success of supervision is jeopardised. The organisation must support supervision and allocate adequate resources for supervision to be effective.

I argue that supervision is most successful when each of the purposes and functions of supervision are integrated into the organisation’s functions. When there is an adequately resourced staff development programme, for instance, the formative function of supervision is less likely to be effaced by the normative. By examining HIH from this perspective it becomes possible to identify the ways in which the organisation needs to evolve to better support successful supervision. It becomes possible to supervise the design of the functions of the organisation such that these connect (rather than collide or collude) to support the functions of supervision. Ultimately this is a reciprocal relationship: supervision also needs to reflect and respond to the needs of the organisation.

**1. The Organisational Context: Hart Integrative Health**

HIH is an interdisciplinary practice that offers the public a number of well-established modalities: counselling, practitioner supervision and yoga classes and several services based on disciplines nascent to the New Zealand context: integrative health, life coaching, structural bodywork and yoga therapy. Education and learning are integral to the culture of HIH. Practitioners are responsible for client education and often need to complete training before they are able to participate fully. HIH was established eighteen months ago, involves eight practitioners practicing from three locations and offering seven modalities. The organisation is undergoing a period of rapid growth, which requires openness to change and transformation.

The Health Practitioners Competence Assurance Act 2003 (2003) does is not require service providers in these disciplines to hold membership with a professional body. Nonetheless, the relevant professional bodies include: the New Zealand Association of Counsellors (NZAC), Yoga Aotearoa International Yoga Teachers Association (YA-IYTA, 2012) and the Australasian Integrative Medicine Association (AIMA, 2012). Of these professional bodies only the NZAC provides a mandate and guidelines for practitioner supervision. Consequently, there are varying expectations with respect to the purpose and functions of supervision amongst staff.

I provide external supervision to client supervisees and I am responsible for the education, management, management supervision and clinical supervision (Yegdich, 1999) of staff who range from twenty to thirty four years of age. Five staff are new to working with clients. Practitioners’ educational backgrounds range from a minimum of two years tertiary training towards a health profession (including general practice, physiotherapy, chiropractic and nursing) to a Masters degree in dance. Alongside their work for HIH, six of the team members are engaged in part or full time study, one works solely for HIH and the last works as a performer on a short-term contract basis.

In sum, the needs of supervisees at HIH are numerous and varied. To meet these needs HIH is developing an approach to supervision and an organisational culture that emphasises learning, reflection and self-transformation (Carroll, 2009; Davys & Beddoe, 2010; Gilbert, 2001; Hawkins & Shohet, 2006; Littrell, Lee-Borden & Lorenz, 1979; Maslow, 1954; Owen, 2008; Smythe, MacCulloch & Charmley, 2009; Zorga, 2002) to ensure that supervision will be developmentally appropriate (Carroll, 2009; Theriault & Gazzola, 2006) and able to play a positive role in bridging the gaps between the different disciplinary backgrounds of HIH practitioners. A thorough examination of these cultural issues falls outside the scope of the present essay.

I am cognizant of the potential for conflict that the multiple roles I perform at HIH could engender and the impact this could have on supervision. I use Carroll’s (2009) five key questions for practitioners and five key administrative considerations to assess the implications of the multiple relationships involved to ensure they are conducted with integrity. In section five I argue that, in the present context, the advantages of management and supervision being conducted internally outweigh the disadvantages. To ensure that management issues do not eclipse clinical supervision I use different times and office settings to demarcate managerial from clinical sessions.

Reporting on Scandinavian practices, Zorga (2002) claims that separating management and clinical supervision protects the clinical supervision space by reducing the presence of performance assessment. When HIH is able to resource these functions separately they will be provided by different individuals. HIH will look closely at: the supervisor’s level of emotional competence, their ability to create a safe environment, to assess supervisees accurately, to educate supervisees, ensure positive results for clients, and to provide a positive role model (Morrison, 2001). Currently this is an example of the needs of supervision being in conflict with the resources available to the organisation (Davys & Beddoe, 2010; Hawkins & Shohet, 2006).

**2. Supervision: It’s Purpose and Functions**

Supervision is neither therapy nor training yet it utilises the insights gained in both (Shipton, 2000) and so exists in a dynamic tension with both. Predominantly supervision occurs between an individual supervisor and supervisee where the supervisor is either a more experienced practitioner in the supervisees’ field or a trained supervisor. Other forms of supervision include: group supervision, peer and peer-group supervision (Gomersall, 2000), self-supervision (Casement, 1985; Gilbert, 2001; Langs, 1980; Littrell et al, 1979) and in some settings, individual and group conferences and the supervision of case studies (Yegdich, 1999). Quality supervision is generally formal and planned. Ad hoc and informal supervision is occasionally appropriate but can lead to poor quality supervision (Morrison, 2001). If it predominates this can suggest the presence of a culture of crisis (Hawkins & Shohet, 2006).

The main purpose of supervision is to ensure the safety of clients by meeting the needs of the supervisee. Supervision needs to be developmentally appropriate and culturally sensitive (Carroll, 2009; Magnuson, Wilcoxon & Norem, 2000). Key to supervision is the supervisory relationship (Ferguson, 2005; Hunt, 1986; Kaiser, 1992), which can be short or long term. If a supervisee has a need that cannot be met by their present supervisor they may choose to engage another supervisor with the relevant expertise (Butterfield, 2001). Regardless of the duration the ‘ground rules’ of the supervisory alliance need to be clearly and ideally collaboratively developed and recorded in a written contract (Gard & Lewis, 2008; Omand 2010; Van Ooijen, 2003). As part of the new client intake process at HIH I establish a written contract with all external supervisees through a process of mutual negotiation. New staff are introduced to supervision at the job interview stage and their supervision contract is negotiated alongside their job contract. This ensures that the organisational mandate for supervision is clear from the outset and reinforces supervision as a high-profile symbol (Hawkins & Shohet, 2006).

Numerous factors motivate the inclusion of supervision within organisations. The manner in which supervision is positioned within an organisation has a significant impact on how that supervision is conducted. Some organisations are responsible for ensuring that their practitioners’ meet the standards set by professional bodies. As the health professions become increasingly litigious environments maintaining standards of practice, managing risk and responding responsibly to employee stress become principal imperatives (Beddoe, 2011; Morrison, 2001). At HIH the main reasons include: retaining skilled staff and developing the existing workforce, managing change, extending existing roles, particularly with young practitioners, promoting self and team assessment and enhancing job satisfaction.

Internal or external clinical supervision concerns a practitioner’s development and can be used to ensure supervisees have a supportive and empowering environment (Yegdich, 1999). HIH claims to offer an empowering and educational experience to clients. The organisation aims to do the same for staff by providing internal supervision that is reflective, self-transformational and promotes life-long learning (Carroll, 2009; Davys & Beddoe, 2010; Gilbert, 2001; Hawkins & Shohet, 2006; Owen, 2008, Smythe, MacCulloch & Charmley, 2009; Zorga, 2002).

One purpose of management supervision is to monitor the supervisee’s workload and ensure that the supervisee is meeting the standards and objectives of the organisation. Finally, an important purpose of supervision is to ensure communication between supervisees and their organisation. While HIH is undergoing rapid growth this purpose will be a strong incentive for the inclusion of supervision.

The functions of supervision reflect the purposes of supervision. Davys & Beddoe (2010) provide a thorough review of contemporary models for supervision and identify four principal functions. Firstly, the normative or managerial function, which is concerned with ensuring supervisees are competent and accountable for their practice. Secondly, the developmental or formative function which enables the supervisee in their continuing professional development. Thirdly, the supportive or restorative function that addresses workplace stress and fatigue and guards against vicarious traumatisation. Lastly, Morrison’s (2001) mediation function, the purpose of which is keep the supervisee engaged with the organisation.

Mediation can involve the supervisor in advocating on behalf of the supervisee or supporting a supervisee to express their needs directly to management. My experience as an internal and external supervisor has demonstrated how necessary all four functions are to a healthy supervision relationship. As manager and supervisor in a young organisation I see how critical to the success of the organisation and the health and satisfaction of supervisees the mediation function is. For this reason, and its strong applicability to a health setting, Morrison’s (2001) model of the functions of supervision is the most appropriate for HIH.

**3. Organisational culture**

The lotus is a symbol for pure love. When the heart opens fully to unconditional love the experience resembles the flowering of an infinite lotus. The HIH logo is a representation of this experience. This artefact represents a core value of the organisation (Hawkins & Shohet, 2006). Providing supervision that embraces unconditional love is a key action HIH takes to ensure that this core value is not just ‘said’ but also ‘done’.

To avoid becoming a culture of ‘personal pathology’ (Hawkins & Shohet, 2006) I ensure that the boundaries between supervision, counselling and management are kept clear. Business systems are thorough and applied consistently so that no one individual can be used as a scapegoat. In supervision, I model (Carroll, 2009; Gray, 2007) health and positive solution centred initiatives rather than problem centred approaches (Hawkins & Shohet, 2006). I encourage my supervisees to use the same approach with clients.

HIH has a no-tolerance policy towards competitive behaviour. I keep very clear boundaries around all of my roles to ensure that my actions cannot be interpreted as favouritism. Wherever possible my decision-making processes are public to staff, transparent and consultative so that staff do not experience ‘surprises’ or feel they need to ‘watch their back’ (Hawkins & Shohet, 2006).

Recently a new staff member began to demonstrate a pattern of producing crises. At first I was supportive. When I identified the pattern, however, I refused to rescue or be labelled as the persecutor and instead began bringing her attention to her response-abilities in each crisis situation. In supervision with this staff member I modelled crisis avoidance behaviours. In my interactions with other staff, managerial and supervisory, I remained alert to any crisis behaviours so that HIH would not develop a ‘crisis culture’ (Hawkins & Shohet, 2006). All staff now function more proactively. This experience taught me not to ignore the potential impact of personal behaviour patterns on an organisation. When a personal behaviour is brought into the workplace it can have a significant impact on the culture of the organisation. The individual that needs to be most proactive in this awareness is the boss. I have recently been geographically displaced and consequently spent considerable time in my own life ‘fire fighting’. I need to be very careful not to let this transfer into my behaviour at work. I am remaining alert to any potential parallel processes between myself and my staff, my life and my work.

There are points in the development of a young business where workloads can become unsustainably high. If the organisation is to prosper these phases must be effectively managed. Due acknowledgement for exceptional effort must not become favouritism or reinforce work addiction. To avoid HIH developing an ‘addictive culture’ (Hawkins & Shohet, 2006) I visibly invest (Gard & Lewis, 2008) in my own self-care and place clear boundaries around my work. I discourage staff from overworking by showing that such ‘heroism’ generally leads to a lower quality of service to clients.

**4. The Role of Supervision in Managing Rapid Growth**

Hughes & Pengelly (1997) state: “times of rapid change require ‘relatively more open systems’ to respond to ‘more turbulent environments’; roles, structures and procedures need to be more fluid. The task of managers in maintaining a workable balance between firmness and flexibility of boundaries is thus even more vital” (p.20). HIH is experiencing a phase of rapid growth. Over the last twelve months there has been one new staff member appointed every two months and two hundred and sixty new clients introduced to the practice.

Initially administration and reception services were licensed from an existing practice. As HIH grew this arrangement led to tensions that precipitated a move of office. It was becoming increasing difficult to maintain a firm boundary between HIH and outside organisations generally (Hughes & Pengelly 1997) and as conflicts over resources increased examining our ‘inside space’ became unreasonably difficult. Implementing decisions made at HIH staff meetings was delayed because actions needed to be vetted by a second party. I was also becoming a bottleneck in the decision making process. Further, decisions involving both HIH and the other practice began to occur in a space that was effectively external to HIH team members. From the team members’ perspective policy and decision-making processes appeared predominantly top-down. Not only was this not sustainable for everyday issues it was also inconsistent with the emphasis HIH places on teamwork and bottom-up and sideways contributions to change.

As Hughes & Pengelly (1997) comment, in an environment of rapid change it is very tempting for an organisation to adopt a ‘top down’ management model. Top down models appear deceptively efficient requiring apparently minimal communication time and resources to implement. My past experience of managing health practitioners suggests that maintaining staff communication over issues of policy and decision-making is crucial to maximising client satisfaction and minimising levels of practitioner fatigue, compassion fatigue and vicarous traumatisation (Etherington, 2009; Meyer & Ponton 2006).

Despite potential disadvantages, in this case, the close alliance, both practically and theoretically, between the management, management supervision and clinical supervision functions within HIH proved prudent. Had these not been well integrated the issues discussed above would have taken longer to identify and address. As manager and sole supervisor I was able to respond immediately to the conflicts that practitioners related in supervision and at staff meetings. Further, in continuing my own professional development, I was able to apprehend the necessary concepts to interpret the situation and learn from it.

In future, daily activities will be kept under the direct control of the HIH team. I have also made a commitment to the team to ensure that the theoretical alliance and strong communication between the three business functions are maintained, regardless of how these functions are staffed. I am an external supervisor by profession and have often argued for the benefits of external supervision. This experience has brought to my attention the need for external supervisors to mediate with the management of the organisations from which their supervisees originate (Ferguson, 2005).

**5. Professional and Organisational Mandate for Supervision at HIH**

The NZAC Supervision Policy (NZAC, 2008) outlines: the role of supervision in ensuring the professional accountability of counsellors, the process of contracting between supervisor and supervisee, the qualities of the supervisory relationship, the purpose of supervision, the quality of reflection appropriate to supervisory sessions, the regularity, frequency and duration of supervision sessions, the necessary boundaries to the supervisory relationship and the fact that supervision should reflect the developmental needs of the supervisee. This policy is further supported by section nine of the NZAC Code of Ethics (NZAC, 2012) which reiterates much of the above and adds the expectation that supervisees prepare for supervision, that supervision contribute to ensuring ethical and culturally sound practice and that supervision should be sought from a qualified NZAC member, or member of another professional body with an ethical code acceptable to the NZAC. The NZAC also provides criteria for the accreditation of supervisors (NZAC, 2012).

With respect to counselling and supervision HIH is committed to applying the NZAC’s supervision policies and ethical code. The challenge HIH faces is promoting these requirements consistently given that the HIH team includes practitioners of modalities that do not have the choice of professional membership. Member practitioners assume that all practice will be governed by an ethical code, supervision policy, personal and professional development criteria and standards of practice. Where there is no professional affiliation available, however, it falls on the organisation to maintain these standards of practice. Supervisors are often responsible for ensuring supervisees understand their roles, responsibilities and accountabilities (Morrison, 2001). In order to ensure that consistent standards of practice are maintained at HIH I have decided to create a supervision policy, code of ethics, guidelines for personal and professional development and standards of practice that will apply to all HIH staff.

The HIH ethical code will be informed by the work of Francisco Varela (1991, 1992, 1999). Varela’s (1992) work on ethics has its basis in Mahayana Buddhism. Varela’s work also provides a powerful account of the relationship between cognition, the generation of experience through action and the development of wisdom (Varela, 1991). His approach to ethics clearly articulates how, in a practical setting, “know what” can become “know how” and how this process can inform the ethics of conduct and the development of wisdom.

One branch of the Mahayana tradition, Prasangika-Madhyamika, provides a sophisticated understanding of human suffering (Pitkin, 2001). Creating a closely aligned approach to cognition, experience, human suffering, ethics, creativity, self-transformation and the development of wisdom, will, I believe, be of considerable value to all HIH participants. Whether it will be possible to integrate these ideas into a code of ethics that also remains consistent with that of the NZAC is a challenge to be met.

The following scenario demonstrates why consistency across all practitioners is necessary. Member practitioners abide by the ethical guideline that a practitioner should refer a client to another practitioner if they recognise that the client’s needs fall outside of their expertise. Non-member practitioners are often not familiar with this practice. In recent staff supervision sessions it became clear that the differences in expectations between member and non-member practitioners, in this instance, were leading to a sense of competition and conflict between staff. Those who refer did not feel that other team members were reciprocating or practicing ethically. This conflict demonstrated the need for HIH to incorporate conflict resolution strategies into the organisations culture; specifically an approach that could be used consistently by management, supervisors, practitioners and in client relations and was premised on a keen awareness of the need to respect difference (Pepper, 1996).

The onus to resolve conflict often falls on the shoulders of the manager and needs to be taken up in management supervision (Mueller & Kell, 1972). To date the best approach I have been able to identify is Marshall Rosenburg’s (Rosenburg, 2003) non-violent communication. In future, all HIH staff will be taught this approach as part of their induction process and it will be incorporated into training for existing staff. I will develop a disciplinary code and disciplinary procedures that will reflect Rosenburg’s approach. Addressing the issue of conflict within HIH revealed one of my learning edges: the ability to tolerate conflict rather than immediately need to fix it. I need to realise that conflict can be productive when it highlights beliefs that need to be addressed and actions that need to be taken.

For a supervision policy to be effective it needs contain clear definitions of the purposes and functions of supervision and guidelines on how to participate in supervision. In future, staff will be given a copy of the HIH supervision policy and the first chapter of Morrison’s (2001) book as part of their induction process and this material will be discussed at staff meetings. It is vitally important that staff see that their input to supervision is respected and responded to. Supervisees will be given an opportunity to provide feedback on the HIH supervision policy and the policy will be adapted to reflect this input.

**Conclusion**

At HIH the role of supervision is considered when developing new positions, changing existing positions, advertising and interviewing for and appointing new staff. Staff contracts make attending supervision a requirement and supervisor’s reports are integrated with general staff appraisal processes. HIH ensures staff have enough time and space to prepare for and attend supervision. Interruptions to supervision sessions are not tolerated. Supervisees enter into a formal supervision contract; both parties record attendance at supervision and the supervisor keeps a record of issues discussed.

To ensure that supervisors remain competent HIH supports their training. Supervisors are required to undergo self-assessment and attend supervision. They are responsible for ensuring that all the functions of supervision are attended to in a balanced manner and in accordance with the developmental level of the supervisee. The HIH supervision policy will outline how supervision will support supervisees to meet the expected standards of practice, and abide by the equal opportunities policy and policy against discrimination.

By these means HIH protects the practice of supervision. Equally supervision serves HIH by ensuring that staff meet the organisation’s goals. Throughout this essay I have discussed how the culture and activities of HIH shape the practice of supervision and how supervision has shaped HIH. I would suggest that this reciprocal relationship functions best when supervision is thoroughly integrated into the organisation and the functions of supervision are, similarly, integrated into the functions of the organisation.

**References**

Australasian Integrative Medicine Association (AIMA, 2012). *Homepage*. Retrieved from https://www.aima.net.au/

Beddoe, L. (2011). External Supervision in social work: Power, space, risk, and the search for safety. *Australian Social Work*, 65(2), June 2012, 197-213

Carroll, M. (2009). Supervision: Critical reflection of transformational learning, Part 1. *The clinical supervisor*, (28), 210-220

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

Davys, A & Beddoe, L. (2010). *Best practice in professional supervision: A guide for the helping professions.* London: Jessica Kingsley

Etherington, K. (2009), Supervising helpers who work with the trauma of sexual abuse. *British journal of guidance and counselling,* 37(3), 179-194

Ferguson, K. (2005). Professional supervision. In M. Rose and D.Best (Eds.), *Transforming practice through clinical education, professional supervision and mentoring* (pp.293-307). Edinburgh: Elsevier Churchill Livingstone.

Gard, D. E., & Lewis, J. M. (2008). Building the supervisory alliance with beginning therapists. *The clinical supervisor,* 27(1), 39-60. Haworth Press

Gray, D. E., (2007). Towards a systematic model of coaching supervision: Some lessons from psychotherapeutic and counselling models. *Australian psychologist*, 42(4), 300-309

Gilbert, T. (2001). Reflective practice and clinical supervision: meticulous rituals of the confessional. *Journal of advanced nursing* 36(2), 199-205

Gomersall, J. (2000). Peer group supervision, in G. Shipton (ed.) *Supervision of psychotherapy and counselling: Making a place to think.* Buckingham: Open University Press

Hawkins, P., & Shohet, R. (2006) *Supervision in the helping professions*. 3rd ed. Berkshire: Open University Press

Hunt, P. (1986). Supervision. *Marriage guidance* (Spring) 15-22

Kaiser, T. (1992). The supervisory relationship: An identification of the primary elements in the relationship and an application of two theories of ethical relationships. *Journal of marital and family therapy* 18(3)283-296

Langs, R. (1980). Supervision and the bipersonal field, in A.K. Hess (ed.) *Psychotherapy supervision: Theory, research and practice.* New York: John Wiley and Sons, Inc.

Littrell, J. M., Lee-Borden, N., Lorenz, J. R. (1979). A developmental framework for counselling supervision. *Counsellor education and supervision,* 19(2): 129-136

Magnuson, S., Wilcoxon, S.A., Norem, K. (2000). A profile of lousy supervision: Experienced counsellors’ perspectives. *Counsellor education and supervision*, 39(3), 189-202

Maslow, A. (1954). *Motivation and personality*. New York: Harper and Row

Meyer, D., & Ponton, R. (2006). The healthy tree: A metaphorical perspective of counsellor well-being. *Journal of mental health counselling*, 28(3), 189-201

Ministry of Health. (2003). *Health Practitioners Competence Assurance Act 2003.* Retrieved from http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act

Morrison, T. (2001). *Staff supervision in social care: Making a real difference for staff and service users* (2nd ed.). Brighton: Pavillion.

Mueller, W. J., Kell, B. L. (1972). *Coping with conflict: Supervising counselors and psychotherapists.* New Jersey: Prentice Hall

New Zealand Association of Counsellors. (2008). *Professional supervision of counsellors for the purposes of membership of NZAC*. Retrieved from http://www.nzac.org.nz/viewobj.cfm/supervision%5Fpolicy%2Epdf?file\_name=supervision\_policy.pdf&objID=2

New Zealand Association of Counsellors. (2012). *Code of ethics*. Retrieved from http://www.nzac.org.nz/viewobj.cfm/nzac%5Fcode%5Fof%5Fethics%5Fjuly%5F2012%2Epdf?file\_name=nzac\_code\_of\_ethics\_july\_2012.pdf&objID=27&f=true

New Zealand Association of Counsellors. (2012). *Supervisor accreditation criteria*. Retrieved from http://www.nzac.org.nz/accredited\_supervisors.cfm

Owen, D., (2008). The ‘ah ha’ moment: Passionate supervision as a tool for transformation and metamorphosis. In Shohet, R. *Passionate supervision* (pp.50-69). Jessica Kingsley Publishers: London

Omand, L., (2010). What makes for good supervision and whose responsibility is it anyway? *Psychodynamic practice,* 16(4), 377-392

Pepper, N. G, (1996). Supervision: A positive learning experience or an anxiety provoking exercise. *Australian social work*, 49(3), 55-64

Pitkin, A. (2001). Scandalous ethics: Infinite presence with suffering. *Journal of consciousness studies* 8 (5-7):231-46.

Rosenburg, M. B. (2003). *Nonviolent communication: A language of life.* Encinitus: Puddle Dancer Press

Shipton, G. (2000). The place of supervision, in G. Shipton (ed.) *Supervision of psychotherapy and counselling: Making a place to think.* Buckingham: Open University Press

Smythe, E.A., MacCulloch, T., & Charmley, R. (2009). Professional supervision: Trusting the wisdom that ‘comes’. Journal of guidance and counselling, 37(1), 17-25

Stoltenberg, C. A. (2005). Enhancing professional competence through developmental approaches to supervision. *American psychologist*,November, 857-864

Theriault, A. and Gazzola, N. (2006). What are the sources of feelings of incompetence in experienced therapists? *Counselling psychology quarterely*, 19(4), 313-330

Van Ooijen, E. (2003). *Clinical supervision made easy: the 3-step method.* UK, Churchill Livingstone.

Varela, F. J., & Shear, J. (1999) (eds). *The view from within: First-person approaches to the study of consciousness*. Thorverton: Imprint Academic.

Varela, F. J., (1992). *Ethical know-how: Action, wisdom and cognition*. Stanford: Stanford University Press.

Varela, F. J., Thompson, E., & Rosch, E. (1991). *The embodied mind: Cognitive science and human experience*. Cambridge, Massachusetts: The MIT Press.

Yegdick, T. (1999). Clinical supervision and managerial supervision: Some historical and conceptual considerations, *Journal of Advanced Nursing*, 30(5), 1195-1204

Yoga Aotearoa International Yoga Teachers Association. (2012). *Homepage*.Retrieved from http://www.iyta.org.nz/

Zorga, S. (2002). Supervision: the process of life-long learning in social and educational professions. *Journal of interprofessional care.*16(3), 265-276