

Clinical supervision models for nursing: structure, research and limitations

Sloan G, Watson H (2002) Clinical supervision models for nursing: structure, research and limitations. *Nursing Standard*. 17, 4, 41-46. Date of acceptance: July 22 2002.

Abstract

This article highlights the diversity of supervision models currently described in the nursing literature, clarifies their structure, discusses research conducted on specific supervision models and outlines their limitations. It offers insight into some of the common models that have received coverage in the nursing literature.

THE 1980s saw the evolution and development of nursing models in the UK. At that time, much of the nursing literature described specific models and how they had been adopted in various nursing contexts (Aggleton and Chalmers 1986, Collister 1988, Martin 1987, Walsh 1991). There was an equal abundance of articles describing the incongruity and ineffectiveness of particular models when introduced into particular nursing contexts (Kitson 1985). A similar scenario may be in danger of developing as the nursing profession grapples with clinical supervision and its related frameworks.

Clinical supervision can be delivered in a variety of formats. For example, a clinical supervisor providing supervision to one supervisee is generally understood as individual clinical supervision. Individual clinical supervision is probably the most common format in nursing (Duarri and Kendrick 1999, Girouard and Marchewka 1983, Jones and Bennett 1998). However, descriptions of group and triad formats have also been published (Feather and Bissell 1979, Price and Chalker 2000, Winship and Hardy 1999, Sloan *et al* 2000). In group supervision, a group of between four and six supervisees is guided by a clinical supervisor. This appears to be the favoured method in the Scandinavian countries (Arvidsson *et al* 2001, Begat *et al* 1997, Berg *et al* 1994, Hallberg and Norberg 1993, Palsson *et al* 1994, Severinsson 1995, Severinsson and Hallberg 1996, Severinsson and Kamaker 1999). A clinical supervisor usually offers supervision for two supervisees when using a triad format (Feather and Bissell 1979, Sloan *et al* 2000).

However, regardless of the particular format adopted, consideration should also be given to the framework guiding the delivery of clinical supervision. A supervision model is a conceptual framework that can assist in the delivery of clinical supervision. Such a framework can highlight significant stages of the supervisory process, important functions of supervision, roles for clinical supervisor and supervisee and suggestions on where to focus attention. While there has recently been an increase in the number of clinical supervision models described in the nursing literature, there is evidence to suggest their uptake in specific nursing contexts is limited (Rogers 1999).

Proctor's three-function model

Proctor's (1987) three-function interactive model has gained increasing popularity in nursing and is probably the most frequently cited supervision model in the UK. Its use has been advocated for a diversity of nursing contexts, for example, mental health nursing (Cottrell 2001, Faugier 1996), practice nursing (Styles and Gibson 1999), occupational health nursing (Bainbridge *et al* 2001) and medical and surgical nursing (Bowles and Young 1999, Butterworth *et al* 1997, Dunn 1998).

This model, derived from counselling, can focus on all or any one of three areas at any time. Proctor (1987) explained: 'Both [supervisor and supervisee] carry some degree of responsibility for the development of the student or worker (the formative task). Both carry some share of the responsibility for the on-going monitoring and evaluating of the student or worker and at certain times – at the end of the course or the point of promotion, for instance – either may carry responsibility for assessment (the normative task). Each carries a share of the responsibility for ensuring that the student or worker is adequately refreshed and re-creative (the restorative function).'

In nursing's adoption of this model, the formative function is concerned with skills development and increasing the supervisee's knowledge: the normative aspect concentrates on managerial issues including the maintenance of professional standards (Cutcliffe and Proctor 1998) and the restorative function is

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Key words

- Clinical supervision
- Models and theories
- Nursing

These key words are based on subject headings from the British Nursing Index. This article has been subject to double-blind review.

focused on providing support in an attempt to alleviate the stress evoked by doing the job of nursing (Jones 1996).

However, the helping exchanges, which can be regarded as necessary for the pursuit of each of the model's three functions, remain unclear. For example, what supervisor interventions might be considered appropriate when working in the formative domain? Mullarkey *et al* (2001) favour such mysticism. They state: 'We would argue that models are not by their nature intended to be too prescriptive. Their main role is to identify central functions, philosophy and principles and act as a framework to guide, rather than dictate practice' (Mullarkey *et al* 2001). The authors do not advocate rigid prescription of any particular clinical supervision model, but rather, argue that such frameworks require more precise clarity otherwise nurses might be at a loss as to what they offer as they engage in supervision. Similar dilemmas were experienced when nurses were confronted with nursing models during the 1980s. They struggled to incorporate ill defined and inappropriate models to their clinical areas (Brwkczyńska 1993).

This issue became apparent following the model's adoption in recent nursing research. Butterworth and his team of researchers (1997) concluded that by using this model they were able to demonstrate slight changes in job satisfaction and slight reductions in emotional exhaustion for recipients of supervision. Wolsey and Leach (1997) have argued that this multi-site evaluation of clinical supervision over an 18-month period highlighted little else. Indeed, in relation to the Butterworth study, Coombes (1997) points out that: 'clinical supervision does not have any clear benefits for nurses'.

Proctor's (1987) three-function interactive model and its vague structure may have had some influence on results from Butterworth's research. As suggested previously, Proctor's framework gives no guidance to clinical supervisors on what to offer when working, for example, in the restorative component of the model. Given that Butterworth *et al* (1999) have stated: 'It was the researchers' expectation that clinical supervision would help reduce staff stress, and the project was set up to evaluate this experimentally.' What were clinical supervisors offering when they were trying to relieve supervisees' anxiety? Furthermore, no quality checks were undertaken to ensure clinical supervisors were continuing to use Proctor's model. And how could they? The model lacks specific guidance on possible helpful exchanges when working in each of its central functions.

Perhaps this omission can be rectified through the model's use in clinical settings. Clinical supervisors and their supervisees can begin to document the interpersonal transactions when working in each of the central functions. Training workshops organised locally can also help to develop this knowledge further. Following on from this, nurses

can submit articles for publication describing their experiences. Through the progression of this work, clinicians and researchers might engage with Proctor's (1987) model in a more informed and meaningful way.

Heron's intervention analysis framework

Johns and Butcher (1993), Chambers and Long (1995), Fowler (1996), Cutcliffe and Epling (1997) and Driscoll (2000a) have described a model for clinical supervision based on Heron's (1989) six-category intervention analysis framework. Heron's framework is a conceptual model developed initially to assist in the understanding of interpersonal relations, specifically to assist in the delivery of interventions within a helping paradigm. Since 1975 the model has been influential in helping mental health nurses progress their interactions with patients (Chambers 1990).

According to Heron (1989), an interpersonal relationship develops between a practitioner and a client. A practitioner is anyone offering a professional service to a client, so the term refers equally to doctor, psychiatrist, psychotherapist, nurse, lawyer and teacher. The client is the person who chooses to involve himself or herself with whatever service the practitioner is offering, to meet a need the client has identified. However, this primary account of practitioner and client roles can be extended (Heron 1989). In the first extension the terms 'practitioner' and 'client' can be applied in formal, occupational settings, where two people in any organisation relate to each other in terms of their work roles, and where one person is mediating with another. Interventions within this context may concern work, discipline, career advice, or even personal matters that have some impact on work. In the second extension, the terms 'practitioner' and 'client' can be applied to non-formal and non-professional settings, whenever one person is assuming an enabling role for another. In these interactions one person is the listener or facilitator and the other is the talker, the one dealing with some specific issue. From this description, the relevance of Heron's framework to clinical supervision seems obvious.

The six categories are: prescriptive, informative, confronting, cathartic, catalytic and supportive. Heron subdivided these under authoritative interventions and facilitative interventions. Authoritative interventions are those which enable the practitioner to maintain some degree of control over the relationship and include the prescriptive, informative and confronting categories. Facilitative interventions are those that enable the locus of control to remain with the client and are cathartic, catalytic and supportive. Authoritative interventions are neither more nor less useful and valuable than facilitative ones. Their importance is determined by the nature of the practitioner's role,

the particular needs of the client, and content or focus of the intervention.

Prescriptive interventions include: offering advice and making suggestions; they seek to direct the behaviour of the client. To be informative is to offer information or instruction. To be confronting is to challenge the person's behaviour, attitudes or beliefs. Cathartic interventions include enabling the release of tension and strong emotion, for example, grief, fear and anger. Catalytic interventions include encouraging further self-exploration, self-directed living, learning and problem solving in the client. To be supportive is to validate or confirm the worth and value of the client's personal, qualities, attitudes or actions (Heron 1990).

Heron's framework: guiding supervision

If the articles appearing in nursing journals are anything to go by, this model is currently less popular than Proctor's (1987) model. Nonetheless, descriptions of its use in the context of nurses pursuing a counselling qualification (Chambers and Long 1995, Cutcliffe and Epling 1997), studying for a degree (Chambers and Long 1995), working in respite care (Johns and Butcher 1993) and paediatric nursing (Devitt 1998) have been detailed.

In the delivery of clinical supervision guided by Heron's framework, Cutcliffe and Epling (1997) highlighted the enabling process that develops through the use of confronting interventions, and argued that such interventions are not at odds with the supportive nature of supervision. Rather than being regarded as hostile attack, Cutcliffe and Epling (1997) suggested that confronting interventions should be viewed as offering a gift; a gift with the capability of increasing understanding and insight for the client (supervisee). Conversely, Chambers and Long (1995) advocated an emphasis on the facilitative category and, in particular, supportive interventions. In their article 'Supportive clinical supervision: a crucible for personal and professional change', critical incidents are outlined but no examples of supportive, cathartic or catalytic interventions are offered. However, adopting Heron's (1989) six-category intervention analysis in these ways perhaps undermines the basic premise of this framework; authoritative interventions are neither more nor less useful and valuable than facilitative ones. Heron stated: 'There is no real hierarchy among the categories. No one of them is in principle good or bad in relation to any other. In the abstract they are of equal value.' Rather, as highlighted earlier, their importance is determined by the nature of the practitioner's role, the particular needs of the client, and the content or focus of the intervention. The authors would argue that all intervention categories have some relevance for the purposes of clinical supervision. Fowler (1996) offered examples for all six categories in his description of 'what to do after

saying hello'. Additional examples are offered by Sloan and Watson (2001).

Heron's interpersonal framework has been used to investigate nurses' perceptions of their interpersonal skills (Ashmore and Banks 1997, Burnard and Morrison 1988, 1991, Morrison and Burnard 1989). However, research investigating its merits for clinical supervision is scarce. One recent exception is the work conducted by Devitt (1998). In this example, the researcher investigated the delivery of clinical supervision based on Heron's (1989) model by supervisors working in acute paediatrics, intensive care and anaesthetics. Interestingly, despite supervisors being limited to the use of only four of the six categories, confrontative, cathartic, catalytic and supportive, it was the prescriptive and informative categories that were used most frequently.

The authors pose some challenges to this framework. Can all helping exchanges be subsumed under the six categories? Can all helping exchanges, at the point of delivery, be considered within one category? Nurses can be informative and supportive simultaneously. Nonetheless, Heron's model appears to have important attributes that make it a worthwhile consideration for clinical supervisors. First, it did not develop from a particular theoretical paradigm. Heron (1989) stated: 'The six categories *per se* and the sorts of interventions that fall under them do not entail any particular theoretical perspective coming from any school of psychology, or psychotherapy'. It is unlikely that Heron's model would clash with other theoretical frameworks used by nurses in their clinical work. Second, in the publications *Six Category Intervention Analysis* (Heron 1989) and *Helping the Client: A Creative Practical Guide* (Heron 1990), there is a wealth of suggestions for each category of intervention. If a clinical supervisor chooses to deliver an informative intervention, he or she has a wide variety of options available. Third, and perhaps most importantly, because of its interpersonal focus, Heron's model is compatible with the interpersonal foundations of clinical supervision.

Cognitive therapy supervision

Supervision, which is provided using the cognitive therapy model, is similar to the therapy process in that it aims to be focused, structured, educational and collaborative. It is also acknowledged that the practice of supervisor and supervisee (within and between supervision) will be influenced by their own core beliefs, underlying assumptions and automatic thoughts. Supervision sessions are structured by an agenda and in the same way that cognitive therapy aims to make links across sessions, cognitive therapy supervision aims to summarise previous session content and review any learning which has occurred between sessions. The clinical supervisor aims to help supervisees apply cognitive therapy to a high standard, develop their assessment,

conceptualisation and treatment skills (Paolo 1998) and, as advocated by Feasey (2002), explore their own reactions to the therapeutic process. A typical list of agenda items would include personal update, agenda setting, link to last session, previously supervised cases, check on homework tasks, discussion of agenda items, assignment of new homework, summary from clinical supervisor and feedback from supervisee (Liese and Beck 1997).

Padesky (1996) also highlighted the parallel between treatment and supervision processes. She went on to outline the differences between supervision modes and foci. A supervision mode is the means by which supervisee learning and discovery occurs. For example, using case discussion, role play, observing their clinical supervisor and the provision of relevant educational literature. The focus of supervision can be the mastering of new skills, conceptualising clinical problems or progressing the therapist's understanding of the client-therapist relationship. When using this supervision model, less emphasis is placed on discussions based on the supervisee's self-report. Instead, other equally legitimate methods are encouraged, such as the review of audio recordings of therapist-client interactions.

Many cognitive therapy educationalists and clinicians now highlight the potential benefits of acknowledging our own cognitions, emotions and behaviour in therapeutic work with clients. This can facilitate our understanding of cognitive therapy methods and processes, and can also help to conceptualise treatment plans for clients. During the supervisory process it will sometimes become

apparent to a supervisor that a supervisee may have an underlying assumption about a client, the therapy process or the supervisor which is compromising his or her application of cognitive therapy, compromising his or her self-care and/or influencing the process of therapeutic change in a contradictory way. Just as cognitive therapy is a collaborative process (Beck *et al* 1979, Safran and Segal 1996), so too is cognitive therapy supervision. This enables the supervisor to negotiate with the supervisee for such observations to be placed on the agenda.

However, cognitive therapy supervision does not aim to provide personal therapy for supervisees; this would detract from the primary task of clinical supervision. As highlighted by Platt-Koch (1986), Anderson and Dorsay (1998) and Yegdich (1998), the purpose of supervision and subsequent content of discussion in clinical supervision differs dramatically from therapy. Instead, this exploration aims to increase awareness of how our own cognitions can influence the therapeutic endeavour and how we can use this to understand the issues which can arise during the process of cognitive therapy. Uncovering the supervisee's thoughts and feelings about his or her relationship with clients has 'the added modelling effect of showing him or her how to work through similar emotions in the client' (Schmidt 1979). These types of issue are not confined to counselling, psychotherapy or mental health nursing – they are relevant to all nursing contexts where the development and maintenance of a therapeutic relationship is a prerequisite to the delivery of quality nursing care.

The cognitive therapy model of clinical supervision

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conflates with findings from the research literature relating to those characteristics that have been identified as necessary for optimal supervision (Balsam and Garber 1970, Rich 1993). For example, providing the opportunity for the supervisee to observe his or her supervisor's clinical practice, demonstrating and encouraging the use of new skills using role play, providing relevant educational literature (Worthington and Roehlke 1979), providing guidance with treatment and direction with therapeutic interventions (Rabinowitz *et al* 1986, Worthington 1984), and having the relevant knowledge, clinical skills and teaching ability (Fowler 1995). A supportive process also underpins cognitive therapy supervision, which is another fundamental requirement of effective supervision (Fowler 1995, Rabinowitz *et al* 1986, Sloan 1999, Worthen and McNeill 1996, Worthington 1984, Worthington and Roehlke 1979).

Cognitive therapy supervision does not have to be confined to the clinical supervision of cognitive therapists. The structure and process of this supervisory model might be of value to nurses working within different specialties where the concepts of supervisory foci and modes of delivery are equally applicable and where the supervisee seeks an educational focus. Moreover, it might be useful in contexts where the clinical supervisor aims to guide discovery on the supervisee's therapeutic work.

The lack of clear guidance of certain supervision models can be a deterrent for some nurses. Further, there is a lack of consensus as to what clinical supervision involves in the nursing literature. At a practical level, nurses may be uncomfortable with the absence of helpful guidance and may be working in ways that

are far removed from what clinical supervision should ideally represent. The cognitive therapy supervision model, which is a highly structured and clinically focused framework, might be a useful resource for practitioners. Moreover, since the model remains loyal to the fundamental intention of clinical supervision, its effect on skills competence in the supervisee may be more readily realised. Perhaps then, those nurses participating in clinical supervision will be able to demonstrate evidence of its impact on client care. As more nurses become conversant with this way of engaging in clinical supervision, opportunities for research should arise.

Other supervision models in nursing

Nicklin's (1997) practice-centred supervision model is very similar to Proctor's three-function interactive model in that Proctor's normative, formative and restorative terms are substituted by Nicklin with managerial, educational and supportive classifications. He also transferred the stages of the nursing process into a supervision cycle, that is, practice analysis, problem identification, objective setting, planning, implementation/action and evaluation. Furthermore, Nicklin incorporated counselling skills, thus emphasising the interpersonal dynamic of the supervision enterprise.

Rogers and Topping-Morris (1997) described a problem-focused model for clinical supervision. Using this model, the clinical supervisor can focus on clinical issues the supervisee is finding problematic. They suggest that it can also be used to resolve problems with the supervisory relationship, improve ineffective care plans and develop the supervisee's understanding

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of clinical issues for which he or she has no experience. Problem-orientated clinical supervision is described as a collaborative process through which problem-solving strategies facilitate the identification of solutions to the clinical problems recognised by the supervisee.

More recently, a solution-focused clinical supervision model has been outlined. Driscoll (2000b) suggested that the solution-focused approach as used in a therapeutic context might have some value in clinical supervision. In this way, clinical supervision might allow the clinical supervisor and supervisee to consider solutions in a more proactive way, rather than focus on why problems arose. Driscoll gives some guidance on suitable questions when using this approach.

Conclusion

This article has discussed selected supervision models. The authors did not set out to provide an all-inclusive overview of the supervision models currently available for nursing. Instead, the aim was to offer some insight into the more commonly referenced models. According to the nursing literature and despite an absence of supporting empirical evidence, Proctor's three-function interactive model is the most popular in nursing. However, it has been argued that there is not one model of supervision that will suit the needs of all nursing

contexts (Fowler 1996). Any attempt to impose one model at the expense of others may be shortsighted and recreate the problems clinicians faced when nursing models were in vogue. The authors would argue that those engaging with clinical supervision should decide the choice of framework. Ideally, there should be some fit in these settings between the adopted model and the ways in which nursing is delivered.

Presently, there is an absence of empirical support for the use of any of the supervision models described in this article. Nevertheless, Heron's (1989) six-category intervention analysis framework, Padesky's (1996) cognitive therapy supervision model, the work of Hawkins and Shohet (1989), Faugier (1994), Nicklin (1997), Rogers and Topping-Morris (1997), Driscoll (2000b) and van Ooijen (2000) warrant some consideration as nurses attempt to introduce a supervision model appropriate to their clinical environment and work practices. Following on from this, research on the efficacy of some of these alternative supervisory models to examine their impact on nursing practice and professional development may occur.

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