KEYWORDS

- clinical supervision
- solution-focused therapy
- reflective practice
- continuing professional development

Clinical supervision: a radical approach

John Driscoll's new book on clinical supervision was published last month. Here, he calls for a fundamental overhaul of traditional approaches to clinical supervision

In many mental health-related disciplines, such as counselling, occupational therapy, social work, and psychotherapy, clinical supervision has already been established and legitimised in practice. But in nursing, clinical supervision is still in its infancy and is not yet the norm for most mental health nurses (Carson *et al* 1995). Yet it presents crucial opportunities for nurses to explore the valuable elements of clinical practice.

Many nurse managers and practitioners who are considering implementing clinical supervision look towards other disciplines' strategies, rather than taking time out to reflect on, or even value, what already happens in everyday nursing practice.

Of course it is useful to consider what other disciplines are doing, but clinical supervision should evolve through adapting elements of everyday practice.

The problem with talking about problems

Traditional models of psychiatry and psychotherapy tend to focus on the clients' 'problems' by exploring the past in some detail to help them develop insights into why a 'problem' emerged. They need to understand why they feel and behave in a particular way. It is interesting to speculate what clinical supervision might be like for mental health nurses in such a setting. Might the supervisee be expected to go into the supervision room with practice 'problems' needing to be 'analysed' and 'treated' by the clinical supervisor?

This could be an attractive option for a supervisee already used to a problem-orientated approach to mental health practice. Likewise, the supervisor can then advise on that problem and the organisation can feel secure that 'problems' from practice are being attended to! Many supervisors and supervisees will, I suspect, feel comfortable adopting a problem-solving approach that is common in clinical practice and is mirrored in the clinical supervision room.

While the above is, of course, an over-simplification, I often wonder how much clinical supervision might simply be based on previous ways of working and so potentially be self–limiting. This is far from the ideal that participating in clinical supervision provides support in practice (Power 1999) and demonstrates individual practitioners exercising their professional responsibilities under clinical governance (Butterworth and Woods 1999).

In examining clinical supervision in mental health nursing, Barker (1998) suggests that nurses are traditionally portrayed as professionals who try to be helpful and routinely intervene on behalf of the person in care. He encapsulates the inherent dangers of a newly-appointed clinical supervisor being helpful, rather than helping in a supervision relationship that could equally apply to all forms of relationships in clinical nursing practice, not just supervision; 'We should not lose sight of the fact that the more useful we are, the more useless the person might become,' Barker notes.

Traditional forms of

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'problem talk' in therapy tend to concentrate on clients' complaints in an attempt to overcome their problems. An alternative is to adopt a solution-based approach to therapy and this has been used successfully in clinical nursing practice (Hawkes *et al* 1993). Solution focused therapy shares many of the values espoused by mental health nurses, as it uses counselling skills and provides a framework for devising strategies that are useful when working with clients (Sandeman 1997; Wilgosh *et al* 1994).

Solution focused therapy

Solution focused therapy is a method developed by De Shazer (1985) and colleagues at the Brief Family Therapy Centre in Milwaukee. Work at the centre gradually shifted from focusing on client problems and how to solve them, to solutions and how they work. Some assumptions underpinning solution focused therapy are contained in Box 1.

The key to solution focused therapy is the idea that even before clients come for therapy they already have ways of coping with their problems. The therapist is not there to direct, but rather gives support and encourages the client to believe in his or her own ability to deal with the situation in the first place.

If, for instance, a person experiences panic attacks for one hour each day, traditional therapy would look in some detail at that one hour. In contrast, solution focused therapists look for exceptions, and explore in detail what goes on in the other 23 hours. In other words, concentrates on the strategies that prevent the person having a panic attack and whether such behaviours could extend to the hour when panic attacks happen, and so, more importantly, prevent them happening.

A central tenet in this form of therapy is to explore with the client what he or she has been doing to make things better, rather than ignoring this change and concentrating on the problem, as so often appears in traditional therapies. By focusing on client goals and the solutions to meet them, therapy is inevitably brief and rarely needs more than a few sessions.

The concept of problem-free talk encourages the therapist to connect to the person rather than with the problem and to look for skills, areas of strength and resources which the client possesses. The therapist assumes from the outset that the client has the strengths to overcome the problem and is helpful by communicating this belief to the client.

From problems to solutions in clinical supervision?

A solution approach could also be used as an alternative model of clinical supervision. Clinical supervision sessions explore solutions, rather than the clinical supervisor attempting to analyse the 'problem' the supervisee has in clinical practice.

At the very least a solution approach to clinical supervision allows supervisors and supervisees to think about solutions in a more proactive way, rather than focusing on why the problem has happened, or is happening. It also supports Johns's (2000) premise in his reflective model that practitioners already have an idea of what good practice is, the contradiction between what that is, and the way they, practise forms the basis for reflection (and action) in clinical supervision. In this way it is more likely to make a contribution to client care and would seem in tandem with modern mental health practice in the light of the current NHS reforms (DoH 1998, 1999a, 1999b).

The principles of solution focused therapy do not seem out of place as part of any practice guidelines for clinical supervision (Box 2).

While more detailed guidelines for facilitating solution focused therapy can be found elsewhere (Chevalier 1995; de Shazer 1985; Hawkes *et al* 1993; Saunders 1996), there are five basic questions to address in the therapy session (Box 3).

Questions like these can form a useful framework for the clinical supervisor to structure a session and are helpful in encouraging the supervisee to adopt a more proactive stance to his or her clinical supervision (Driscoll 2000). The structure of the session becomes supervisee centred and action based, rather than merely being a

Box 1. Some assumptions underpinning solution focused therapy

- Success depends on knowing the client's goals. After establishing this, the task of therapy is to find the quickest possible route to this point.
- However long-standing a problem appears to be, there will always be times when the client is not experiencing the problem and is therefore contributing to part of the solution. Therapy involves having the client do more of what already works.
- Small change is all that is required in order to set in motion larger changes and movement towards the solution. Small goals are therefore necessary and are more likely to lead to success.

Adapted from Sandeman (1997)

Box 2. The principles of solution focused therapy as practice guidelines for clinical supervision?

- Therapy (clinical supervision) should take place in a setting where clients (supervisees) feel safe and their opinions valued
- Clients (supervisees) set the goals (agenda) and work towards them.
- Clients' (supervisees') strengths are identified and highlighted in the session.
- Change is anticipated, talked about, watched for and expected following the session.

chat over a coffee about everyday practice problems. Sessions should involve:

- setting goals;
- seeking out exceptions;
- searching for strengths;
- assessing motivation to change (or not);
- joint setting of tasks to try out in practice.

The scenario in Box 3 will also require the supervisor to take risks, rather than take charge, to allow for Mr Webb's professional growth and development. Perhaps, from a safety point of view and his junior status in the community, the nurse should be told what to do. Bear in mind that the mechanism of clinical supervision is aimed at already qualified and accountable practitioners. A more directive strategy might need to be employed with a healthcare assistant or student in the scenario, but this then becomes 'supervised practice' not clinical supervision.

Box 3. Case history: a traditional 'problem' for clinical supervision (CS)

Paul Webb, a senior staff nurse, has recently changed posts from working in a hospital setting to get some experience as a community nurse, in which he eventually hopes to become a qualified CPN. Clinical supervision has been the norm for the last two years in the health centre in which he is based. Prior to this, Paul hadn't really heard of CS and this is only his third session. He intends taking to CS his concerns about being referred a client who he remembers from his ward days as being aggressive and difficult to manage. He is anxious about whether the client might become disturbed with him and being alone with the client's in his house.

Five basic questions for the clinical supervisor from solution focused therapy that could form the basis of a clinical supervision session with Mr Webb are:

- What has to be different as a result of you talking to me today, Paul? (setting goals)
- When was the last time you cared for this client when you didn't feel this way? (seeking out exceptions - this may need to be repeated several times)
- What were you doing differently at that time? (continuing to search for strengths - this may need to be repeated several times)
- On a scale of one to ten, with ten being very sure and one not sure at all, how sure are you that you could do some of the things that have previously helped while working on the ward with this client? (assessing Mr Webb's motivation)
- On that same scale, how likely is it that you might try some of these things in your practice? (setting behavioural tasks to try out between sessions)

Adapted from Chevalier (1995)

Conclusion

As clinical supervision, for the most part, remains a curiosity, rather than the norm, it is useful for mental health practitioners to explore different methods and approaches to clinical supervision. It would seem appropriate to at least consider the possibilities of incorporating some of the principles of solution focused therapy into clinical supervision.

The principles of this type of clinical supervision are action based and can be measured in practice, so that the supervisee becomes more aware of his or her growth and development and this has real potential benefits for clients.

Finally, it would be unhelpful to suggest that all clinical supervision be carried out in the same way, or to imply that the way a supervisor facilitates a supervision session will work with all supervisees. I agree with Power (1999), who suggests that supervisors should develop a style of their own. But this will take time and new supervisees are arriving every day. Is this a problem or part of the solution?

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