

A conceptual model for clinical supervision in nursing and health visiting based upon Winnicott's (1960) theory of the parent–infant relationship

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This paper consists of a review of mostly nursing literature with the purpose of developing a conceptual framework for understanding the process of clinical supervision and the nature of the supervisory relationship utilizing a psychodynamic perspective. The paper explores the experiences of nurses and health visitors during clinical supervision in order to illustrate how the dynamics of clinical supervision can be understood and enriched by using the concepts 'Holding, handling and object presenting' (Winnicott 1960) as a conceptual schema.

Keywords: clinical supervision, facilitating environment, psychodynamic theory

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Introduction

A number of authors when writing about clinical supervision have employed Winnicott's concept of 'holding' to suggest features of the supervisory relationship in the context of nursing and health visiting. Holding can be understood as the ability to have an empathic concern for the supervisee, along with the capacity to provide the conditions for 'safe' supervisory work and the potential for enabling appropriate growth and change. Here Winnicott's concept the 'good enough mother', referring to the parental need to provide adequate care and concern for the child aids consideration of the 'facilitating environment' in clinical supervision. It demonstrated that perfection should not be the expectation of the supervisor but that the goal should be to provide 'enough holding and containment for confidence and trust to be established' (Swain 1995, p. 43). Winship's (1995, p. 228) account of clinical supervision with nurses working with acutely disturbed patients suggests that for mental health nurses to 'hold the patient in their distress' they... 'need some form of supervisory

holding in order that they may process their subjective experience'.

However, when Hughes & Pengelly (1997, p. 178), refer to Winnicott's (1960) 'sense of being held' to convey the importance of 'consistency, regularity, clear boundaries and minimizing intrusion', they are describing a more complex scheme than is conveyed by the concept of holding. Thus drawing attention to the need to explain concepts described by Winnicott which address the other dimensions of the facilitating environment and relationship which are 'handling' and 'object presenting'.

A starting point to applying a Winnicott orientation to clinical supervision in nursing and health visiting would see 'holding' as an active, empathic concern for the professional health and welfare of one's colleagues which leads to a defined relationship based on mutual trust. Such a concern then extends into the concept of 'handling' through the identification and provision of the necessary conditions for professional development via the capacity to find useful meanings out of the challenges of loss, change and adaptation. The creation of such conditions for

professional growth has then the potential to lead to a relationship centred on 'object presenting'. This process includes mutuality, a furthering of professional self belief and thus the ability for the supervisee to be independent and the author of acts of good for self, colleagues and patient.

The aim of this review is to further explore Winnicott's theory of the parent-infant relationship in order to explain its strengths as a possible and relevant conceptual framework to guide the process of clinical supervision in nursing and health visiting.

The concepts of holding, handling and object presenting

Winnicott explored the early infant-maternal experience and relationship drawing attention to the 'importance of personal and environmental influences in the development of the individual's (1960, p. 37). Maternal provision according to Winnicott, 'protects (the young infant) from physiological insult... by taking account of the infant's sensitivity to touch, temperature, sound and light, falling and lack of knowledge of the existence of anything other than the self'. He subsequently identified three ways in which the mother protects, orientates and enables the baby to progressively gain control over the self and the environment by learning from experiences. These are 'holding', 'handling' and 'object presenting' (see Table 1).

The use of a theory about child-parent relationships as a means of explaining the needs and experiences of adults in clinical supervision could be seen to be controversial. It is however, the intention of this paper to demonstrate how such ideas are valuable when illustrating and explaining a model of the supervisory process.

Holding and clinical supervision

One advantage of using Winnicott's theory to inform supervisory practice in nursing and health visiting is that as a result of its preoccupation with the child-parent relationship, its primary concern is with growth, development and the conditions by which these will occur. This therefore mirrors the intended process of clinical supervision. As a result it is possible to associate the use of such ideas with meeting the ordinary and healthy needs of nurses.

Clinical supervision can be seen to contain maternal aspects in that the activity involves containing and managing the feelings and impulses of the supervisee through the demonstration of empathy and the protection of the supervisee from the effect of too many 'jarring experiences' (Gomez 1997). The presence of jarring experiences in care work is increasingly recognized. Caring for individ-

Table 1
The concepts of 'holding', 'handling' and 'object presenting'

HOLDING

Maternal 'holding' is both a physical and an emotional act. The good enough mother contains and manages the baby's feelings and impulses by empathizing with him and protecting him from too many jarring experiences. Her protective holding is expressed through the way she carries, feeds, speaks and responds to her baby and in her understanding of his needs and experiences.

HANDLING

The second aspect of this early relationship arises from the mother's 'handling'. At its best, her sensitive touch and responsive care of the baby's body will enable him to experience physical and emotional satisfaction in an integrated way. This helps the baby to bring together the worlds of sensation and emotion and build a stable unity of mind and body. The individual who has received enough sensitive handling in early life will experience his mental, emotional and physical capacities as connected, personal and authentic to self.

OBJECT PRESENTING

'Object presenting' is the way in which the mother brings the outside world to her baby. When this goes well, the baby is ready to receive and explore and the mother is happy to allow him some independence. Through presenting objects and experiences in a way which is sensitive to her baby's state, the mother helps him build a primitive conviction of his omnipotence and the ability to be the author of his own success. Thus the baby develops a sense of oneness and trust in the world which grows into an appreciation of both his connection with others and his separateness. He gains a confidence in his ability to reach out and to make changes in the world and he expects to be met with understanding and responsiveness.

Adapted from Gomez (1997, p. 89–90).

uals with dementia has been found to engender feelings of meaninglessness, helplessness and anxiety (Hallberg & Norberg 1993). Lawler (1991) suggests that general nurses find it very difficult to talk about their work with anyone other than nurses as it involves aspects of life which are considered dirty or too sexual for others' comfort. Smith's (1992) narrative of the care experiences of general student nurses points to the unbearable dissonance that can exist between social expectations of how the nurse should behave and their ordinary impulses. Adams (1996) found loneliness was a feature of the work experience of community psychiatric nurses (CPNs). Palsson *et al's* (1994) analysis of the clinical supervision narratives of district nurses showed they were troubled by: coming too close to the patient; keeping and restoring patients' hope; feeling powerless and feelings of disgust, shame and guilt.

Severinsson (1995) found that during clinical supervision involving psychiatric nurses significant emotional states occur which involve feelings of guilt about care and work relationships and that these impacted negatively upon job satisfaction and their ability to develop professionally. Snelgrove's (1998) comparative study of the occupational stress levels experienced by health visitors, district nurses and community psychiatric nurses generated find-

ings which suggest that factors inducing job stress included emotional involvement, unpredictable work events and an instability surrounding the work content. Clearly, jarring experiences in professional care are varied, somewhat specific to the client group and point to the need for development of more creative and supportive supervisory relationships.

Given such illustrations it is possible to see why the case for an 'emotional support system' (Hallberg 1994) has led to the acceptance that clinical supervision should provide support and restoration (Proctor 1987). Such thinking is in tune with the notion of 'holding' and its demonstration of empathy for the experience of the supervisee. However, there are problems in accepting that clinical supervision is just an unconditional empathic activity by which the supervisee is to be relieved of the emotional strain of their work (Hallberg 1994). This, according to Hughes & Pengelly (1997), would suggest that clinical supervision is an act of unconditional positive regard, making support the principal function of clinical supervision rather than a basis for ensuring and promoting safe and higher standards of care.

A related issue is the relative reticence in nursing of dealing with the emotions engendered by caring. From a psychoanalytical perspective, intimate care can be seen to expose the nurse to both the patient's libidinal and aggressive impulses as well as his or her own (Fabricius 1991). Work with ill patients constantly confronts nurses with severe, often life threatening illness and with death. As a result nurses have to struggle with their anxieties about illness, death, dying, loss, guilt and helplessness (Skogstad 1997).

Social systems traditionally employed to deal with emotionality in the work place have relied upon the processes of psychosocial distancing, task allocation and the depersonalization of patients (Menzies 1959) and denial, splitting and projective identification (Dartington 1993). The adoption of a process of clinical supervision which attends to the emotional world of the worker means that nursing has to confront the emotional dimension of care.

According to Yegdich & Cushing (1998), nursing literature in the UK is unknowingly re-enacting the debate about the purpose of clinical supervision which has preoccupied psychoanalysts since the acceptance of the practice in the 1920/30's. In other words, is its primary purpose 'treating or teaching'? As previously stated, Winnicott's theoretical perspective helps to establish a position in relation to this question by suggesting an appropriate way to work with emotions. Such an orientation centres on the belief that the human inherited tendencies for growth will always reassert themselves given the right conditions (Phillips 1988). Clinical supervision would therefore be seen as a growth orientated relationship process concerned

with teaching in the broadest maternal sense. This would avoid turning the emotional world of the nurse into a source of pathology or dysfunction and allow the emotions engendered by care to be used as a way of accessing intuitive knowing and thus a means of learning from practice experiences.

Winnicott's notion of maternal containment helps to identify ways in which the supervisor can work with the emotions of care. Palsson *et al.* (1994) employ the term 'overwhelming situations' to convey the nurses' sense of not knowing what to do, which was a feature of the narratives brought to clinical supervision. Butterworth *et al.*'s (1997) extracts from clinical supervision are other examples of such emotional states of doubt and the associated inability of the supervisees to make useful sense out of experience. For instance, a nurse presented as 'feeling incompetent and guilty of poor judgement' and a nurse had to deal with the fact that 'a patient set fire to themselves'. Another nurse who had 'a family member diagnosed with cancer' found that this impacted negatively upon her ability to care for patients with cancer.

In the extracts the supervisor demonstrated containment by being a person who could take on the overwhelming experience of the supervisee and then enable meaning to be achieved by the supervisee that could be tolerated and understood. Supervisory containment is about helping the supervisee to 'name' an emotional experience 'in order that they can mobilise appropriate defences to a situation which is wrong or downright unbearable and then be helped to protect themselves from stress in order that the care task is protected' (Dartington 1993, p. 34).

A link can be made here with Winnicott's notion of 'unintegration' (Gomez 1997). For the infant this is a state of being which either produces senses of being real and comfortable with the world or unreal, ill at ease and at odds with the world. What makes the difference is how the mother manages the maternal environment to ensure that its quality is such that the infant is able to manage without being jarred, overexcited or frightened and avoid the baby coping by 'withdrawing' as a means of self protection. Where maternal care is provided which is 'good enough', threats to the infant's sense of self are managed, leading to a state of 'unintegration', which enables the infant to experience a relaxed and undefended openness to the world of experience. Such states make it possible for the infant to develop a sense of true self based upon experiences which have coherence, continuity and novelty.

In the literature related to clinical supervision in nursing and health visiting it is possible to determine a call for an adult equivalent of such a provision and the hope of similar beneficial consequences for the nurse. A study of the practice of clinical supervision (Rafferty *et al.* 1998), suggests

that an appropriate environment for clinical supervision had characteristics of comfort, privacy and reasonable control of distractions. Palsson *et al's* (1994) work revealed that nurses valued undisturbed analysis of situations. Ritter *et al's* (1996) settings for clinical supervision 'ensured psychological and physical safety and comfort'.

Some of the literature can be seen to call for a process which implies 'a relaxed and undefended openness to the world of experience'. For instance, Winship's (1995) supervisees brought their work related dreams to clinical supervision. Part of Hallberg's (1994, p. 46) process included 'free association to key words'. McCormack & Hopkins (1995, p. 164) worked toward creating a reflective milieu, which was both consistent and spontaneous. Jones's (1997, p. 241) supervision of his work with a dying client provided 'creative holding conditions'. Dudley & Butterworth (1994, p. 39) supervisees valued the 'interplay' that occurred as part of the interaction in clinical supervision. Such examples support the value of helpful unintegrative experiences in clinical supervision.

Clinical supervision has to be concerned firstly with the 'here and now' world of the supervisee. Based on the limited descriptions available about the supervisory process, core issues are often about professional anxieties (Bishop 1998) and situations involving demanding interpersonal issues (Rafferty 1999). Use of Winnicott's notions of the maternal provision as an aid to thinking about clinical supervision helps to keep in mind that 'when it goes well' it does not lead to the 'closing down' of the supervisee's being, but rather to a state of creative play. This can enable sensations and ideas about practice to be put into a tangible, useful form, leading to an enhanced ability to be the author of our own and colleagues good.

The literature about clinical supervision consistently points to descriptions of the qualities that the supervisor will need to bring to the relationship (Faugier 1992a, Jansson & Norberg 1993, Chambers & Long 1995, Jones 1996). From the idealistic to the realistic; many of the qualities listed by these authors are relationship skills which supports Jones' (1996) claim that the relationship quality is of greater significance than the issues of method. Winnicott's thinking not only helps us to keep a sense of proportion (supervisory care can only be 'good enough' not perfect), but aids the acknowledgement of the importance of the supervisor recognizing and responding appropriately to the unique needs of the supervisee. Thus the level of the supervisor preoccupation with the needs of their supervisee has to vary at different points in their supervisee's professional development.

It may therefore be argued that supervisor preoccupation with the needs of the supervisee, establishes the conditions for a supervisor to become an 'attachment figure'

(Bowlby 1988). The complex ideas of the attachment theory suggest that, 'all of us, from the cradle to the grave, are happiest when life is organized as a series of excursions, long or short, from the secure base provided by our attachment figures' (Bowlby 1988, p. 62). This would mean that the more securely 'attached' we are as nurses, the more able we should be to explore our world of practice.

The first concept in Winnicott's theory of maternal provision 'holding', has been used to explain the developmental case for nurses to have helpful 'unintegrative' experiences which aid them to make sense of threats to their self so that they remain authentic to themselves and their profession. 'Holding' has been seen as central to the supportive — restorative function of clinical supervision and this has been understood in terms of meeting a legitimate need for a professional attachment figure.

Handling and clinical supervision

For Winnicott, sensitive and responsive body care allows the baby to establish a stable integration and unity out of the worlds of sensation (of the feelings of the body) and thinking (of the images of the mind). That is, to establish a 'psychosomatic relationship' (Gomez 1997) by knowing of the body, its responses and links with developing mental images of self and the world.

In this context Butterworth *et al.* (1997) in an evaluation of clinical supervision in England and Scotland, advised nursing to take a particular interest in psychosomatic issues. Their findings suggested clear associations between how individuals estimate their personal physical fitness and then rate their psychological well being. Levels of sickness and absence were lower when respondents reported better fitness levels.

However, this research does not suggest any explanations or make a link with any of the work environments to explain this phenomena. Butterworth *et al.* (1997) simply recommend that employers 'encourage' the pursuit of healthy lifestyles by their workers. More could have been made of their finding that nurses are more stressed in work now than years ago. Something of the current turbulent nature of the health service is revealed by the reduction in the numbers of respondents in this study, which had decreased by 36% by the end. Reasons provided by Butterworth *et al.* (1997, p. 8) for this were 'regrading, relocation and staff turnover'. Such turbulent working conditions and their potential consequences for body health forms the basis of much needed future research.

Many reports by nursing practitioners during educational preparation for clinical supervision (Rafferty 1998), have left the impression that the current nature of the nursing work experience (particularly in acute care) has

led to unhealthy body experiences whilst at work. The historical nursing defence of stoicism (displayed particularly by senior nurses) has led to the acceptance of a norm of missed breaks and meals, lengthy spans of duty, duty changes at short notice and the frequent taking of administrative work home for completion.

Wolsey & Leach (1997, p. 25) note that it is important to accept that '45 minutes per month of even world class supervision is unlikely to be enough to help people who may spend the remaining 149 hours . . . in hostile working environments'. Perhaps though if clinical supervision is established as an orientating rhythm or custom and practice via the concept of 'handling', it can provide reference points for bringing the mind and body experiences of the world of work together. This is necessary in order to help nurses determine good enough responses to demands from others (health/educational organizations) which have implications for their body (e.g. physical demands) and their mind (e.g. competency demands).

'Handling' has relevance to the management and delivery of clinical supervision and the need to address the delivery systems for supervision. The literature would suggest a need to examine issues to do with structure (Bodley 1992) and authority (UKCC 1996).

In the early maternal relationship it is the mother who, through understanding the infant's developmental needs, determines the form of 'handling'. She has the power to determine the form of the maternal delivery system, though society is quick to call her to account for abuse of such power. In current thinking about clinical supervision there is no such clarity about when it might be developmentally appropriate for the supervisor to have the potential or ability to limit or stop another's practice. This is possibly a result of the widespread worry that clinical supervision will become managerially driven. As Jones (1996, p. 291) suggests the 'literature reads like a litany of fears. . . . that supervision will become contaminated with overseeing, directional and inspective functions'.

As identified by Rafferty & Coleman (1996), effective clinical supervision involves the exercise of appropriate authority. Failure to see that the 'handling' dimension of clinical supervision, out of necessity involves authority of purpose and therefore the potential for appropriate limit setting, could reduce clinical supervision to a series of isolated, unaccountable, undirected and under-resourced interactions.

The principle purpose of maternal 'handling' is to provide the baby with a sense of connection and orientation to his body and his world. Failure of such a provision can leave the child with an incomplete idea about what is up or down, inside or out, forward or backward. That is the ability to connect together what he feels and thinks is

right or wrong. The mother, through her monitoring and responses, makes decisions about what to 'fuss about or not fuss about' (Winnicott 1988), thereby supporting the infant's orientation about what is mentally or physically significant or important. The failure to provide secure maternal 'handling' has been linked with the development of an antisocial tendency (Gomez 1997). Therefore it should be a concern of any caring discipline to ensure that its practitioners have the ability to act in a way which is congruent with what they feel and think, within the boundaries of acceptable professional conduct. Clinical supervision could provide regular opportunities for such an orientation to be achieved and maintained.

How this monitoring or normative function in clinical supervision should be actualized is currently a cause of debate and concern in nursing. There is a widely held conviction that what to 'fuss about', should not be driven by an organizational or hierarchical agenda (UKCC 1996). While a professional agenda for monitoring is preferred none of the professional infrastructure to make this possible is in place (e.g. certification and registration of supervisors or lines of communication with UKCC about a supervisor's practice), although a professional orientation for the 'handling' work of clinical supervision is available.

The Chief Nursing Officer for England, Yvonne Moores, views clinical supervision 'as fundamental to safeguarding standards, the development of professional expertise and the delivery of quality care' (DoH 1994). The task is to translate this orientation into patterns of 'handling' in clinical supervision within which it is possible to both feel and think about the characteristics of safe and appropriate professional care.

Attention to the 'handling' dimensions of time, frequency and to some extent the modes of interaction adopted (Butterworth *et al.* 1997, Jenkins *et al.* in press), suggest that a pragmatic, as opposed to a theoretical understanding, is driving the delivery aspects of clinical supervision. As Jones (1996) points out, creating an environment conducive to the contemplation of practice which employs the custom and practice of clinical supervision will have daunting resource implications. The recent study by Butterworth *et al.* (1997) could be seen to be compromised by the practitioners' inability to meet the time demands for clinical supervision. Whilst many Trust executive nurses are supportive of the general need for clinical supervision, they can take it no further than pilot projects because of 'the lack of a costing model which could be set against hard outcomes' (Bishop 1998, p. 148).

Therefore it seems that theoretical explanations have to date been able to tell us something of the 'handling' process, e.g. how to talk, etc. (Faugier 1992b), but not really established in a convincing enough way, an

overarching conceptual framework which provides an imperative to carry out clinical supervision within an established context of time.

Returning to the orientating principle for clinical supervision (DoH 1994), it could be argued that the function of 'handling' in clinical supervision is to produce developmentally appropriate professional change. The development of professional expertise is overtly about change, while the fundamental need to safeguard standards and deliver quality care implies the need to at least question what we do.

Change processes are difficult. In the growth of infants, which is driven by a powerful biological imperative, it is possible to show that even they can get stuck when forced to deal with upsetting or unpredictable events, without a secure relationship within which it is possible to 'protest, adapt and/or mourn' (Hughes & Pengelly 1997, p. 136). The work of Marris (1986) suggesting a similar process, is observable in studies of how adults cope and adapt in situations of loss and change. The assertion here (designed to help answer the question of how often clinical supervision should occur) is that the 'handling' dimension in clinical supervision has to be good and frequent enough to meet human needs for protest, determination of meaning, followed by adaptation and/or mourning, within the context of the delivery of quality care.

Object presenting and clinical supervision

'Object presenting' refers to the ways the mother brings the outside world to the baby. The development of reciprocity between the infant and the mother facilitates the baby's instinctual abilities to both receive and explore. Maternal attunement by its good enough responsiveness to the infant's exploratory drive provides a provision which is neither too quick or too slow. When 'all goes well' the baby develops an ability to associate his responses with a desirable outcome. So begins the infant's belief that he has the capacity to bring about change through his own actions.

With regard to clinical supervision and adults, it is possible to suggest that the literature is calling for something similar to maternal responsiveness in the supervisor and in the nature of organizational arrangements. For instance, the best kind of organizational arrangements will be 'responsive' to what practitioners see as needed (UKCC 1996). The literature drives home that clinical supervision has to be led by the interests, excitements and concerns of the supervisee (Faugier 1992a, Morton-Cooper & Palmer 1993, Chambers & Long 1995, Titchen & Binnie 1995, Ritter *et al.* 1996). That clinical supervision is a reciprocal relationship is consistently identified although expressed in

terms such as 'exchange' (Butterworth *et al.* 1996), 'sharing' (Dudley & Butterworth 1994), 'collegial' (McCormack & Hopkins 1995) or 'mutual' (Jones 1996).

The reciprocity which the mother-child couple have to achieve in order to feed successfully, suggests that the restorative and learning functions of clinical supervision are more likely to be met in reciprocal conditions and that such functions are congruent with the essential nature of nursing, which is to nurture (Nightingale 1860, Peplau 1988).

However, it has been argued that nurturing is an inadequate concept to capture the purpose of clinical supervision as it is supposedly not about enabling and affirming (Morcom & Hughes 1996). Though Inskipp & Proctor's (1993, p. 6) definitions of supervisory restoration and learning, which include 'the provision of space, the chance to explore opportunities', 'discharging held emotions and recharging energies, ideals and creativity' and 'shared responsibility for...development in skill, knowledge and understanding' are well capable of being understood within the concept of maternal nurture.

Returning to an earlier point, we carry into adulthood the instinctual abilities to receive and explore. A Winnicott orientation would suggest that what we are doing in our supervisee interactions, be they okay, clumsy, awkward or distracted, is enacting our instinctual capacity to receive and explore. This in order that we may again achieve the hope of self confidence that we can be the authors of our own good and that this can arise with the understanding and responsiveness of others.

The requirement for effective relationships in clinical supervision has been discussed earlier, but it is important to reiterate that effective 'receiving and exploring' by supervisees takes place when there is a belief such activities are occurring in a relationship of understanding and responsiveness (Astrom *et al.* 1993, Severinsson 1995). Effective 'object presenting' in clinical supervision is the ability to carry out 'person and task orientated behaviors in an integrated way' (Kermode 1985). The research literature reviewed supports Winnicott's idea that successful 'object presenting' should lead the supervisee to realise a sense of his/her own ability to reach out and make changes in their world of practice. Attention to 'what the patient has said and done' (Jones 1996, p. 292) reportedly leads to discovery of 'knowledge embedded in practice' (Hallberg 1994, p. 51), and 'helps nurses to be more patient centred' (Paunonen 1991). Other reported changes include increased 'willingness to act, freedom of action' (Paunonen 1991, p. 983), 'courage, self-assurance, mental strength and a sense of well being' (Palsson *et al.* 1994, p. 391) and the ability to 'return to the work of patient care

with '(re-new(ed)) strategies for collaboration' (Ritter *et al.* 1996, p. 150).

An interesting research finding, given the attention on the importance of pace in 'object presenting', is Edberg & Hallberg's (1996, p. 145) report of measurable improvements in nurses' abilities to achieve mutuality with patients. This was demonstrated by the nurses' ability to show more capacity to 'act in the same pace' in their care of patients with dementia following a period of clinical supervision when compared with a control group.

As identified earlier, supervisory facilitation begins with attunement to the issues of the supervisee and then a response at an appropriate 'pace'. Therefore the dimension of pace is important to consider. The only direct reference found is by Watkins (1995, p. 572), who when reflecting and making observations about psychotherapy supervision, observes that a supervisor requires a 'good enough sense of timing'.

Another important dimension of 'object presenting' in clinical supervision, namely the impact of the person who is the supervisor, has received little attention in nursing literature. It is only Palsson *et al.* (1994, p. 392), who report different consequences in the work of two clinical supervision groups which might be explained by the supervisor's 'different personalities and training'.

Turning to the current portrayal of nurses, it is fair to suggest that their experience of 'object presenting', be it as a result of their personal, educational or clinical relationships, has not led to a fortuitous state where they have the self-confidence to believe they can reach out and make changes to their world of practice; with the expectation that they will be met with understanding and responsiveness (Chan & Rudman 1998). As a generalization we are more prone to believe that we cannot make things happen rather than that we can.

The failure of nursing to have a shared voice or conviction about its boundaries makes it difficult to define our core purpose and means we are ever open to redefinition by others. The essential ability of maternal provision to be 'good enough' has been devalued in order to achieve 'through put' as opposed to care. It is therefore hardly surprising that in many adult care settings there is high nurse turnover, sickness and absence, along with problems in recruiting to the profession.

In clinical supervision, the act of 'object presenting' provides the supervisee with a sense they can be separate and be the author of their own good. With useful supervisory provision the supervisee as a result of 'object presenting' achieves or maintains a conviction in the value of their professional self and their actions and a belief that they can bring about change which will be helpful to themselves and to others.

Conclusion

A theory of maternal provision as a conceptual framework for clinical supervision in nursing is fraught with problems and potential misunderstandings. The interpretation of Winnicott's ideas contained within this paper could be construed as advocating a pedagogical as opposed to androgogical facilitation approach. This has not been the intention. Hopefully the case has been made that in providing a facilitating environment it should be possible for there to be appropriate equality and chances for self-direction by the supervisee.

What the framework does suggest, which may be controversial, is that the supervisor, by virtue of their responsibilities for enabling the growth of another, has to have authority of professional purpose. Along with the accountability for creating the 'handling' conditions necessary to maximize the supervisee's inherent capacity for growth, supervisors must have the freedom to set limits or assert professional boundaries.

It could be argued that such a conceptual framework just replaces an existing paternalistic hegemony with one which is maternalistic. The author's intention though, was to demonstrate the potential for such a set of ideas to inform the supervisory relationship and process in order that clinical supervision can be a means of liberating the developmental potential of the individual and the profession.

The concepts of 'holding', 'handling' and 'object presenting' have been used to illustrate the key functions of clinical supervision. An attempt has been made to articulate some of the core elements of each concept in supervisory work. An overarching set of purposes for the clinical supervision process has been suggested. These have to do with:

- creating the conditions for professional attachment and security;
- making professional and personal change and adaptation possible and
- enabling the supervisee to believe that they can be the author of his/her own professional good.

It is proposed that this framework of meaning is true to the maternal nature of nursing and at its most basic, is an understandable and coherent nursing explanation of clinical supervision.

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