3RD EDITION

# Supervision in Clinical Practice

## A Practitioner's Guide

JOYCE SCAIFE

ROUTLEDGE

*There is a vast difference between a supervision session characterised by all that Joyce Scaife advocates and a session where these crucial essentials are missing and are not being addressed. I suspect that many psychologists literally have no idea what they are missing.*

– **Dr Michael Pomerantz**, former senior educational psychologist in Derbyshire and trainer of educational psychologists on the Sheffield University Doctoral Programme

*For a thorough, detailed and accessible book on supervision, clinical practitioners need look no further. The third edition of this book is up-to-date, grounded in relevant theory and brought alive through personal insights and experiences. It offers not just the 'what' but also the 'how' in terms of delivering high quality clinical supervision.*

– **Dr Jan Hughes**, Joint Programme Director, Clinical Psychology Training Programme; Visiting Associate Professor, Leeds Institute of Health Sciences, University of Leeds, UK

# Supervision in Clinical Practice

This fully updated edition of *Supervision in Clinical Practice: A Practitioner's Guide* is packed with practical examples from personal and professional experience. Since the publication of the first two editions, health and social care organisations have become increasingly risk averse, resources more strained, and moves have been made towards stifling levels of clinical governance. In this edition Joyce Scaife counters the idea of supervision as a constraint and challenges some of the thinking associated with 'evidence-based' practice when this focuses on what can be easily measured rather than what matters.

Joyce Scaife explores frequently encountered dilemmas including the following:

- How can supervisors facilitate learning?
- What are the ethical bases of supervision?
- What helps to create and maintain an effective working alliance?
- How can supervisors balance management and supervision roles?
- How can supervisors work equitably in an increasingly diverse and pluralistic world?

*Supervision in Clinical Practice* remains an indispensable text for supervisors and supervisees who practice clinically in a range of professions, including applied psychology, counselling, psychotherapy, psychiatry, nursing and social work.

**Joyce Scaife**, former Director of Clinical Practice for the Doctor of Clinical Psychology training course at the University of Sheffield, is a clinical psychologist with a career-long interest in supervision.

# Supervision in Clinical Practice

## A Practitioner's Guide

3rd Edition

Joyce Scaife

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# Contributor

**Jon Scaife** teaches in the School of Education at the University of Sheffield. His main research interest is the development of radical constructivist accounts of learning and their implications for teaching and assessment.

# Preface to third edition

I confess to having a weakness for the Bear of Little Brain and the characters that occupy his world. In *The House at Pooh Corner*, Pooh made a pertinent observation about what happens when something inside your head gets outside. What seems very 'Thingish' inside can appear to be quite different when it is released into the world and subject to the scrutiny of others. And this is one of the opportunities that supervision provides.

Since the previous editions of this book have been published, I have become less certain about how to 'do' supervision than I used to be. This could be beneficial or a hindrance to my supervision practice. In the context of this uncertainty I retain some convictions that influence how I understand and enact the roles and tasks of supervision either as supervisee or supervisor which I want to state at the outset so as to orient the reader to my current perspectives.

I continue to believe that supervision in different contexts and settings is much more similar than it is different. In my experience, there is always a need to engage with more than rational matters, to respond (even if this is to minimise them on occasion) to feelings. Whatever the context, supervisees are in all cases opening up their work and their committed behaviours, performance, practice, writing, thinking and feelings to scrutiny by another. Judgements will be made, usually by a person with greater experience and often in the context of a formal power relationship. The supervisor is handling supervisees' education and development but also their vulnerability, needs, hopes and desires. Supervisees will bring (explicitly or not) their varying degrees of distress: my intervention went wrong, one of my clients died today, I don't know how to write my report; and their joys. For this reason, the central task of supervision is the creation of a trusting relationship in which I can get my thinking and feelings about Things into the open so that I can explore them from different angles with the help of a collaborative partner.

My views have not changed regarding the following:

- The most common supervisory need that I have encountered is for people to develop greater confidence in their work.
- Learners need to feel safe enough within the supervisory relationship to acknowledge their vulnerabilities and anxieties. Rather than seeking to avoid anxiety, supervision best works when it supports learners in facing their anxieties.

- Supervisors can have greater confidence in their own work if it has been seen.
- However it might appear at times, people are generally doing their best at work.
- Supervision is an entitlement that safeguards clients and workers.
- Supervisors need to be able to exercise the authority vested in the role.
- The tasks of supervision are best accomplished when both/all parties take responsibility for the outcomes.

## Feeling valued

In my professional lifetime, health and social care organisations seem to have become increasingly risk averse, resources more strained, and moves have been made towards stifling levels of managerial control so that someone can be held responsible when things go wrong, as if radical overseeing and rigid protocols can prevent errors. This contrasts with the ethos of successful private companies such as Google where lateral and creative thinking, flexibility and support for new ways of doing things are encouraged. Staff are regarded and treated as a valuable resource that needs to be nourished. I believe that if staff feel valued at work, then they in turn will appreciate their patients and clients, responding to them as individuals with respect, care and concern. Minding about people seems to me more likely to generate outstanding practice than any number of rules and regulations. I regard supervision as being primarily about the well-being and health of staff and thereby the quality of care that they are able to provide.

## Diversity

I struggle to keep up with the changing landscape of the increasingly pluralistic cultural histories and individual identities of the people with whom I live and work. I am increasingly uncertain about whether I am using the appropriate language or meeting others' implicit assumptions about the nature of the supervisory relationship. For this reason, although I have decided to retain a specific chapter addressed to issues of diversity, I have also attempted to incorporate consideration of the issues and concerns of members of minority cultures throughout the text. I am grateful for the learning that has emerged from conversations with family, friends and colleagues who have greater experience than me, and appreciate the time and patience that they have shown in helping me to understand how and why my old ways of doing things may no longer fit.

## Use of language

The terminology by which we express the professional relationship between the helper and helped both expresses and is capable of constraining or shaping the relationship. I like the thinking that has to go into choosing specific vocabulary since this can bring to the fore my beliefs and values about the relationship in question. I prefer the words and will use 'client' and 'patient' to describe the

person who is seeking assistance since clients and patients (for the most part) can vote with their feet and change their consultant should they wish. The problem with trying to find words that deny the 'them and us' aspect of such relationships is that they risk sounding convoluted and clumsy and continue to imply a status differential.

## The place of evidence

Evidence-based practice is a mantra that has come, during my professional lifetime, to dominate what can and cannot be offered to people who need help from health and social care services. By no means do I deny the value of evidence, but I prefer the view that it relies on the 'integration of best research evidence with clinical expertise and patient values' (Centre for Evidence-Based Medicine, Toronto, 2000–2017).

These elements of evidence-based practice are defined as follows:

- by best research evidence, we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative and preventive regimens. New evidence from clinical research both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.
- by clinical expertise, we mean the ability to use our clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, their individual risks and benefits of potential interventions, and their personal values and expectations.
- by patient values, we mean the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient.

  When these three elements are integrated, clinicians and patients form a diagnostic and therapeutic alliance which optimizes clinical outcomes and quality of life.

  (Centre for Evidence-Based Medicine, Toronto, 2000–2017: no page numbers)

For me this encapsulates what I want from the services that I access. When I am the patient, I can sit at home, do my own research and evaluate a service for myself. I can read books, watch recordings, join online groups. I have thought about what I think I know and how I feel. In my view this personal expertise needs room for expression in relationships both between practitioners and the people who seek their services, and between supervisors and supervisees.

## Group supervision

In earlier editions of this book I invited Brigid Proctor and Francesca Inskipp to write a chapter on group supervision, acknowledging their enormous experience and skills in running supervision groups. In the intervening period, Brigid has published *Group Supervision* which is a comprehensive text to which I direct the reader who is interested in issues related to successful supervision in groups. For want of space, the topic of group supervision has therefore been omitted from this edition.

## Worldviews

I have increasingly begun to question the possibility of knowing 'reality'. When I find myself at odds with another person, we sometimes seem to occupy different worlds. As a therapist and supervisor I may have one idea of what transpired in a session whilst the client or supervisee takes something completely different and may even return it to me in the next session as some advice that I ostensibly gave without any awareness or intention. So in this text I am not offering a book of knowledge but a tale of my own experiences. I hope you can take something from it that will help you to do your job better.

# Acknowledgements

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Chapter 1

# Supervision

## Is it worth it?

Most every decision approached with care
Prompts doubt or delay. But we wear
Rose-tinted glass when life is peaking
And if, retrospectively speaking,
Effort brings progress, strength or mirth,
Why dwell unduly on questions of worth?
(Hannah Scaife, 2018)

Before going further and exploring the subject of supervision, it struck me that right at the outset there are some fundamental questions to address in deciding whether or not to expend effort on reading and learning about it, such as these:

Is it worth doing?
Is it worth training to do it?
Is it worth organisations introducing/supporting it?

I have concluded that the literature does not provide easy and straightforward answers to these questions although my own perspective is that supervision is essential to my practice and well worth the effort necessary to do it well both as a supervisor and supervisee. I may not be able to convince you of this but want to highlight the issues that I think are worthy of consideration in exploring answers to these questions.

### Is it worth doing?

When I first became a psychologist, I was taught to be a scientist practitioner and that my approach to the work needed to be founded in sound scientific research and findings. A scientific approach involved carrying out research in which I made attempts to control extraneous factors in order to explore the relationship between the dependent and independent variables in which I was interested. In my clinical work, the randomised controlled trial (RCT) was the gold standard for deciding whether evidence was valid and reliable. The scientific paradigm continues to exert a major influence on the practice of psychology and could be seen as

underpinning movements advocating evidence-based practice, demonstration of competencies and 'what works for whom' (Roth and Fonagy, 1996).

Over time, as a result of my practice and wider life experiences, I have come to be sceptical about this approach in so far as it is able to encompass and account for all of my experiences. Some of my colleagues appear to have had similar thoughts since the skills now required for qualification as a clinical psychologist emphasise the importance of the reflective practitioner as well as the scientist-practitioner. I tried to express this in a 'soapbox' article about the meaning and place of evidence in considering the process of supervision (Scaife, 2012). Extracts are reproduced here:

> The Mexican Sierra has "XVII-15-IX" spines in the dorsal fin. These can easily be counted, but if the sierra strikes hard on the line so that our hands are burned, if the fish sounds and nearly escapes and finally comes in over the rail, his colors pulsing and his tail beating the air, a whole new relational externality has come into being – an entity which is more than the sum of the fish plus the fisherman. The only way to count the spines of the sierra unaffected by this second relational reality is to sit in a laboratory, open an evil-smelling jar, remove a stiff colorless fish from the formalin solution, count the spines and write the truth. . . . There you have recorded a reality that cannot be assailed – probably the least important reality concerning the fish or yourself.
>
> > It is good to know what you are doing. The man with this pickled fish has set down one truth and recorded in his experience many lies. The fish is not that color, that texture, that dead, nor does he smell that way. . . . The man with his pickled fish has sacrificed a great observation about himself, the fish and the focal point, which is his thought on both the sierra and himself.
> >
> > (Steinbeck, 2000: 2)

Although I am not a fisher, I am in sympathy with John Steinbeck in his preference for the experience of the live creature, in my case as an avid snorkeller. And as a clinician and supervisor, there is much about practice which I find does not lend itself to the counting spines approach. This is because I experience my work as a relational process in which I aspire to be fully engaged both personally and professionally with other live creatures, which does not always seem to map well onto the ubiquitous mantra of 'evidence-based' practice. I want to use my soapbox to offer a challenge to the notion of 'evidence' as it often seems to be portrayed in my discipline.

I sometimes find myself in situations at work where I am unsure of what I am doing or taking actions which do not appear in a treatment manual, especially when I am under my desk with a child shooting aliens or walking round the town centre talking to a teenager who is unable to sit still long enough otherwise to bear to talk about his feelings. Donald Schön (1987) said:

> In the varied topography of professional practice, there is a high hard ground overlooking a swamp. On the high ground, manageable problems

> lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lie the problems of greatest human concern. The practitioner must choose. Shall he remain on the high ground where he can solve relatively unimportant problems according to prevailing standards of rigor, or shall he descend to the swamp of important problems and nonrigourous inquiry?
>
> (Schön, 1987: 3)

I am reassured by the writing of authors such as Michael Mahoney who describes working with a man who had been struggling with chronic and intense depression. The sessions were invariably difficult and draining and on this occasion he seemed even more despondent than usual:

> "How are you, John?" I asked.
>
> Almost a minute went by before he responded, "I am getting worse," he whispered.
>
> I waited for him to elaborate, but there was only silence. (Meanwhile, inside me, there were the voices of my very human self saying, "Oh, God! Why me? Why tonight? He is my last client. I just want to go home.") Finally, to break the silence and foster some movement, I said, "How so?"
>
> He was silent for perhaps half a minute, and then he said, "I used to be depressed. [long pause] Now I can't feel anything. . . ." His words and voice died off in weakness as he uttered this.
>
> Quietly, unconsciously assuming his voice tone, I said, "*Nothing?*" (Inside me the voices continued, "Damn! This is going to be a long hour!")
>
> [short pause] "Nothing."
>
> We continued in silence for several minutes. Finally, without looking up he said, "You don't say anything . . . just like my analyst."
>
> Perhaps his words struck an old sensitivity. I don't know. But I heard myself say, "John, would you mind standing up?" When I heard myself voicing these words, my immediate internal reaction was one of panic ("Michael, what the hell are you doing? Where are you going with this?").
>
> John looked at me for the first time in the session. His puzzlement was obvious as he said, "What? . . . What did you say?"
>
> Almost mechanically, I repeated, "Would you mind standing up?" Again, my insides echoed disbelief. ("Jesus Christ, Michael! What are you going to do if he *does* stand up? What are you going to do if he *doesn't?*")
>
> (Mahoney, 2003: 183)

John finally did stand up and asked, "Now what?" Michael Mahoney said to him sheepishly, "I don't know." The client became angry. His voice became stronger as he made critical comments. 'His face was alive with contempt.'

Mahoney suddenly said, "John, are you *still* not feeling anything?" The client's face went from ashen to red and his mouth fell open. He said, "You son of a bitch! You tricked me!" thinking that his therapist's actions had been planned.

For me, this extract illustrates Donald Schön's murky swamp of professional practice and the value, importance even, of spontaneity and clinical experience in the difficult work that we do because the materials we work with are our fellow human beings. I don't think that Michael Mahoney's intervention would, by most accounts, conform to the requirements for evidence-based practice but some definitions do encompass clinical experience and intuition as falling under its umbrella. I think this is often overlooked. 'Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values' (University of Toronto Libraries, 2000). Clinical expertise and patient values often seem to be missing. In addition, I believe that practitioners' assumptions, beliefs and values determine how they judge the evidence from these sources and so the personal qualities, thinking and reflecting skills that they bring also need to be included in the equation of effective clinical practice. The challenge of including such factors within an evidence- and competency-based approach has been acknowledged (Falender, 2014a). Many professions, including clinical psychology, have moved towards encompassing this perspective by acknowledging the importance of reflective practice in addition to scientific practice (British Psychological Society, 2017; Practice Guidelines).

John Steinbeck concluded that the two kinds of 'truth' (derived from the experience of the pickled fish and from the pulsing being on the end of a line) could be complementary and that neither need detract from the evidence provided by the other. Jan Horwath (2007) distinguishes between technical-rational activity which emphasises traditional views of knowledge, standard procedures and empirical research, and personal-moral activity, which recognises that individuals do not fit neatly into boxes and that personal and professional values and beliefs influence judgements. My concern is that the evidence-based mantra of professional practice appears to privilege the technical-rational over the personal-moral to the potential detriment of the accomplishments that our discipline is capable of helping people to achieve. Peter Cropper of the Lindsay String Quartet argued that technique is useful (essential even) to the extent that it opens up the possibility for creativity. What I want from my therapist and from my supervisor is someone who is involved with me and who minds about what happens to me. I want to work with someone who thinks about what they are doing and uses their experiences to reflect upon and develop their practice. I do not want to work with a technician, but rather with someone who is happy to wade with me in the murky swamp, making discoveries as we go, using the research literature as a map which helps me to plan but does not constrain me from taking interesting and informative detours as my intuition and experience dictate. And this means broadening the definition of evidence to include those things that do not readily lend themselves to measurement.

In writing the article I wanted to emphasise the value of what might be regarded as two different kinds of evidence in which one kind tended to be underrepresented in the debate about the efficacy or effectiveness of supervision (Lambert, 2013). The two kinds come from different underlying worldviews or paradigms: 'worldview (and the theories which are generated by it) determines what gets studied, how it gets studied, how the data gets interpreted, and what counts as valid findings' (McMillan, 2015: 16).

Worldview reflects underlying beliefs, values and foundational assumptions which determine our perspectives on life and which guide actions. It has been argued that these beliefs, 'must be accepted simply on faith,' irrespective of how well argued they may be because, 'there is no way to establish their ultimate truthfulness' (Guba and Lincoln, 1994: 107). Jon Scaife (2018) summarised the differences between three different worldviews in the following table:

*Table 1.1* Worldviews

| | *Positivism* | *Constructivism* | *Criticalism* |
|---|---|---|---|
| **Ontology** *(assumptions about the nature of Reality or reality)* | • There is a Reality 'out there', and it can be known.<br>• Laws and mechanisms govern the workings of that Reality. | • There is an underlying Reality 'out there' but its nature cannot be known.<br>• Each individual constructs their own experienced reality.<br>• Research can produce rich accounts of people's realities. | • Reality may be objective or subjective, but truth is continually contested by competing groups. |
| **Epistemology** *(assumptions about the nature of knowledge)* | • Knowledge, if carefully found, describes aspects of Reality.<br>• The researcher and the object under investigation are independent entities. This is known as an 'objectivist' view.<br>• Good research aims to reduce or eliminate | • Knowledge is constructed from each person's unique history and ways of constructing.<br>• Knowledge is a resource that we use to navigate through our life experiences.<br>• Perceptions and experiences of both the researcher and | • Power relations determine what (and whose) knowledge counts.<br>• Power is implicated in the relationship between the researcher and the researched.<br>• What can be known is inextricably intertwined |

(*Continued*)

*Table 1.1* (Continued)

| | *Positivism* | *Constructivism* | *Criticalism* |
|---|---|---|---|
| | any influence on the objects of study by the researcher.<br>• Researchers find, collect or discover data in the world. The same data is available for others to collect. | the research participants affect what is seen and conceptualised.<br>• Researchers generate or produce data from their experiences.<br>• The outcome of research is the researcher's story of the participants' stories. | with the interaction between the researcher and the researched. |
| **Methodology and methods** *(decisions the researcher needs to make about how to carry out an inquiry)* | • Hypotheses and/or questions are specified in advance and rigorously tested under controlled conditions.<br>• Main methods are more likely to be quantitative than qualitative. | • Multiple modes of inquiry are employed and synthesised in pursuit of a rich, trustworthy story.<br>• Qualitative methods are likely to be used but quantitative methods may also be used. | • A dialogic approach may be taken, with dialogue aiming to raise participants' and researcher's awareness and bring about transformation.<br>• Qualitative and quantitative methods may be used. |
| **Example of a research question, hypothesis or line of inquiry** | • Hypothesis to be scientifically tested: 'Musical training enhances children's second language learning' | • Constructivist research explores people's realities through research questions, e.g. 'What skills are needed for students to succeed in inquiry-based learning?' | • Value-rich area of inquiry and potential transformation: 'How are behavioural sanctions in primary schools used with students from different ethnic groups?' |
| **Related ideas** | • Science<br>• Scientific method<br>• Realism<br>• Behaviourism<br>• Objectivity | • Interpretivism<br>• Subjectivity<br>• Relativism<br>• Diversity<br>• Pluralism | • Ideology<br>• Critical theory<br>• Critical realism<br>• 'Race'/class/gender theory<br>• Feminist theory |

Source: Scaife, 2018

From a positivist worldview it is assumed that with very careful and controlled studies it is possible to generate absolute, universal 'true' descriptions of Reality or a 'God's-eye view'. From a constructivist worldview, it is assumed that each person creates, builds up and constructs an individual version of reality on the basis of everyday experiences. Assessing the evidence about whether supervision is 'worth it' is a very different prospect from these contrasting worldviews. Later in this chapter I will review research findings from both a constructivist and positivist worldview.

## Is it worth training to do it?

People entering a profession are generally required to demonstrate competence before being admitted to the register. Assessments are carried out by educational institutions and licensing bodies which determine whether a candidate can join the profession. Educational institutions define curricula and evaluate the adequacy of training programmes. Competence is defined by Epstein and Hundert (2002: 226) as, 'the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.' They include a wide range of skills in their definition of competence and state that: 'Competence depends upon habits of mind, including tentativeness, critical curiosity, self-awareness, and presence. Professional competence is developmental, impermanent, and context-dependent' (Epstein and Hundert, 2002: 227). Competence is expressed in 'doing'. Competencies are descriptions of the actions that, if demonstrated, would lead a person to be defined as competent within a specific domain. In other words, the former means a skill and the standard of performance reached, while the latter refers to the behaviour by which it is achieved.

Epstein and Hundert (2002: 227) go on to argue, after Polanyi, that competence is defined by tacit rather than explicit knowledge. Tacit knowledge is not conscious and relies on rules of thumb, pattern recognition and intuition. In consequence, evidence-based assessment of competence is difficult since the heuristics or protocols employed by practitioners in training tend to be replaced by shortcuts once expertise has been developed. 'Among clinicians trained in empirically supported treatments, few continued to use them 6 months to 3 years post-training' (Spence *et al*., 2001 reported in Hoge *et al*., 2014: 171).

An example in my experience would be learning to cook. At first I would stick rigidly to recipes but as my confidence developed I gave up measuring quantities, threw in whatever took my fancy and adjusted the dish as I went along according to taste. Although with such an approach there is a danger of producing something inedible, with sufficient experience such a result is unlikely since adjustments can be made along the way. Experience on its own is not regarded as sufficient for learning and competence to be achieved (Langer, 1997). Practitioners need to develop awareness of their cognitive and affective states in order to question their practice, be oriented towards ongoing learning and to identify their biases. It is

perfectly possible to pass a driving test and have all the practical skills necessary to accomplish the task, but if I am unable to control my road rage, these skills will not help to keep me and other drivers safe.

In an attempt to ensure competence, there has been a movement towards the identification and measurement of defined competencies across a range of health and social care professions. Strong arguments are made in favour of the 'competency movement' in supervision by authors such as Falender and Shafranske (2012), taking the view that it brings greater accountability to the profession. 'Competency-based training requires task analysis, frequent feedback, and assessment of progress towards the knowledge, skills, and attitudes determined necessary to perform the job' (Falender and Shafranske, 2012: 134). Carol Falender (2014b: 14) argues that the introduction of guidelines, standards and competency requirements enhances the status of clinical supervision as, 'a distinct professional activity that requires specific training and competence.' I support movements towards this end whilst being cautious about the belief that when all competencies are demonstrated, an assumption of competence can be made.

Professional competence is more than a demonstration of isolated competencies (Eraut, 1994). Epstein and Hundert give the example of a student who, 'can elicit historical data and physical findings, who can suture well, who knows the anatomy of the gallbladder and the bile ducts, and who can draw the biosynthetic pathway of bilirubin (but) may not accurately diagnose and manage a patient with symptomatic gallstones' (Epstein and Hundert, 2002: 227). These authors argue that competence cannot be determined solely by the demonstration of specific competencies. They refer to Schön's murky swamp in which problems are ambiguous and where decisions must be made with limited information. Two patients presenting with similar symptoms may require entirely different interventions based on their social and economic circumstances and previous episodes of care. The authors argue that only a few studies show associations between assessments based on competencies and actual clinical performance. These typically employ 'standardised patients' who may not be representative of the wide range of presentations in a physician's practice.

Epstein and Hundert make what I find to be a very useful distinction between 'knows', 'knows how', 'shows how' and 'does'. They relate these to clinical tasks, knowledge content including special topics such as spirituality, ethics and economics, and the context of care. In a systematic review of assessment of clinical or professional competence of medical practitioners and students, they found little attention to the 'does' level of competence. Whilst performance can be measured, competence is inferred.

However, I am not against the generation and description of competencies as a way of helping novitiates to understand what is involved in the practice of the profession and as useful adjuncts to making decisions about whether a person is ready to be certified as an independent practitioner. In the profession of psychology much effort has been expended in attempting to reach a consensus on the specific competencies that are necessary for effective supervision (Olds and

Hawkins, 2014). But in the context of supervisory skills, I do not believe that competencies alone adequately can reflect the complexity of the system that involves the supervisor, supervisee and client.

In my social life I am a caller for ceilidhs or barn dances at events celebrating weddings, birthdays, anniversaries and other special occasions. My aim in this role is to coordinate a roomful of people in a way that results in them having fun, a rather intangible outcome. A number of competencies are involved that include matters such as turning up on time, ensuring that my voice is amplified sufficiently to be heard, being able to count an 8-bar musical phrase, calling movements a few bars before that action is required, describing dance movements succinctly, taking an encouraging rather than bullying approach to reluctant dancers, managing over-enthusiastic participants who risk hurting the people they are swinging, and uplifting the mood at an event when at an earlier point something has gone badly wrong. I can do all these things, but my audiences cover a wide spectrum and their behaviours are unpredictable. Adults may be the worse for wear after drinking too much alcohol, children of different sizes may make some dances impracticable, people may drop out of the dance part way through and cause chaos, the band may accidentally play the wrong number of bars, people sometimes fall over, or introduce new movements of their own accord that are incompatible with what everyone else is doing, and I have to respond on a moment-by-moment basis. I do not think it possible that I could be assessed on every eventuality since so many variables are beyond control. But I think you would be able to go home from a dance with an opinion about my competence.

It is this kind of variability that contributes to the imperfect findings of the research literature regarding the outcomes of supervision. But evaluation of this literature does give some indication as to the answers to the questions, 'Is it worth doing?' and 'Is it worth training to do?' I am satisfied that there is sufficient positive evidence to make the activity worthwhile. The evidence has been generated by researchers who subscribe to both positivist and constructivist worldviews. When making evaluations of the evidence I find it helpful to include consideration of the researcher's worldview.

## Research outcomes

### *Methodological issues*

Those attempting to seek evidence about the outcomes of supervision have adopted a wide range of methods including randomised controlled trials, satisfaction surveys, systematic reviews involving meta-analysis of a body of work, and small-scale qualitative studies. Questions such as, 'Does supervision make a difference to client outcomes?' tend to be investigated from a positivist worldview with manualised treatments provided to clients and manualised training to supervisors. Attempts are made to control as many variables as possible. The aim is to determine the efficacy of the practice, the classic model being the RCT. According

to Seligman (1995) efficacy studies of *psychotherapy* are characterised by the following:

- Random assignment to treatment and control conditions
- Controls are rigorous
- Treatments are manualised
- Patients are seen for a fixed number of sessions
- Target outcomes are well operationalised
- Raters and diagnosticians are blind to which group the patient belongs
- Patients meet the criteria for a single diagnosed disorder
- Patients are followed for a fixed period after termination and an assessment battery administered

In this type of study the research protocol sets the criteria for practice in order to make it more amenable to measurement. Towards the end of the 20th century a number of thorough and extensive reviews of supervision outcome studies were published which often raised doubts about methodology and the conceptualisation of the studies. Sterling efforts have continued to be made since, with continuing methodological concerns expressed (Bradshaw *et al*., 2007; Carpenter *et al*., 2013; Freitas, 2002; Inman and Ladany, 2008; Milne *et al*., 2007; Roth *et al*., 2010; Schoenwald *et al*., 2009; Watkins, 2011; Wheeler and Richards, 2007) and a tendency for the studies to yield disappointing results. Efforts are continuing (Alfonsson, 2017). The difficulties inherent in the studies have been attributed to a number of factors:

- Supervision research was limited by the extent to which effective therapist behaviours had been identified (Lambert and Arnold, 1987). It was argued that progress in psychotherapy research and the advent of therapy manuals defining standards of therapist behaviour (Neufeldt *et al*., 1997) would facilitate the progression of supervision research. More recently it has been argued that the lack of manualised and standardised supervisor training is at the heart of the problem (Falender and Shafranske, 2012).
- One oft-stated intention of supervisors is to facilitate development of their supervisees (the formative role of supervision). This implies changes in the ways that practitioners conceptualise their work and interact with their clients. To obtain samples of behaviour and thinking at different points in a professional training or subsequent career is a massive undertaking. Even where change can be demonstrated, to link it specifically to supervisor interventions presents a further challenge.
- There are no adequate measures that link therapist thoughts and behaviours to therapist development, and no empirically defined models on which these could be based (Neufeldt *et al*., 1997).
- Studies have not set about testing existing supervisory theory. This may have been hindered by a lack of common agreement about what constitutes supervisory theory.

- There is a scarcity of replication studies (Ellis and Ladany, 1997) which means that findings from one study cannot be generalised to supervision in other contexts.
- 'Supervision' and 'training' have been considered as interchangeable whereas it can be argued that training refers to the teaching of more specific skills in laboratory courses without direct client contact (Goodyear and Bernard, 1998).
- There has been a widespread reliance on satisfaction measures to assess supervision outcomes (Goodyear and Bernard, 1998). Goodyear and Bernard argued that that this approach is unsatisfactory; they likened it to asking a number of people leaving a doughnut shop whether they were satisfied with their doughnuts. Most would probably give an answer in the affirmative but their answers would be of no value in establishing the nutritional value of doughnuts. Enquiry into the shopper's view of the nutritional value however, might yield appropriately relevant and useful information.

The disappointing results do not surprise me. In the days when we used to repair our own cars, the relevant Haynes manual was the bible we followed. This was all very well until the car did not behave in the ways prescribed in the manual. When the bolts resisted and eventually sheared, the manual had no advice to offer on the next step. What we needed was a more experienced friend with whom to pore over the engine together. The manual was helpful as a starting point but could not cover all eventualities. How much more so when the material worked upon is a human being who has not even seen the manual. Whilst it can be argued that the acid test of supervision effectiveness is evidence of a causal link between supervisor interventions and client outcomes, this is a tall order and an aspiration which Reiser and Milne (2014) have argued may be misplaced. Nevertheless, a systematic review of the contribution of psychotherapy supervision to improved patient outcomes by Edwards Watkins Jr. (2011) led him to conclude that the topic can be studied and the research done well. He highlighted a study by Bambling *et al*. (2006) in particular as a 'truly stellar, model study' (Watkins, 2011: 249). And even though research exploring the impact of supervision on client outcomes reaches patchy conclusions, supervisors and supervisees have nevertheless perceived it as essential for psychotherapy training (Rast *et al*., 2017).

Since multiple variables impact client progress, supervision is only one factor in the mix. Over one hundred published studies support the idea of the therapeutic relationship as an important predictor of final outcome in therapy, along with client variables such as readiness to change, and the availability of social supports as important mediators and moderators of recovery (Harmon *et al*., 2007). Supervisory interventions bring about their effect through the supervisee, only one factor amongst the many that impact upon the client. Some studies have therefore attempted to examine individual links in a chain which runs from consultant to supervisor, supervisor to supervisee and supervisee to client. Milne (2007a) described this as an educational pyramid and reviewed 24 studies reported between 1991 and 2005 which focused on different parts of

the pyramid. The studies included an overall total of 13 consultants, 72 supervisors, 499 supervisees and 711 clients. The review concluded that supervisors learn from consultancy (sample size 10, 87% impact), supervisees learn from supervision (sample size 24, 79% impact), and clients benefit clinically (sample size 17, 76% impact).

Bernard and Goodyear (1998: 254) described a tension between rigour and relevance in supervision outcome studies, which might be exemplified by the difference between efficacy studies and effectiveness studies. Effectiveness studies research the ways in which clinicians work in the field, which is too cumbersome and convoluted to be evaluated using an efficacy study. Intervention is not of fixed duration, it is self-correcting – if one thing does not work the practitioner tries another, patients arrive serendipitously not by random allocation, they usually have multiple problems or issues, and there is concern with improvement in general functioning, not only specific symptom alleviation. It can be argued that effectiveness studies are methodologically flawed but they can be very large scale, they sample 'live' interventions and capture the qualitative experience of the person using the service. Martin Seligman's (1995) 'Consumer Reports' study (similar to Which? in the UK), reported in American Psychologist, found that, averaged over all mental health professionals, of the 426 people who were feeling *very poor* when they began therapy, 87% were feeling *very good/good* or at least *so-so* by the time of the survey. Long-term therapy produced more improvement than short-term therapy. So, there is evidence that what therapists do in the field works, and that what works involves flexibility and responsiveness to individual clients in individual relationships. There is more to inter-subjectivity than we know how to measure.

In order to address the balance between rigour and relevance, Milne *et al*. (2007, 2008) argued the case for an approach to reviewing the literature entitled Best Evidence Synthesis (Petticrew and Roberts, 2006). The reviewer works with whatever evidence is available, however flawed, rather than lamenting the lack of methodologically rigorous material. In this approach, studies are not excluded for lack of rigour, but those with findings based on sound methodology are given greater weight. The approach combines the meta-analytic approach of extracting quantitative information from a series of studies whilst taking into account study quality and relevance. It takes the perspective of reaching a richer picture of what is regarded as a high standard or good practice through critical judgement and selection.

The difference between what is taught and learned about practice and subsequent actual practice in the field can be substantial and is illustrated by Jennifer Worth (2008) who wrote about midwifery in the 1950s. It also illustrates how 'fashions' in intervention and the use of language change over time:

> I remember lectures during my part I midwifery training about the advantages of bottle-feeding which sounded very convincing. . . . These classroom pundits were remote from silly young girls who would get the formula mixed

> up, get the measurements wrong, fail to boil the water, be unable to sterilise the bottles or the teats, fail to wash the bottles. Such theorists could not even imagine a half-empty bottle being left for twenty-four hours, then given to the baby, nor envisage a bottle rolling across the floor, picking up cat hairs, or any other dirt. Our lecturers never mentioned to us the possibility of anything else being added to the formula, such as sugar, honey, rice, treacle, condensed milk, semolina, alcohol, aspirin, Horlicks, Ovaltine.
>
> (Worth, 2008: 34)

Advantages suggested for effectiveness studies are that they can be very large scale, they sample how treatment is offered in the field, they are addressed to people who seek out treatment, they measure multiple outcomes and they capture how, and to whom, treatment is provided and to what end.

Observational data routinely collected in clinical practice may also be more representative of outcomes in practice. The work of Michael Lambert (Harmon *et al*., 2007; Lambert *et al*., 2005; Lambert, 2015) and his colleagues has made something of a bridge between efficacy and effectiveness studies by randomly assigning clients to control and experimental conditions whilst allowing clinicians to work as usual in the field.

In any system which has an inherent complexity (a multi-variable system) and/or where there is a significant time lag between the action of the 'input' variables or design factors and the outcomes; where various paths of causality or causal loops may pertain, then it is not suited to an analysis which is conducted on the expectation of a measurable or a clear and direct simple connection between input and outcome (Scaife, 2004). Complex processes do not lend themselves to simple statements of linear causality. It is also important to remember that measurement typically plays a very restricted part in the achievement of outcomes – a pig is not fattened by weighing it. The approach suggested by Milne *et al*. (2007) takes a much more optimistic position and there is evidence of increasing efforts to explore supervision outcomes in creative and original ways.

### *Large-scale studies*

Several researchers have carried out large-scale studies that focus on the impact of supervision on supervisees. These have generally reported positive impacts and fewer methodological limitations than studies attempting to link supervision with client outcomes. Helen Beinart (2004: 48) reported a study which she carried out to test aspects of two models of the supervisory relationship propounded by Bordin (1983) and Holloway (1995). Data was generated from just under a hundred supervisory relationships involving trainee and newly qualified clinical psychologists. Supervisees were asked to rate and describe the characteristics and qualities of the supervisory relationships that had contributed most and least to their effectiveness as a clinical psychologist. The main qualities of the relationship which were reported to have contributed to effectiveness were rapport between

supervisee and supervisor and the supervisee feeling supported by the supervisor. Beinart (2004: 49) stated:

> Clinical psychology supervisees described a strong preference for collaborative supervisory relationships where both parties were involved in setting the agenda and goals of supervision. A certain amount of flexibility of both approach and therapeutic model seemed to aid the collaboration. The two tasks of education and evaluation were helped if the supervisor was sensitive to the supervisee's needs, both in terms of their previous experience and stage of training and the personal impact of the work. Unlike in findings from previous studies, the wisdom and experience of the supervisor seemed less important than opportunities to observe the supervisor's work and have curious and stimulating discussions. The most important aspect of the educative code seemed to be collaborative work on formulation, which included theory-practice links. Again, flexibility was important to supervisees who found didactic supervision or inflexible adherence to models less helpful. Interestingly, the evaluative aspect of supervision was only an issue in poorer-quality supervisory relationships. Supervisees valued and appreciated feedback and challenge in good collaborative relationships, and the formal elements of evaluation did not seem to impact on this.

Beinart concluded that helpful supervisory relationships are similar to other good relationships and are based on mutual trust and respect. The setting of clear boundaries at the outset, both in terms of structure and what can be brought to supervision was also regarded as facilitative of effective supervisory relationships. Similar results were reported by Anderson *et al*. (2000).

In a study of 201 nurses in the UK, Bowles and Young (1999) attempted to examine whether clinical supervision outcomes could be related to each of the three functions of supervision described in a framework of supervision by Inskipp and Proctor (1988) as Normative, Formative and Restorative. The findings indicated that clinical supervision relationships reflected each of the three functions with no single function dominating the other two. Respondents reported experiencing greater benefit the longer that they had participated in supervision. The normative function appeared to increase in salience with the greater experience of the participants.

A survey of 280 BABCP accredited cognitive behavioural psychotherapists (Townend *et al*., 2002) indicated that satisfaction levels were high and that the ratio of time spent in supervision to therapeutic contact was, on average, higher than the recommended minimum. A review of the impact of clinical supervision on counsellors by Wheeler and Richards (2007) concluded that supervision enhanced the development of self-awareness and therapeutic skills. Positive outcomes of supervision have also been reported in systematic reviews of the literature by Dawson *et al*. (2013) and Francke and de Graaff (2012)

### *Small-scale studies*

Small scale studies have attempted to answer questions such as, 'When supervisees report that they have found supervision valuable, what is happening?' Such questions tend to lend themselves to investigation from a constructivist worldview which results in the researcher telling a story about the supervisees' story.

A small-scale qualitative study carried out in 2000 by Wulf and Nelson reached similar conclusions to the larger-scale studies about the importance of the supervisory relationship. This was a retrospective study of six psychologists who had been accredited for at least five years. They were asked to reflect on their predoctoral training experiences through the use of a semi-structured interview. A grounded theory approach was used to identify superordinate categories, the first of which was 'supervision dynamics.' Positive experiences were evidenced in the following quotes:

> He had a pretty profound impact on my clinical style, helping me to become more practical, maybe more results-oriented, less theoretical in my thinking, and less kind of ethereal and pedantic in my thinking – being more of a human being.
>
> It was just a wonderful experience that really kick-started me in a lot of ways in family work. And so that's had a long-term impact. And in the context of feeling kind of beat up by a couple of these other supervisors, it was a really good experience in constructive feedback. They had good things to say about my work, and bad things to say about my work . . . I was able to really take in the constructive criticism and use it.

Examples of negative experiences were cited thus:

> It was a bit her style to be aghast at anything that wasn't quite in its little place. . . . I still think that way of going about it is really not helpful, at all, and added in a really ridiculous stress that really didn't need to be there.
>
> He would tell me things that nobody would ever tell anybody, like which hand to hold out to shake hands with, stuff like that, just bizarre stuff, just very nitpicky. My sense in looking back on it was that he really could not take criticism or disagreement, and all he was dishing out was criticism and disagreement. Whenever I criticized his criticism, he would just get furious. He screamed at me a couple of times; just weird stuff.

The authors argued that their study provided evidence in support of the findings of Worthen and McNeill (1996: 29):

> The most pivotal and crucial component of good supervision experiences that was clearly evident in every case studied was the quality of the supervisory

> relationship. All trainees described the supervisor as conveying an attitude that manifested empathy, a non-judgemental stance toward them, a sense of validation or affirmation, and encouragement to explore and experiment.

This is convergent with the finding that *non-confirming* supervision experiences are so potent that the memory of them remains affectively charged, even years later (Skovholt and Rønnestad, 1992). The conclusion that the supervisory relationship is a critical factor in the success of the enterprise was reported by Beinart and Clohessy (2017) and Briggs (2010) who argued that it facilitated the management of anxiety for both supervisor and supervisee. It was this that was most highly valued by supervisees in a study by Pack (2015). Person-centred supervision was reported to result in the enhancement of coping skills, and the development of understandings which enhanced supervisees' skills in employing a wider range of alternative actions in practice (Nørdboe and Enmarker, 2017).

Continuing efforts have been directed towards researching the impact of supervision on supervisee self-awareness and self-reflection (Burkard *et al*., 2006; Connor, 1999; Fowler and Chevannes, 1998; Kilkullen, 2007; Raichelson *et al*., 1997), supervisee satisfaction (Bruijn *et al*., 2006; Busari *et al*., 2005; Edwards *et al*., 2005; Ho and McConville, 2004; O'Donovan and Kavanagh, 2014), therapeutic skills (Alleyne and Jumaa, 2007; James *et al*., 2008; Ogren and Jonsson, 2003; Patton and Kivlighan, 1997), confidence and self-efficacy (Cashwell and Dooley, 2001; Crockett and Hays, 2015; Lehrman-Waterman and Ladany, 2001) and client outcomes.

Currently various professional bodies in Europe, the USA and Australia offer, or are developing opportunities or requirements for their membership to be accredited as supervisors (e.g. American Psychological Association; Association of Counselling and Psychotherapy; British Psychological Society, Division of Clinical Psychology). Training manuals for supervisory skills have begun to appear (Milne, 2007b). The formalisation of the training process is likely to make supervision more amenable to empirical study whilst qualitative studies will continue to put flesh on the bones.

## Is it worth organisations supporting it?

Over the course of my career, there has been a movement across professions in health, education and social services in the UK towards mandatory ongoing supervision throughout a professional career. Explanations for the proliferation of supervision in these settings have looked to factors such as the introduction of clinical governance. This is a system, 'through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish. Clinical governance encompasses quality assurance, quality improvement and risk and incident management' (Public Health England, 2017). Davy (2002) argued that the drivers for the proliferation of supervision

have been the prevailing political and social conditions, and that it merits much more critical attention through research.

It has been argued (Kieseker, 2013; Worcestershire NHS Primary Care Trust, 2008) that organisations that support clinical supervision are able to provide better services, and experience improved staff recruitment and retention, greater staff efficiency and effectiveness; it has also be argued that it is a core activity within clinical governance systems, facilitating accountability and responsibility. It supports skill development and provides professional support to participants. It has been associated with safer surgery and other invasive procedures for medical practitioners (Snowden *et al*., 2016). Although staff had been concerned that the introduction of clinical supervision would compromise patient care, results of a study by O'Keefe *et al*. (2014) indicated that it facilitated integration of students into the team, unexpectedly enhanced relationships between team members in general and improved clinic functioning.

Supervision has a place in the wider framework of activities that are designed to manage, enhance and monitor the provision of high quality clinical services (Butterworth and Woods, 1999). But also, 'properly conducted it will ensure that standards are maintained, that interventions are appropriate, and that despite a frenetic pace of work, individuals can function therapeutically, rather than become mini bureaucrats or broken professionals distanced from the humanity of care' (Bishop, 2008: 5).

David Goleman (2006) in a book called *Emotional Intelligence* argues for the benefits of a supportive and calming workplace. The slogan 'banish fear' by Richard Deming arose from his perspective that fear immobilises staff so that they become reluctant to speak up and share ideas or try to create improvements. High anxiety leaves less cognitive space for paying attention and means that it is more difficult to take in new information and generate fresh ideas or perspectives (Goleman, 2006: 268). 'Google argues that consistent leadership from managers actually provides a secure working environment for staff to express themselves, as they know that, within certain parameters, they can do whatever they want' (Haughton, 2015). If supervision is able to contribute to the creation of a workplace in which anxiety is reduced and staff can think creatively, then this would be a factor in its favour.

In order for supervision to become established meaningfully within an organisation, members of management teams need to be seen as fully committed to it by prioritising their own supervision as an example to other staff. A very effective strategy can be to model how practitioners from different disciplines or of different statuses in the organisation can provide each other with support and challenge. It is not enough for managers to espouse supervision by dictat, it needs to be lived within the manager's practice.

In recent years, articles have begun to appear, particularly in the field of nursing, which are critical of clinical supervision. It has been argued that its introduction was a fashion within nursing and that nursing as a discipline has a habit of taking on new concepts and ideas without first investigating the evidence base

(Thompson, 2009). Critical reflection within the process of supervision has also been subject to question with arguments put forward that it can be not only ineffective but harmful (Thompson, 2009 cited in Wright, 2012: 44). This author argued that the problem with fashions in nursing arises from them being, 'introduced overnight with little consideration given to planning, implementation or evaluation.' When ideas are introduced from the top down, there is a risk of engendering resistance and half-hearted implementation. As a member of staff 'on the ground,' uninvolved in the decision-making process and lacking experience, education or training in the mandated innovation, I am unlikely to welcome this change to my practice with open arms, ready to show resistance from the outset. Telling people what to do has generally not been a successful strategy in my own experience of either work or family life. Instead, involvement, persuasion, a catching kind of enthusiasm and willingness to listen and respond to alternative ideas are critical to successful organisational change.

Wright argues that with resistance at the ward level, only partial implementation of clinical supervision will occur. Combined with uncertainty regarding evidence of benefit to patient care and limited resources, the innovation may readily be abandoned for the next fad.

Sometimes staff are asked to become supervisors after minimal consultation, training or practice. McColgan and Rice (2012) describe the replacement of a one-day training course with an e-learning programme following which students complete a questionnaire to evidence their learning. Whilst such programmes may well be contributory to the development of supervisory skills, this would need to be in the context of a wider programme of learning and development involving theory and practice. Just because someone is a skilled practitioner within their discipline, this does not mean that they can be assumed to have the knowledge and skills to participate effectively in clinical supervision.

If clinical supervision is to fulfil its functions effectively, participants need to have sufficient knowledge, skill and experience. An extended period of theoretical study and supervised application in practice is typically necessary before novices are considered sufficiently qualified to be unleashed on the public (in nursing, psychotherapy, medicine, counselling, etc.). Clinical supervision is a discipline in itself with its own body of theory and practice skills but few professions have yet introduced a registration process or require evidence of appropriate knowledge and skills as a prerequisite to becoming a supervisee or supervisor. The case for this has increasingly been argued by proponents such as Falender and Shafranske (2012, 2014).

So, if an organisation wishes to introduce ongoing clinical supervision for all staff, it can only be accomplished, in my opinion, through an extended period of consultation and training which allows for a change of ethos and the development of knowledge and skills across the staff group as a whole.

Changing an organisational culture is a particularly difficult challenge (Denning, 2011) because the interlocking elements (goals, roles, processes, values, practices, ways of communicating, attitudes and assumptions) fit together as a mutually reinforcing system which works to keep things as they are. Denning

argues that too often power tools such as threats and punishments are used rather than persuasion, conversations, role modelling, training and incentives. Denning analysed the impact on its purpose and functioning of a series of presidents of the World Bank. He described the organisation's resistance to change which meant that when new managers were brought in from outside, the organisation, 'responded like an immune system reacting to invading pathogens.' He advised the next president to come with a clear vision promulgated rapidly through leadership storytelling, to identify the core stakeholders and drive the organisation to be responsive to these, to define the role of managers as enablers of self-organising teams, to introduce radical transparency, to communicate horizontally through conversations and stories rather than top-down commands and to draw staff into the leader's vision. James Reason has argued that:

> It is simply not possible to order in a package of EM [Error Management] measures, implement them and then expect them to work without further attention. You cannot put them in place and then tick them off as another job completed. Here, the bulk of the effort lies in the process rather than the product. In an important sense, the process – the continuous striving toward system reform – *is* the product.
>
> Reason and Hobbs (2003: 101)

Denning highlights the importance of the change *process*. In my own experience of being involved in the introduction of a group task as an element in the selection process of clinical psychology trainees, my colleague, Sue Walsh began by drawing together representatives of all stakeholders, including the existing trainees, and shared the logic behind the proposed change. She facilitated conversations between us about the design of the task and tested the draft design with role-plays. This allowed the identification and remediation of snags. Support for the change to the selection process grew through a process of dissemination and inclusion of more people in the refining process. The group task became one of the most highly regarded aspects of the selection process in the years that followed.

It has been argued that efforts to introduce and establish clinical supervision within NHS Trusts has begun, and all too often ended, with a programme of supervisor training (Waskett, 2009). The particular staff members, already overworked, fail to produce the desired results. Waskett describes a 4S model for introducing supervision within a culture in which the process is carefully planned and each step is taken in succession. This first involves management commitment and the creation of a lead group which has the authority to make decisions and to act as facilitators and guardians to the scheme. She argues against mandating supervision since willing supervisees are more likely to benefit, so that supervision will show its worth and generate demand organically. In a mandatory system a form of policing with its attendant negative connotations would be necessary. She also argues for choices given to participants about with whom they will work and whether it will be in individual or group formats.

If organisations are to test the worth of clinical supervision, then the process of implementation is critical.

> Over the past decade, the science related to developing and identifying "evidence-based practices and programs" has improved – however the science related to implementing these programs with fidelity and good outcomes for consumers lags far behind. As a field, we have discovered that all the paper in file cabinets plus all the manuals on the shelves do not equal real-world transformation of human service systems through innovative practice. While paperwork and manuals do represent what is known about effective interventions, these tools are not being used effectively to achieve behavioral health outcomes for children, families and adults nationally. Clearly, state and national policies aimed at improving human services require more effective and efficient methods to translate policy mandates for effective programs into the actions that will realize them.
>
> (Fixsen *et al*., 2005: vi)

Chapter 2

# What is supervision?

Some years ago I was asked to run a series of workshops on supervision for social work managers. I thought that I had agreed to lead some half-day events for people who were going to be enthusiastic about developing their skills in supervision. Not long before the first workshop it became clear that these had turned into mandatory events for overworked, stressed managers and instead of being faced with volunteers, many of the participants were conscripts with their own well-established ways of 'doing' supervision. We appeared to have little common ground so as a way of trying to connect and establish fruitful ways of communicating, I suggested that I enact a brief supervision session with a willing member of the group, which we could then analyse, discuss and work out together our ideas about purpose and process.

I was grateful to the group member who agreed to work with me. The focus was on an issue which I have long forgotten, but it threw up many choices about the supervisory process and the direction the session could take dependent upon the identified needs of the supervisee. Was it going to be about seeking advice on case management, about how their feelings towards the client were impacting on their work, or about the impact of and constraints imposed on the work by the professional system? Were we going to discuss what they felt, what they thought or what to do? Was I going to ask questions, listen, make interpretations or give advice? Participants made various contributions to the subsequent discussion. I was struck by the body language of one of the group members who sat with crossed arms and what I took to be a steely expression. It prompted me to ask what he had made of it. He responded, 'I've never seen anything like it in my life.' I did not discern a tone of admiration in his voice. I wanted to ask him to show me how he participated in supervision so that we could examine the differences between our ideas and what lay beneath them in terms of our conception of the process. But I did not manage to find a way to accomplish this.

When I play recordings of different examples of supervision in educational workshops, the same recording typically generates markedly different responses from the variety of participants. I hope this serves the function of helping people to learn more about their underlying beliefs, expectations, preferences and constructions of supervision.

I ask participants to focus on these questions:

- What did you like/think was useful?
- What did you dislike/think was not useful?
- What did you notice about supervision process issues?
- What does this tell you about yourself as a supervisor/supervisee?
- What have you learned about your own preferences in supervision?
- What do you want as a supervisor/supervisee?
- What don't you want as a supervisor/supervisee?
- How does this influence what you offer as a supervisor?

The following scenarios are offered to provide a stimulus to thinking about how you might answer the earlier questions.

## Scenario 1

SUPERVISOR: You've mentioned she's quite good at mothering.

SUPERVISEE: *Watching her in the room she is good at mothering*.

SUPERVISOR: But it's harder for her to mother herself?

SUPERVISEE: *Yes, because she sees herself as ugly inside. That she's so ugly inside that if she goes out in the street, people will see it, and that she can't bear to go out or come and see me because people will see her absolute ugliness. That's one day, but another day*.

SUPERVISOR: I'm wondering what those ugly feelings are.

SUPERVISEE: *It's the anger and the hatred I think*.

SUPERVISOR: That seems likely, the anger and the hate. Maybe in the sessions with you she could express them.

SUPERVISEE: *That's been one of my themes, to get her to express that, not just in the present, but to events in the past and I've tried to do that using drama because it seems to need a fairly powerful expression, but she's very frightened of the power of those feelings*.

SUPERVISOR: Power of them, and I wonder if she's frightened at showing *you* what they are because you might again reject her. If she shows you those ugly awful feelings, are you going to do the same as the rest and reject, abandon. She's got herself some mothering, and if she expresses those, maybe the fear would be that she's got a lot to lose.

SUPERVISEE: *Would it be appropriate to raise that as an idea?*

SUPERVISOR: Yes. Certainly would, and even maybe, does she feel angry with you, or even envious. She's got a woman therapist, and I'm wondering if she also has feelings towards women. Does she know you're a mother?

SUPERVISEE: *Yes, I would think so. It's fairly obvious*.

SUPERVISOR: It could be that there's some envy around. That she can see you are together with a good job.

SUPERVISEE: *I think there is anger towards women as well. She almost got close to a woman who she met at a course she went on, and clearly prevented the relationship developing further*.

SUPERVISOR: That could be another reason why the sessions haven't developed. It's quite dangerous for her to show those feelings, not just because they're dangerous feelings as such but also they may be towards you. This thing of her ugly feelings, can you remember what you said that you feel when she picks up the 'phone? What do you feel towards her?

SUPERVISEE: *I said I didn't feel as sympathetic*.

SUPERVISOR: What does that mean?

SUPERVISEE: *Well it's actually a slight feeling of detachment. Is it rejection? I don't know*.

SUPERVISOR: You do feel detached?

SUPERVISEE: *Well, I think I see it, when she 'phones and it's a crisis time, I see it as part of a repeating pattern. I don't get overtaken by the current crisis like I think I would do, or I'm capable of being with some other people. I think, 'Well, here's another crisis, and I know I'm not going to be able to do anything to put this right, so I don't actually need to dive in here.' I suppose with some people I would dive in and rescue them or something. It's hard to put a label on it*.

SUPERVISOR: Do you feel that in the sessions? Does she give you any other strong feeling?

SUPERVISEE: *Yes, some of the things she's described about her life have been very sad. I've felt very sad about them and I've felt very much like wanting to help her put those right as far as it's possible to do that*.

SUPERVISOR: I think what I was wondering about, I seemed to pick up something from what you said earlier which was different from, what you say, experience with your other clients, and I was trying to put that together with the case. Given the fact that in your experience of her, you've been seeing her a long time, and there hasn't been much apparent change. Putting that together with, you said you feel detached in some ways as though here's another crisis and you can't do anything. I'm wondering if that's how she feels.

SUPERVISEE: *Helpless would be the right thing, I think, which prompted me to start writing this letter which I've decided not to send because I think it was prompted by speaking to her on the 'phone, which was a helpless letter to the G.P. basically, saying I can't do anything*.

(Scaife, 1995: 121–123)

## Scenario 2

SUPERVISOR: Would it be helpful to think about some of the theories around schizophrenia?

SUPERVISEE: *Yes*.

SUPERVISOR: If we think about it, there's the role of stress. There seems to be a high risk of schizophrenic episodes following discrete events like the death of a close relative or a relationship breakdown. Have you covered this in your university course?

SUPERVISEE: *I'm not sure really*.

SUPERVISOR: Then there's family relationship theory. What do you know about that?

SUPERVISEE: *Er, I think there's the idea of contradictory messages from parents like saying that they are proud of what the child's created but putting it in the bin at the first opportunity*.

SUPERVISOR: Are you familiar with the idea of expressed emotion?

SUPERVISEE: *I'm not sure we covered that. Do you mean when there's a lot of negative emotion and hostility being expressed in the family?*

SUPERVISOR: That and the idea of over-involvement. If we took that idea of expressed emotion in relation to your client, what do you think the implications for treatment might be?

SUPERVISEE: *Would it involve working with the family?*

SUPERVISOR: Well, George Brown's study showed that patients discharged from hospital to stay with their wives or parents, were more likely to need readmission. What does that make you think?

## Scenario 3

I was sitting in the corner of my supervisor's office. He walks in and takes a seat. Silence. Lots of silence. I read him visually . . . White male, straight, loads of class privilege. Then, I see his Freud "action doll" sitting on his desk.

Me – queer, South Asian, daughter of a turban-wearing immigrant Sikh and a White woman brave enough to marry him. I was told to come ready to present a case for this supervisor. I really want to tell him about the couples seminar I just came from, where the word "couple" translated to straight, white couples – but not sure if it will be safe. I wanted to share with him that I have not met one other single queer person on staff – that I feel isolated.

Instead, I fill the silent spaces with a case presentation. Trans-gender woman, Black, 43 years old, sex worker, poet, and resilient as heck in my eyes. Case conceptualisation – feminist, multicultural, narrative approach, with a focus on strengths. In my view, the client has so many ideas of what the world should 'look like.' This transgender woman self-describes as 'political.'

"This world isn't fair" (she told me). I share her story with my supervisor – a story about her father who was 'never political' – he always 'bowed down to the White man' . . . but when Dr. Martin Luther King, Jr. died, he brought her as a child to see his burial. She loved her dad for this moment – despite his internalized racism. More than that, she loved her dad because he saw her for the girl she was when she was being raised in society as a boy. He introduced her to his friends as 'his daughter.'

SUPERVISOR: 'Why do you think she is SO political – what is she defending against?'
ME: 'Hmmm – maybe because it's a way she survives, is strong, is flexible, is resilient?'
SUPERVISOR: 'You seem a bit protective of her – how are you feeling right now?'
ME: [I feel disconnected, distant, analyzed – and I feel like I am defending my client. Forget about connection in supervision!]

(Singh and Chun, 2010: 36)

## Scenario 4

SUPERVISOR: How did you get on writing the client's homework down?
SUPERVISEE: *I just jotted down some reminders of the session for them*.
SUPERVISOR: So it wasn't like the equivalent of a 'prescription' for them, do 'x' and 'y' and we can review how it works out?
SUPERVISEE: *No*.
SUPERVISOR: When you saw the client the next time was there a focus on these 'reminders'?
SUPERVISEE: *No, I didn't have a copy of what I had written down for them*.
SUPERVISOR: So you had no written reference session to session to ensure continuity between sessions.
SUPERVISEE: *No*.
SUPERVISOR: So you haven't actually addressed homework?
SUPERVISEE: *No, but I have possibly taken a first step*.
SUPERVISOR: I remembered to ask you about the 'homework' because I have written down that it was a focus of our last session. There doesn't appear to be anything in your record keeping that ensures continuity, follow through.
SUPERVISEE: *Well, I write down whether the client is making use of the sessions, whether they are feeling better, what has happened since the last session*.
SUPERVISOR: But what is there in the records in terms of accountability, that would enable the Organisation to say that in this session there was evidence that an evidence-based skill was taught and procedures were put in place to review and refine acquisition of that skill?
SUPERVISEE: *I hadn't thought of records in terms of accountability*.
SUPERVISOR: I think with GP commissioning, questions are going to be asked by GPs about 'what am I paying for?' Unless an Organisation can meaningfully answer this they will likely be dropped as a provider.

(Scott, 2014: 54–55)

Further examples of approaches to supervision are available on YouTube. Some of them can be viewed as follows:

Irvin Yalom Live Case Consultation Psychotherapy Video (psychotherapy.net) www.youtube.com/watch?v=7R_-KBmU5g0;

James Bugental Live Case Consultation Psychotherapy Video (psychotherapy.net) www.youtube.com/watch?v=Zl8tVTjdocI;
Live Clinical Supervision: Talking About Supervision with Bob Cooke TSTA www.youtube.com/watch?v=R0gsnnmS4DQ;
Clinical Supervision for Counseling – Moving Sessions Beyond the Superficial (Todd Grande) www.youtube.com/watch?v=oWMNskk8nzY;
An Example of a First Supervision Session: Field Placement 1st Supervision Roleplay (Jill Hanlon, Liesl Krebbs) www.youtube.com/watch?v=saCn4nmLuKo;
Role-Play: Demonstration of a Supervision Session: Mental Health Academy, Australian Institute of Professional Counsellors www.youtube.com/watch?v=9UAnXNQYvYU;
Supervision: Supporting Staff and Improving Care: Social Care Institute for Excellence www.scie.org.uk/socialcaretv/video-player.asp?v=supervision01

The thumbs up and thumbs down evaluations of these clips reflect how personal are individual preferences for what takes place in supervision. My own tastes have been influenced by my cultural history, prior personal experience, the stage of my professional career, how confident I feel about my work and how I view the purposes and tasks of supervision. What I want and what I like have changed radically over time from early in my career when I most certainly needed supervision but viewed it more as an imposition than an entitlement that helps me to do better work. I have also moved from a position of receiving what I get to one of ensuring that I get what I think I need.

In this chapter I discuss the aims and purposes of supervision, its defining characteristics and what it has in common with or how it is different from other ways in which practitioners can get help with their work.

## What is supervision?

However supervision is defined, and whatever it means to you and me, it can be regarded as one way of getting help with our work. There are many others. Most ways involve talking with other people and these might include family, friends and informal conversations with colleagues over lunch or in the kitchen. Whilst such conversations have the potential to jeopardise confidentiality, there is evidence that they are widespread. The results of a study (Pope *et al*., 1987) examining the ethical beliefs and behaviours of therapists found that whilst three quarters of the sample believed it unethical to disclose confidential information, including unintentional disclosures, almost two thirds reported that they had engaged in behaviours that jeopardised their clients' privacy. Whilst only 8% of the sample reported discussing clients by name, about three quarters said that they discussed clients without naming them with friends: Ninety six per cent of participants reported disclosing client information to their significant others in a study by Boudreaux (2001).

McAuliffe and Sudbury (2005) interviewed 30 social workers in depth regarding their sources of support and consultation in cases where they had experienced ethical conflict. All respondents regarded supervision as critical in their work but less than half had discussed the matter in organisational supervision. Social workers were more likely to bring the matter to supervision when this was external to the organisation. In many cases ethical dilemmas were discussed with colleagues who were thought to have had relevant experience, and to a lesser extent with family and friends. Dudley (1988) stated that one of the most common problem areas faced by the American Association for Marital and Family Therapists is 'pillow talk' or therapists sharing clients' confidential information with their spouses or other family members. The reasons given for disclosure were in order to reduce stress, to help clients and to gain self-understanding. These could all be regarded as appropriate aims of supervision in which the participants are bound by confidentiality agreements made in the contracting process.

Providing the client is unidentifiable, therapists may discuss their thoughts and feelings with a range of people without breaching confidentiality. The nature of the work, in which other humans are the materials worked upon, has the power to evoke strong feelings which need an outlet. One function that can be served by supervision is that of 'restoration', providing a space for thinking, reflecting on and exploring these feelings. The space provided by supervision is not only a channel for such feelings, but also can provide the opportunity for working out how to make use of them constructively in the work. A formal and effective supervision arrangement can obviate threats to professional integrity through breaches of confidentiality.

### *Meaning and purposes of supervision*

The meaning and purposes of supervision differ between professions, cultures, organisations and within these, an individual's constructions of the term. It is wise for practitioners to determine the applicable guidelines and policies in their specific employing organisation and to clarify how supervision is defined and understood in that context. There has been a proliferation of guidance, supervision policies and approved supervisor registers since the previous edition of this text was published which are likely to make it necessary to consult more than one document. The complexity is highlighted by Borders *et al*. (2014) who outline the evolutionary process of supervision's guiding documents in the profession of counselling. In America, the American Psychological Association (APA) has approved guidelines in health service settings (APA, 2015) and Australia has introduced mandatory training requirements in order to attain approved supervisor status (Psychology Board of Australia, 2015).

There are many definitions of supervision within the wide literature. I like the following description of the purposes of clinical supervision because the supervisee's needs at work are central. It emphasises the imperative to feel safe, it