# Suspicion, resistance, tokenism and mutiny: problematic dynamics relevant to the implementation of clinical supervision in nursing

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**Suspicion, resistance, tokenism and mutiny: problematic dynamics relevant to the implementation of clinical supervision in nursing**

In this paper I will discuss some of the more common pitfalls inherent in attempts to introduce clinical supervision to hospital wards or community teams. I will consider pre-existing relationships and how these may, if unexamined and unaccounted for, result in clinical supervision becoming less than optimally effective. Drawing upon the theory of Transactional Analysis, in particular the concept of 'psychological distance', I consider four possible interpersonal dynamics and examine how these may impact upon the implementation of clinical supervision. These problematic dynamics can result in undue resistance, suspicion, tokenism or interpersonal difficulties. Finally, I will consider ways in which the aforementioned problems may be addressed and their effects minimized through the use of co-operative contracting.

*Keywords*: collaborative contracting, implementation, interpersonal dynamics, relationship rhombus

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## Introduction

This paper is not intended to be an empirical account or even a 'scientific study'; rather it is my intention to offer the following as a discussion paper, to stimulate thought and debate as to why efforts to implement clinical supervision so often fail in practice.

## Background

It has been argued that healthcare work can be one of the most stressful and personally costly areas of work (Hawkins & Shohet 1989). Yet according to Swain (1995, pp. 18–19):

> It beggars belief that we have, for so long, failed to incorporate it [clinical supervision] as a defined component of clinical practice. Looking . . . at the human pain and social distress of others to which we have been exposed, not to mention our own.

Butterworth *et al.* (1996) observe that as nursing moves further from an alliance with the traditional paternalistic medical model of healthcare, the psychological protection historically afforded nurses by such a symbiotic relationship diminishes. The more nurses are exposed to the tensions and stresses of patient care from an increasingly autonomous position, the less effective become their traditionally adopted defensive measures.

Despite the potential of clinical supervision to open up traditionally closed systems of practice to compassionate critique, and so intervene meaningfully and directly upon the process of care delivery, many attempts to introduce supervision seem to either fall at the first hurdle, end in crisis of one form or another, or tend to slowly 'peter-out' over time.

## The relationship rhombus

Ekstein and Wallerstein (1972) offer a four-sided diagram, the clinical rhombus, to help illuminate the relationships

between the participants in clinical supervision. Whilst Ekstein and Wallerstein include the patient in their quadrilateral, I have adapted their model to include only members of staff, as employees are our primary concern here (Fig. 1).

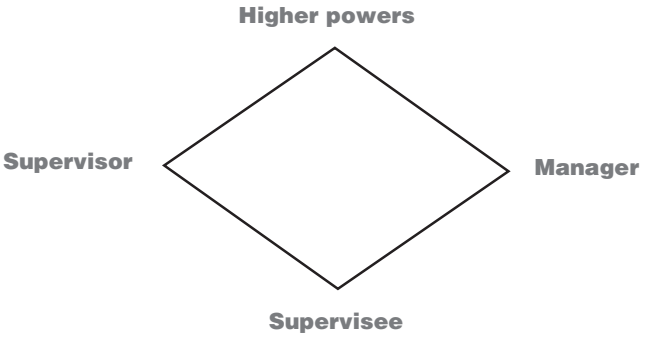


**Figure 1**
The relationship rhombus

The Trust ('the higher powers') can be seen at the top corner of the rhombus; the manager, the supervisor and the supervisee at the others. This model does not account for the manager also taking the role of clinical supervisor, this not being in accord with the model of clinical supervision considered here (Feltham & Dryden 1994).

Vectors may be drawn on the rhombus to signify degrees of psychological distance (Micholt 1992) between the participants. Should any participant be (or be perceived to be) in collusion with another, we may diagram this as shown in Fig. 2.

By collusion I mean: 'a special relationship between two or more participants, having the unaware aim of fostering closeness through the exclusion of another'.

It is important to note that collusion has only to be perceived, it does not have to be 'real', only to be seen to be 'real' by others for these dynamics to become significant and influential.

## 1. The Trust and manager are thought to collude: token supervision (Fig. 3)

In this example, the Trust (the 'higher powers') may be a somewhat ethereal presence, a shadowy imago of the perceived culture. Alternately it may be an embodiment of such in, perhaps, a senior charismatic figure or a group having significant psychological influence. In this situation, which I have termed 'token supervision', practitioners are mindful of the apparent close relationship between the manager and the Trust.

This in turn may engender a cynical 'them and us' attitude, particularly if there is little trust placed in the integrity of authority figures. Supervision is likely to occur, at

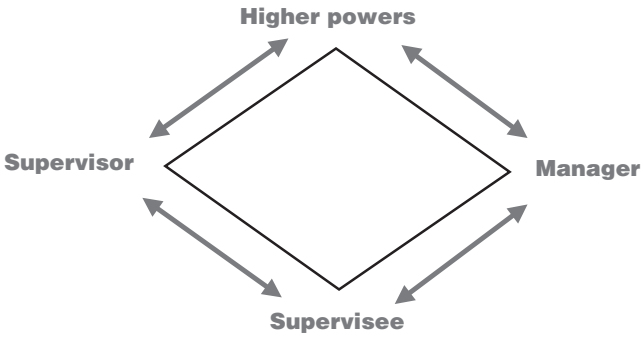


**Figure 2**
The relationship rhombus, showing participants in collusion

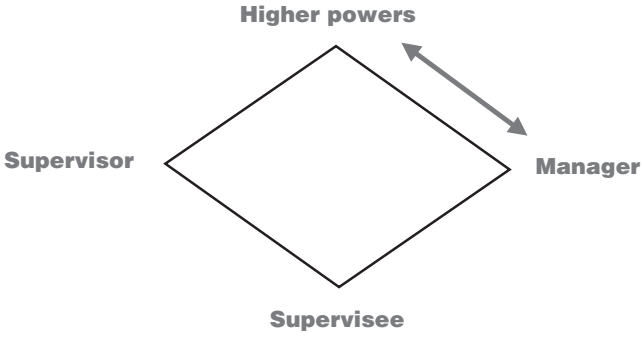


**Figure 3**
Tokenism

least at first, motivated by obedience to perceived authority. Ultimately the anxieties and resistance of the staff are likely to become manifest in a number of ways, such as 'forgetting' to prepare work for supervision, or in only addressing 'safe' issues, those which they may already have reflected upon or resolved prior to supervision.

Acting in parallel (Doehrman 1976), supervisors may inadvertently collude with supervisees to preserve the status quo, perhaps unhelpfully identifying with the position of the supervisees, particularly if they hail from a similar background. There may sometimes be an unaware escalation of the needs of the patients, so that a somewhat simplistic dichotomy is promulgated: 'I can look after the patients or I can attend supervision, which is it to be?' The general manifest reaction to this form of supervision is often boredom, sometimes frustration. All parties may breath a sigh of relief (either in public or in private) when attempts at supervision finally end, often through accumulated ennui.

This situation may be exacerbated when:

- The manager is seen as being overly concerned with self-promotion.
- The Trust is seen to be keen to 'mentor' the manager, or they are seen to be being 'groomed' for another post;
- Supervisees are unsure as to the nature of the information the supervisor passes on about them.


 

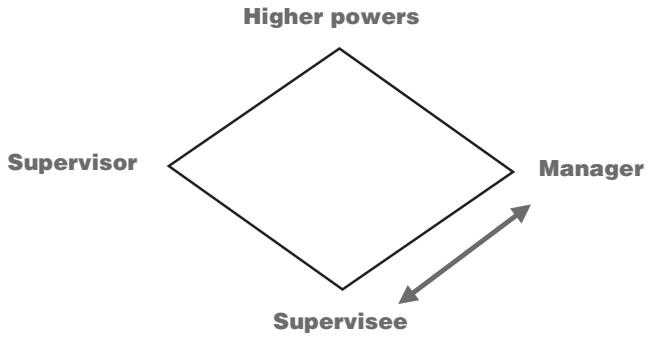


**Figure 4**
Local resistance

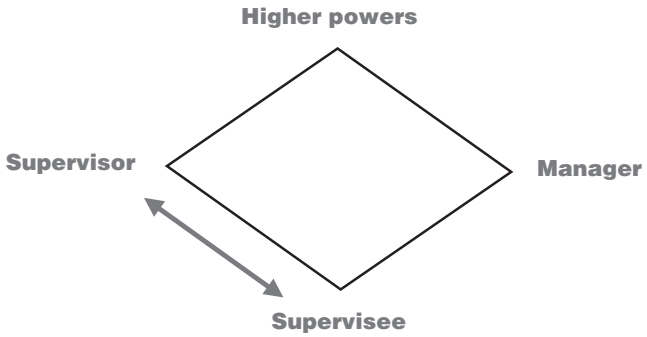


**Figure 5**
Mutiny

- The Trust are perceived to be overly controlling, uninvolved, uncaring or impersonal.
- Supervisees are uninvolved in the process of planning and implementing supervision.

## 2. The supervisee and manager are seen to collude: local resistance (Fig. 4)

This position I have termed 'local resistance'. The supervisees are 'in cahoots', consciously and/or unconsciously with the ward manager. Perhaps one or both parties remain unconvinced of the benefits, or are overly anxious about the process of clinical supervision. Perhaps they fear the shame of exposure, or feel the need to group together to resist another 'attack' upon stable practice (Liddle 1986). The results are similar to tokenism, except it is often difficult to get supervision 'off the ground' at all.

In this scenario, all manner of events may begin to take on a new importance; schedules and rotas may be changed, staff may 'need' to attend meetings or go off sick, or again patients' perceived needs may suddenly change, necessitating staffs rapid intervention. In this scenario the supervisors often become dispirited and may call a halt to supervision.

This situation can be exacerbated when:

- Clinicians have been exposed to a lot of recent change, or paradoxically, too little change over time.
- The ward manager shares a similar background to their staff, or over-identifies with them.
- The ward manager has high control needs.
- Managers see themselves becoming less powerful or less in control as a result of supervision.
- The staff believe themselves to be different in some way, or to provide a special service or have unique and special needs, different to those of others in the organization.
- When the supervisors are younger, are seen to be overly career-minded or to be courting favour with the Trust.
- When the team feel beleaguered by change.
- When the integrity of the 'higher powers' is called into doubt.

## 3. The supervisees and supervisors are believed to be 'in league' with one another: mutinous supervision (Fig. 5)

Sometimes members of staff appear to stand out from the crowd; these 'tall poppies' described by Faugier (1992), may meet and form a subgroup within an established system. Typically they may wish to provide peer supervision for one another, or start a process of supervision for others. Unfortunately, this can result in envy and hostility becoming mobilized towards those who apparently wish to escalate themselves above others: 'Who do they think they are?' (Roberts 1983). Soon the tall poppies are scythed down. This dynamic I have called 'mutinous supervision', because of other's reactions to it, and the typical fate of the 'mutineers'.

> The innovator makes enemies of those who prospered under the old order.
>
> (Machiavelli 1961)

In this scenario, the needs of the Trust for information and the needs of the manager for control and authority are often neglected by the supervisee(s)/supervisor(s) dyad, who practice mindless of the organization's rights and requirements. They may inadvertently persecute other team members by failing to make empathic contact with them, thus failing to recognize and appreciate the requirements and abilities of others.

This situation may be exacerbated when:

- Supervisors and supervisees are recently qualified, their enthusiasm is believed to be more developed than their wisdom, '*furor therapeuticus*'.
- The ward manager feels insecure, and inadvertently mobilizes others against the supervision process.
- The Trust is seen to be weak, ineffective or conflicted.
- Supervisee and supervisor have many areas in common, and may over-identify with one another.
- The Trust fails to issue clear direction and requirements.
- The supervisees are mandated or under duress.

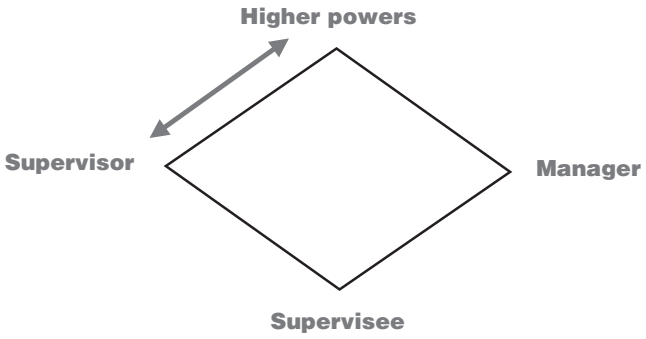


**Figure 6**
Suspicion position

## 4. The Trust and supervisors are believed to be 'hand in glove': the 'suspicion position' (Fig. 6)

The final position I have termed the 'suspicion position'. Here I have envisioned the supervisors as 'agents' of the Trust. The Trust may have embarked upon a well-meaning programme of clinical supervision, recruited and trained the supervisors, but neglected to tell others enough about the project. Suspicion may well be engendered.

Without clear information from the Trust relating to what subjects may be discussed and, vitally, what will happen to the information gleaned through supervision, suspicion and hostility are fostered. If you discuss a personal frailty, what use may be made of that information? Will you find yourself asking for a reference from someone to whom you've bared you're soul, or at least been especially honest about your struggles and difficulties? Shame and doubt may be fostered; splits and tensions intensified.

This scenario can also be engendered when a manager acts as clinical supervisor. The perceived links between managerial and clinical supervision create anxiety and mistrust in the supervisee and a conflict of interests and role confusion in the supervisor/manager (Webb & Wheeler 1998). Participants are guarded, until they are provided with what they feel they need to know.

> Clinical supervision is not a managerial control system. It is not therefore the exercise of overt managerial responsibility or managerial supervision.
>
> (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1996)

In the meantime, not much happens. A lot of work may be done, a good deal of energy expended, but the outcome will not be great, even if supervision is mandated. We learn that you can lead supervisees to supervision, but that you cannot make them do meaningful work.

Unless something changes, the whole enterprise may disintegrate. The Trust may be uncomfortably aware of the time, and the cost of the venture, but results are likely to be limited. Negative propaganda relating to supervision may be set in motion. There may be an acknowledged inevitability to it all, in the light of past information: 'Another short-lived fad bites the dust'.

This situation is exacerbated when:

- The Trust is in a hurry to start supervision, so preparation is inadequate.
- The Trust recruits external supervisors.
- Information systems are slow or ineffective.
- The Trust is perceived as untrustworthy, or eager to achieve 'Brownie points'.
- Supervisors believe themselves to be, or are encouraged to see themselves as 'the chosen few'.
- A culture of suspicion or blame prevails.

## What can be done?

Is this somewhat wry perspective as inevitable and predictable as it may seem? There has been much debate concerning the relevance of clinical supervision to nursing practice. Now many areas are almost paralysed by conflicting information overload (Reuters 1996). Meanwhile, stakeholders remain rightfully concerned about the people who use the service, those employed by it, and by how much it all costs.

How can we move from suspicion to trust, from resistance to acceptance, from mutiny to loyalty and from tokenism to commitment?

What can be done to help clinical supervision be successfully adopted by those involved? As mentioned earlier, the sense of *déjà vu* relating to the climate of past failures can inhabit and inhibit the implementation of clinical supervision, particularly in a climate of pessimism where communications may be confused and interprofessional collaboration lacking (Bond & Holland 1998). In our current culture the pace of change can be frightening, leaving staff feeling powerless and vulnerable (Toffler 1973).

As witness to many different teams and their adoption of clinical supervision, I became interested in why some succeed so well, while others fail, often for related reasons. It seemed that clear, mutual contracting is typically at the core of many successful implementations. Teams that have carried out the 'groundwork' in terms of attending to the basic roles, responsibilities and expectations of all parties – supervisees, supervisors, managers and the Trust as a whole – are provided with an advantage in shared, collaborative working. They are then able to withstand the inevitable assaults upon the process that occur when problems arise. The relationship rhombus acts as a reminder to attend to all the interrelationships, not to unwittingly exclude or minimize the importance of informed co-operation between the multiple stakeholders in a system of supervision. Of course, the four roles identified here are not exclu-

  

sive; other important (and often neglected) stakeholders are user groups, health authorities/PCT's, trades unions, and other allied professionals.

The mutuality of the dialogue occurring within the contracting process is essential, underlying all co-operation (Freire 1993) and enhancing the likelihood of successful outcomes. With an emphasis on collaborative contracting, a collegiate relationship can be established (Beck *et al*. 1979), leading to a sound basis upon which participants may build and develop their self-esteem.

Time devoted to clarifying participants expectations of one another, motivations, roles and working relationships is time well spent. We have all heard the (some believe to be apocryphal) tale of the supervisee who discloses sensitive information within supervision, and who is alarmed to find their supervisor informing their manager, when the supervisee expected the relationship to be completely confidential. Such unexplored assumptions are capable of bringing a system of supervision to the ground very rapidly, and indeed have already done so. We neglect the basic collaborative groundwork at our peril. Clear dialogue between managers and supervisors and supervisees concerning their expectations of one another is essential if supervision is to fulfil its promise.

## Conclusion

As we seek clarity, openness and collaboration within the supervisory relationship, so must we maintain our integrity in striving for the same degree of clarity and open communication during the process of introducing supervision to any clinical area. Clarity and inclusiveness of contracting provides us with a collaborative structure within which we may pursue such a vision. The relationship rhombus alerts us to the fundamental importance of the relationship between supervision stakeholders.

### Key points

- Current changes in nursing culture highlight the need for new and developing skills.
- The clinical supervision relationship offers a framework to help nurses review and develop clinically relevant skills.
- Many attempts to introduce clinical supervision are unsuccessful, due to key stakeholders in the process being uninvolved during the planning, promotion and implementation stages.
- Common problematic factors in the process of implementation can be identified and addressed to forestall later difficulties.
- Time and energy spent addressing core issues of roles, responsibilities and expectations will lead to a more consistent and successful adoption of clinical supervision.

## Acknowledgements

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