Clinical supervision: beginning the supervisory relationship

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Abstract

While much has been written on clinical supervision (CS) in the nursing literature, there appears to be minimal attention afforded to the supervisory relationship and in particular the early phases of this relationship. It is understood that the quality of the supervisory relationship has a significant contribution towards the efficacy of CS. In acknowledging the struggles in demonstrating the effectiveness of supervision it seems reasonable to turn attention towards the relationship between supervisor and supervisee. This article begins by providing an overview of the supervision literature concerned with the supervisory relationship. Following this, attention is focused on the commencement of this alliance by describing the processes and attributes needed to commence a supervisory relationship. A comprehensive template for establishing a supervision agreement is presented. However, it is suggested that this template does not have to be confined for use in this particular clinical context but may be applicable to a variety of nursing environments. It is proposed that such an agreement/contract facilitates healthy beginnings for the supervisory relationship and goes some way towards enhancing the trajectory of this alliance.

Key words: Clinical supervision ■ Nursing: education ■ Mentoring

It has been suggested that the supervisory relationship is probably the single most important contribution towards the effectiveness of clinical supervision (CS) (Kilminster and Jolly, 2000). However, this is an aspect of supervision that appears to have received limited up-to-date attention by the nursing profession. A comprehensive search of the current literature on CS in nursing was conducted using health CD-ROMS, CINAHL, Medline, Psychlit and the British Nursing Index. The key words used included 'clinical supervision', 'supervision', 'supervisory relationship', 'relationship' and 'interactions'. In a literature search of the period 1985–2003, only a limited number of articles made reference to the supervisory relationship and even fewer mentioned 'beginning' in the title/key words. This would suggest that minimal attention has been afforded to this phase of the relationship.

This article discusses the processes and attributes needed to commence a supervisory relationship. Before presenting an overview of the supervision literature concerned with the supervisory relationship and related fields, the article provides an overview of how CS is represented in nursing.

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Representation in nursing

Definitions of CS suggest that it serves a broad purpose in nursing. Moreover, these definitions appear to imply a lack of consensus on its focus (Community Psychiatric Nurses Association (CPNA), 1985; Barber and Norman, 1987; Butterworth and Faugier, 1992; Department of Health (DoH), 1993; United Kingdom Central Council, 1996). It would appear that in less than 10 years the remit of CS has extended from the development of therapeutic proficiency to the acquisition of professional skills, the protection of healthcare consumers from nurses and reflecting on the diversity of professional practice.

In light of these definitions it would appear that the core functions of CS in nursing now include education and support for the clinician, and the provision of quality care for patients. Jones (1999) clarified this by suggesting that CS offers nurses guidance, support and education, and is concerned with quality, safety and protection for clients. In nursing, the focus of CS encompasses nursing practice in its entirety. There appears to be endorsement for no boundaries as to what can be discussed during CS (Rafferty and Coleman, 1996; Hadfield and Booton, 2003). Similarly, CS is often merged with managerial supervision or supportive counselling (Jones, 1996; Wilkin et al, 1997; Yegdich, 1999a). It has been proposed that these expansions place CS in a precarious position, that of 'becoming idealized and viewed as the panacea for the ills of nursing practice' (Todd and Freshwater, 1999, p1383). Nonetheless, these expansions are evident in the multiplicity of expectations and alleged benefits as depicted in the nursing literature.

The scope of clinical supervision

There is a growing body of nursing literature advertising a variety of wide-ranging benefits. CS is believed to have benefits for nurses, the workplace, their home life and the clients for whom they care (*Table 1*).

In addition to these benefits for nurses, it has also been claimed that health service organizations will benefit by a reduction in the number of complaints to the health service (Goorapah, 1997) by the promotion of standard setting and audit (Gorzanski, 1997), and by promoting the clinical governance agenda (Lipp and Osborne, 2000). Furthermore, it is alleged that patient care will be improved (Timpson, 1996; Wray et al, 1998). According to Driscoll (2000) patients will experience a certain type of care from nurses engaged in CS. He suggested that they will appear confident, be knowledgeable, interested in their patients, go the extra mile for patients and have an open and honest approach.

The traditional focus of CS

This broad scope appears to overshadow the traditional intent of CS. Other areas of practice, for example, counselling psychology, clinical psychology and social work, consider CS to provide an opportunity to facilitate development of the therapeutic competence of the supervisee (Doehrman, 1976; Loganbill et al, 1982; Kilminster and Jolly, 2000; Fleming and Steen, 2004). The exploration of therapeutic interactions and enhancing competence in therapeutic intervening as a focus of CS has some value for nursing. Indeed, the advantages CS could serve in general nursing contexts and the mental health nursing speciality if focused on the promotion of therapeutic competence has been acknowledged.

A small proportion of nurse authors have endorsed CS because it provides an opportunity to contemplate therapeutic practices of nurses (Yegdich, 1998, 1999a; Sloan et al, 2000; Cutcliffe, 2001). Yegdich (1999a) asserted: 'talking about patients and one's therapeutic work, in preference to oneself and one's personal issues, is the cornerstone of supervision'. She continues: 'it would seem that an undue focus on nurses' personal issues, repeats Menzies' (1960) original claim that nurses avoid patients, albeit through supervision' (Yegdich, 1999a).

There may be significant barriers and resistances to having this specific focus for CS. CS is an expensive, time-consuming activity, which does take practitioners away from direct clinical work. Consequently, major stakeholders want as many gains as possible from CS. Perhaps certain assumptions exist in the nursing community, for example, 'the broader the scope of CS, the greater the outcome'. Not surprisingly, and as highlighted earlier, CS ends up having a broad scope. Furthermore, CS is often used to discuss management issues but if it were used for the sole purpose of developing the supervisee's therapeutic competence, other opportunities for managerial supervision would have to be made available.

As suggested previously, another 'relationship', that is, the relationship that develops between supervisor and supervisee, has received limited attention thus far as nursing grapples with CS. This article will now focus attention on the supervisory relationship and consider the relevant empirical literature.

Supervisory relationship

In addition to implying particular benefits, the multiplicity of CS definitions also signifies a relationship demanding a level of interpersonal competence. For example, the CPNA (1985) referred to a 'dynamic, interpersonally focused experience', Barber and Norman (1987) highlighted 'an interpersonal process', and Butterworth and Faugier (1992) described 'an exchange'. Yet, it would appear that only a small number of nurse authors in the UK have acknowledged the importance of the supervisory relationship (Butterworth and Faugier, 1992; Bond and Holland, 1998; Sloan, 2000; Chambers and Cutcliffe, 2001; Jones, 2001). Bond and Holland (1998) asserted that the quality of the supervisory relationship has an important influence on the overall effectiveness of CS. These assertions parallel the significance afforded the supervisory relationship in the psychotherapy, counselling psychology and clinical psychology professions. A review by Kilminster and Jolly (2000) concluded: 'The quality of the supervision relationship is probably the single most important factor for the effectiveness of supervision'.

Table 1. Benefits of clinical supervision for nurses

- Feel supported (Farrington, 1995)
- Experience less stress, burnout and sickness absence (Kopp, 2001)
- Develop personally (Royal College of Nursing, 1999)
- Be less inclined to leave nursing (Bishop, 1998)
- Notice an increase in their confidence (Dunn et al, 1999)
- Feel less isolated (Cook, 1996)
- Develop their clinical competence and knowledge base (Nicklin, 1995)

Overview of the empirical research

Despite the supervisory relationship receiving some attention in the nursing press (Sloan, 2000; Chambers and Cutcliffe, 2001; Cottrell, 2002), evaluative research has tended to overlook this important aspect. Following a review of the research measuring the effectiveness of CS in nursing, it is apparent that there has been minimal attention afforded to the supervisory relationship (Palsson et al, 1996; Butterworth et al, 1997; Nicklin, 1997). Similarly, with the exception of Sloan (2004), there has been minimal focus in the nursing research literature on the interpersonal interactions between clinical supervisor and supervisee. Subsequently, the nature of the supervisory relationship has not been captured. What remain under-researched and shrouded in a degree of mystery are the interactions that take place within the supervisory relationship which contribute to its knowledge development and confirmation capabilities.

While the interpersonal interactions during CS in nursing have received limited attention, there are a few studies that have attempted to highlight important characteristics of clinical supervisors. While Pesut and Williams (1990), Severinsson (1995) and Severinsson and Hallberg (1996) have investigated characteristics of a clinical supervisor from the supervisor's perspective, Fowler (1995) and Sloan (1999) have explored supervisees' perceptions. From an experienced clinical supervisor's perspective, good characteristics of a clinical supervisor include giving specific ideas about interventions, providing feedback on performance, creating a warm and supportive relationship, promoting autonomy, being knowledgeable and competent (Pesut and Williams, 1990), confirming supervisees' professional practice (Severinsson, 1995), being willing and prepared to demonstrate understanding and bring out genuine feelings (Severinsson and Hallberg, 1996). The ability to form supportive relationships, having relevant knowledge and clinical skills, expressing a commitment to providing CS, and having good listening skills were perceived as important characteristics from the supervisee's perspective in Sloan's (1999) investigation and were consistent with Fowler's (1995) earlier findings.

Nonetheless, it is argued that there is a dearth of any guidance on how to commence this important relationship. The remaining section of this article will illustrate how a supervision agreement checklist (Howard, 1997) can be useful during the early stages of the supervisory relationship. If the beginnings of the supervisory relationship are thoughtfully

considered it is suggested that CS can remain loyal to its traditional intent and so provide an opportunity where nurses can develop their therapeutic acumen. While the author was unable to locate any published empirical support, his personal experiences provide confidence for him to suggest that other nurses consider experimenting with Howard's template.

Beginnings: an essential phase of the supervisory relationship

The early phases of the supervisory relationship can trigger a great deal of anxiety for the supervisee and clinical supervisor (Bond and Holland, 1998). Anxiety is a frequent and natural experience for both participants. Some are able to acknowledge it as such and work though this phase whereas others are disabled by their anxiety and protect themselves using various defences. In this context, for the supervisee, anxiety is often related to their need for approval and believing that the only way of achieving this is by being 100% competent, an unattainable task. Following on from this, the supervisee can get stuck in a cycle of denying deficits in their therapeutic competence and become unable to discover anything new about themselves or contemplate opportunities for further development. Another supervisee reaction, according to De La Torre and Applebaum (1974), is to hide behind a plethora of clichés. In their attempt to be part of the established psychiatry 'club', supervisees used clichés to mask their ignorance and uncertainty.

The clinical supervisor may also experience anxiety as a consequence of the pressure exerted from the insurmountable expectations nursing has for CS. Clinical supervisors may, unnecessarily, feel they are responsible for improving the emotional wellbeing of the supervisee, reducing their sickness absence, resolving the stress and burnout experienced by nurses, increasing nurses' job satisfaction and improving the health of the nation. Consequently, as Fowler (1996) has suggested, it is worthwhile arranging some initial sessions to explore some of these concerns and accommodate this 'getting to know you' stage.

So what about the beginning stages of the supervisory relationship? In his book, *Nursing Supervision: A Guide for Clinical Practice,* Power (1999), affords some attention to the first supervision session. In particular, suggestions on what both the supervisor and supervisee need to know about each other are made. Following on from this, constituents of the supervision contract are described. However, Howard (1997) suggested a more comprehensive template in her 12-item supervision agreement checklist (*Table 2*). A supervision agreement in the context of providing CS for a nurse undertaking a formalized course in cognitive behaviour therapy will be used to illustrate the 12 items.

Purpose

When a practitioner approaches a potential clinical supervisor, one of the first tasks is to clarify his/her understanding of CS. This is particularly relevant if consideration is given to the multitude of interpretations nursing has placed on CS. As highlighted earlier, CS serves a broad purpose in nursing and its scope ranges from providing an opportunity for a practitioner to contemplate their interactions and relationships with patients to reducing the experience of stress experienced by the supervisee. Supervisor and supervisee should take time to clarify the opportunities and boundaries of this resource with each other. If there are considerable anomalies the search for another supervisor is advisable. Alternatively supervisor and supervisee might be able to negotiate with each other and reach a mutually satisfying compromise.

There is evidence in the literature that highlights the potential difficulties that can result from the lack of a shared understanding of the purpose of CS (Cutcliffe and Proctor, 1998). In a study conducted in mental health nursing, some participants experienced the phenomenon 'intrusive enquiry' when the clinical supervisor tried to provide a therapeutic focus which had not been negotiated (Sloan, 2004). It is argued that a shared understanding of the purpose of supervision sets a solid foundation for the supervisory relationship.

Table 2: supervision agreement checklist

- Purpose
- Professional disclosure statement
- Practical issues
- Goals
- Methods and evaluation
- Accountability and responsibility
- Confidentiality and documentation
- Dual relationships
- Problem resolution
- Statement of agreement

Source: Howard (1997)

Professional disclosure statement

Howard (1997) implies that this aspect of the supervision agreement checklist is an opportunity for the clinical supervisor and supervisee to get to know each other's current professional experiences. The clinical supervisor can share information regarding his/her training and experience in providing supervision, his/her professional background and training and any particular specialist skills. The supervisee is encouraged to share information about his/her professional training, clinical experiences to date, clinical interests, strengths and limitations and experiences of CS. Both parties should take the opportunity to describe their particular theoretical orientation to clinical work and supervision. The sharing of this information may reduce the possibility of a supervisor providing supervision in such a way that is in conflict with what the supervisee requires.

Practical issues

In recent years, recommendations regarding the frequency and duration of supervision sessions for the nursing profession have been suggested. Results from a validation study of the Manchester CS Scale prompted Winstanley and White (2003) to recommend that supervision sessions should be monthly or bi-monthly in frequency and last 1 hour, although they suggested this could be extended a further 30 minutes for community practitioners. Ideally,

details concerning the frequency of supervision sessions, their duration and the length of contact are negotiated between clinical supervisor and supervisee. Perhaps the nursing profession needs to consider establishing a minimum amount of supervision for its practitioners. Negotiating a protocol for cancellations and procedure for emergency contact is recommended.

Supervision goals

The next stage of the supervision agreement checklist encourages the supervisee and his/her supervisor to consider what the supervisee expects to achieve from CS. Ideally, the supervisee will have considered his/her goals for any opportunity of CS. Supervisor and supervisee can begin to explore methods that will be effective in achieving such goals. The supervisee goals, which follow might be relevant to a mental health practitioner developing knowledge and skills in cognitive and behavioural therapy:

- To develop my assessment of mental health problems
- To increase my understanding and delivery of evidenced-based interventions
- To be able to develop an individual case formulation with someone suffering from major depression
- To enhance awareness of my interactions with clients.

And, as clarified earlier, once initial goals have been reached, further goals for supervision can be generated. For example, once the practitioner has developed his/her ability in devising an individual case formulation with someone suffering from major depression they might set a goal for developing their ability to formulate with some of the anxiety disorders.

Methods

The clinical supervisor should be open and collaborative with regards to methods adopted during CS. He/she needs to clarify the supervision framework and its integral methods for the supervisee. For example, if using Padesky's (1996) cognitive therapy supervision model, some explanation and description of the available modes and foci is required (*Table 3*). In nursing, case discussions based on the supervisee's self-report appears to be the most commonly used mode during supervision. It has been highlighted elsewhere (Sloan, 2003) that varying the modes in supervision, for example, incorporating the use of audio recordings of nurse-client interactions, can be useful.

It was Rogers (1942) and Covner (1942) who introduced the review of audio recordings of the supervisee's therapy of his/her client during CS. By reviewing the audio recordings of nurse–patient interactions, opportunities to explore the finer nuances of nursing interventions and their impact are made available. It is important that supervisor and supervisee can negotiate some flexibility and experimentation with these methods in an open and collaborative manner. The clinical supervisor cannot be prescriptive in the use of such alternatives. Ideally, supervisees have the freedom to decide whether or not they take an audio recording of their interactions with a patient to their CS. Before audio recordings of a supervisee's clinical work are made available, it is necessary to secure the patient's informed consent (Nursing and Midwifery Coucil (NMC), 2002).

Evaluation

The mechanisms of evaluation must be negotiated between supervisor and supervisee. Ideally, both supervisor and supervisee should be willing to receive feedback/evaluation on their contributions. The opportunity for feedback between supervisor and supervisee should be provided at each session. A more structured evaluation can be organized at frequent intervals, for example, 6-monthly (see example of supervision agreement). This evaluation can determine if supervision goals are being attained and can provide useful feedback on the delivery of supervision and the supervisory relationship. It is suggested that commitment to the on-going evaluation of these processes will make a positive contribution to CS outcomes.

Accountability and responsibility

Any code of ethics/practice concerning both the supervisee and clinical supervisor must be discussed. The supervision agreement example highlights the importance of the NMC, British Association of Behavioural and Cognitive Psychotherapy (BABCP) and United Kingdom Council of Psychotherapy (UKCP) codes of practice.

Confidentiality

According to Driscoll (2000), confidentiality is essential in CS, but he acknowledges that it will take time before the

Table 3. Cognitive therapy supervision grid (Padesky, 1996)

		MODE				
		Case discussion	Video/audio/ live observation	Role-play	Co-therapy with supervisor	Peer co-therapy
	Mastery of cognitive therapy methods					
	Case conceptualization					
	Client–therapist relationship					
	Therapist reactions					
	Supervisory process					

supervisee feels comfortable enough to begin to disclose certain aspects of his/her practice. Consequently, clarification regarding the extent and limits of confidentiality must be provided (see supervision agreement example). It has been suggested that clinical supervisors should consider breaking their agreement of confidentiality only when they consider that the supervisee has disclosed or demonstrated professional misconduct and/or that they are unfit to continue to practise nursing (Power, 1999).

When audio recordings of nurse–client interactions are used in supervision, as stressed earlier, the patient's informed consent must be obtained.

Documentation

This is an aspect of CS that can instil a great deal of anxiety. This concern is often related to who will keep such documentation, what information will be recorded and for what purpose. Ideally, this should be negotiated in a collaborative and open manner between supervisor and supervisee (Power, 1999; Cutcliffe, 2000).

Until quite recently, the administrative aspects of CS had not received a great deal of coverage in the nursing literature. However, issues relating to this are now beginning to be addressed, for example, Bond and Holland (1998) support the recording of some information relating to the content and structure of supervision. When notes are made they should, according to Bond and Holland (1998), include general subject headings, have the agreement of the supervisee and supervisor and not contain any client or colleague identifying information. Using such records as an *aide-mémoire* is an obvious benefit. Furthermore, keeping records of supervision is believed to help clarify what the supervisee wants to discuss; over time they can illuminate recurring themes (Cutcliffe, 2000) and uncover supervisee development (Driscoll, 2000). Such documentation, argues Rolfe et al (2001), can be progressed towards a valuable learning resource for the supervisee.

As clinical supervisor, I agree to:

- Meet punctually at regular intervals to offer a minimum of 1hour and 30minutes of supervision per week
- Meet in an environment in which there is as little interruption as possible
- Maintain confidentiality, which means no information brought up by _____ will be discussed outside the supervisory session apart from:
  1. Within my own supervision (of supervision) where only christian names will be revealed
  2. When there has been a breach of BABCP code of ethics/practice and following discussion with the supervisee it may be necessary to divulge information to other parties (manager, BABCP)
- Treat _____ in a professional manner
- Keep records of supervision sessions in a secure place — locked filing cabinet in my office
- Make myself available by telephone between sessions for consultation for urgent matters
- Adhere to the NMC Code of Conduct, BABCP and UKCP codes of ethics
- Prepare for supervision sessions
- Support, encourage and give constructive feedback
- Challenge practice which is unethical, unwise, insensitive or incompetent
- Challenge blindspots
- Review the usefulness of the work done after 6months and if necessary re-negotiate the contract
- Negotiate with _____ when and if necessary to make changes to the contract
- Support _____ in his/her pursuit for BABCP accreditation

BABCP = British Association of Behavioural and Cognitive Psychotherapy, NMC = Nursing and Midwifery Council, UKCP = United Kingdom Council of Psychotherapy

Figure 1. Supervision agreement. Clinical supervisor.

Dual relationships

In nursing, the supervisory relationship often coexists with another relationship. CS is often provided in a hierarchical fashion (Lyle, 1998; Yegdich, 1999b; Gray, 2001), where the supervisee's clinical supervisor is also their line-manager. When this occurs there is a structural power differential and often an appraisal function that accompanies the manager's role. Where this is unavoidable, and alternative opportunities for CS are absent, appropriate boundaries for the defined purpose of the supervisory relationship must be clarified. Nonetheless, problems can occur. In a recent study, the category Dual Role Incompatibility uncovered the tensions created as a result of supervision being provided by a line-manager (Sloan, 2004). Interestingly, both clinical supervisor and supervisee contributed to this blurring of roles; supervisors acted as managers and supervisees engaged as subordinates during CS. Perhaps in an ideal world CS should be provided by someone outside line-management structures. However, it is often the most convenient way of organizing supervision for the nursing workforce of a healthcare organzation.

Problem resolution

If a supervision agreement contract is negotiated between supervisor and supervisee during the early stages of the relationship then the likelihood of problems are reduced. Furthermore, if the supervision framework adopted encourages frequent feedback between supervisor and supervisee then potential problems can be identified before developing into something insurmountable. Nonetheless, options for both supervisor and supervisee, should a problem surface that cannot be resolved between them, should be clarified.

Statement of agreement — contract

The example provided highlights the commitment and requirements for both clinical supervisor and supervisee (*Figures 1 and 2*).

Conclusion

This article highlights that the supervisory relationship has been a neglected aspect of CS in much of the nursing literature. A publication by Chambers and Cutcliffe (2001) focused attention on 'ending' in this relationship. While these considerations are important, it can be argued that the early stages of this relationship also warrant attention. By incorporating a supervision agreement, healthy beginnings may reduce the potential for difficulties at later stages of this relationship and goes some way towards enhancing the trajectory of this alliance. In this article, a template for the supervision agreement devised by Howard (1997) has been described. Nurses who have embraced the opportunity of CS but find themselves without a supervision agreement/contract are encouraged to consider the usefulness of Howard's (1997) template. BJN

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KEY POINTS

- A supervision agreement can contribute towards healthy beginnings of this relationship.
- This agreement can help to focus the tasks of supervision.
- Clinical supervision can enhance the therapeutic competence of nurses.

As supervisee, I agree to:

- Meet punctually at regular intervals for a minimum of 1 hour and 30 minutes of supervision per week
- Maintain confidentiality of clients by using only christian names
- Seek client informed consent if audio recording therapy sessions
- Consult with _____ by telephone between sessions only when an urgent matter arises
- Adhere to the BABCP and UKCP code of ethics and NMC code of practice
- Take responsibility for the work carried out with clients
- Bring issues to supervision for which consultation is necessary
- Prepare for supervision sessions and formulate supervision questions
- Raise difficulties about supervision with _____ when and if these arise
- Review the usefulness of the work done after 6 months and if necessary re-negotiate the contract
- Re-negotiate with _____ when and if necessary to make changes or terminate this contract
- Pursue BABCP accreditation

BABCP=British Association of Behavioural and Cognitive Psychotherapy, NMC=Nursing and Midwifery Council, UKCP=United Kingdom Council of Psychotherapy

Figure 2. Supervision agreement. Supervisee.