1 Introduction

BACKGROUND TO THE STUDY

INITIAL EXPERIENCES

I started my registered mental nurse (RMN) modular training in 1982. Clinical supervision (CS) was something I did not experience as a student. When I qualified in 1985, I worked for six months in an acute psychiatric admissions unit; again, CS was not available. It was when I took up the post of staff nurse (SN) in an adult psychotherapy day hospital that I was offered the first opportunity of CS. A psychoanalyst working in the unit provided CS; it was delivered in a group format, and all staff had to participate. There was a great deal of conflict among some members of the team and this animosity seeped into supervision. On reflection, in many ways supervision was used to contain team dynamics and provide an opportunity to explore staff relations. I do not recall client issues being discussed. I was uncertain of what I should be doing in CS, since being relatively new to the team I did not have any tensions with my colleagues.

Around the same period, the charge nurse (CN) started to provide individual CS to the nursing staff in the unit. At that time, CS had not stimulated much interest and there was a distinct lack of conceptual analysis and empirical research on CS and its relevance to nursing in the United Kingdom (UK). I did not receive any training in CS; nor was I given the option not to participate. As far as I can recall, the CN explained that CS would give me an opportunity to discuss my work with clients and anything that was of concern. Being a new member to the team, I had much enthusiasm for my work and wanted to fit in and create a good impression with my colleagues and line manager. At that time, I understood CS as a ‘must do’ activity and that it was provided by the CN.

I can recall talking about several clients, and in particular one gentleman who suffered from depression. He had been in and out of psychiatric hospitals most of his adult life and had been seen by numerous psychiatrists, psychotherapists, clinical psychologists and community psychiatric nurses. Throughout our contact, despite conveying a motivation for change, by asking for help, the client always appeared reluctant to engage in working on ideas that had emerged during sessions. In addition to feeling deskillled, I found myself irritated, confused and critical of his inability to take things forward.

What appeared to trigger my need to take these issues to CS was an awareness that my reactions and subsequent interactions with certain clients were
not as helpful or enabling as I had intended. I was hopeful that through CS I would reach a better understanding of my clients, their needs and how I might contribute more effectively towards their recovery. Following my presentation of these clients, my supervisor would respond with supportive comments. I would hear him telling me how well I was doing and how impressed he was with my nursing care, compassion and persistence. Having my CN’s approval was very important to me, and his comments were reassuring. From his perspective, I was doing OK. Nonetheless, I remained somewhat perplexed at my reactions when working with certain clients.

DEVELOPMENT

I have had many positive experiences with CS since my initial introduction. Its delivery has ranged between individual, group and triadic formats. Nursing staff who have undergone psychotherapy training have provided some of these experiences, and at other times CS has been provided by a psychiatrist, clinical psychologist or occupational therapist. I would argue that this consistent provision has assisted me in achieving a high standard of care. Intuitively, I would argue that the care I have provided to clients has benefited from my commitment to CS. Together with other professional development opportunities, consistent engagement with CS has progressed my professional competence. However, it has also had other significant benefits that are not as easily evidenced or appreciated.

As I alluded to earlier, engaging in a helping relationship is not always an easy or straightforward activity. Supervision has enabled me to tolerate my uncertainties when working with particular clients and helped me identify ways of working that have been positive for my clients, but which I have not always immediately acknowledged. It has assisted me in developing confidence in my provision of clients’ care and has guided me towards appreciating unhelpful ways of working and supporting new ways of engaging with clients. In these contexts, in addition to CS being didactic and cognitive, it has facilitated the working-through of emotional material inextricably associated with my clinical work.

During the past 15 years, I have also provided CS to others. Initially, this was mainly to nursing colleagues but more recently has included consultant psychiatrists, clinical psychologists and nurses trained in cognitive and behavioural psychotherapy (CBP). The focus of the majority of this work has been facilitating the exploration of clinicians’ therapeutic interactions with clients, their delivery of therapeutic interventions and reactions to this work.
CURRENT EXPERIENCES

Clinicians who approach me for CS usually have a desire to develop their therapy, and particularly the application of CBP. To assist in this process, I provide CS guided by Padesky’s CBP supervision model (Padesky, 1996). I had been introduced to this framework 10 years ago and since then developed my understanding of its application. Attending training workshops on the framework has been beneficial. Supervision, guided by the CBP model, is similar to the therapy process in that it aims to be focused, structured, educational and collaborative. It also acknowledges that the practice of the supervisor and the supervisee (within and between supervision) will be influenced by their own core beliefs, underlying assumptions and automatic thoughts. In my role as clinical supervisor, I aim to help supervisees apply CBP to a high standard, develop their assessment, conceptualisation and treatment skills and, as advocated by Feasey (2002), explore their own reactions to the therapeutic process.

Personal experience suggests that this highly structured and clinically focused framework is a useful model for CS. The CBP supervision model remains loyal to the fundamental intention of CS – the development of therapeutic competence (Sloan et al., 2000). Consequently, it is focused on the skills of therapy, their application by the supervisee, their impact on the therapeutic relationship and the alleviation of clients’ psychological distress.

These recent experiences have reinforced my belief that the therapeutic relationship and the delivery of helpful interventions, particularly with mental health nursing colleagues, is an important focus for CS. Throughout their professional careers, mental health nurses are expected to engage with clients in an intentionally therapeutic manner and to ease clients’ suffering by dealing with a heavy burden of emotional distress. Had I had the opportunity of CS during my early years as an RMN, which I receive currently, I might have gained a better understanding of the issues emanating from my relations with clients.

CLINICAL SUPERVISION IN NURSING

Despite having a presence in nursing since the 1920s (Burns, 1958), it is only in the comparatively recent past that an interest in CS in the UK has grown. It is well known that Florence Nightingale encouraged the supervision of junior nurses by more senior nurses to improve their practical skills (Abel-Smith, 1960). Nurse scholars from North America have written about the concept since the 1970s confining its use to psychiatric nursing, particularly for nurse therapists (Muecke, 1970; Termini and Hauser, 1973; Benfer, 1979; Critchley, 1987; Farkas-Cameron, 1995). According to Fowler (1996a), contemporary interest amongst UK nurses has been influenced by developments
within the nursing profession, an increase in nurses’ accountability, attempts to establish nursing as a profession and the recognition of the therapeutic focus of nursing.

In the UK, CS is now a frequently debated concept in nursing, as evidenced by the extensive literature on this topic in nursing journals. Many of the popular publications, for example Nursing Times and Nursing Standard, particularly during the latter part of the 1990s, regularly featured articles on CS. The scholarly journals Journal of Psychiatric and Mental Health Nursing and Journal of Advanced Nursing have provided a platform for critical debate from clinicians, educators and researchers. Furthermore, following the Butterworth and Faugier (1992) publication Clinical Supervision and Mentorship in Nursing, one of the first CS texts for nursing in the UK, several other books have been written (e.g. Bishop, 1998a; Bond and Holland, 1998; Power, 1999; Bassett, 2000; Driscoll, 2000a; van Ooijen, 2000; Cutcliffe et al., 2001). There can be little doubt that a familiarity with CS is expanding within the nursing profession. Nonetheless, the differences between its representation as depicted by policy directives emanating from the Department of Health (Department of Health (DoH), 1993) and my own understanding stimulated a need for further critical appraisal.

DoH (1993) emphasises the development of CS as one of the key elements that enable nurses to maintain clinical competence, describing it as:

A formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations. (DoH, 1993, p. 15)

In addition to acknowledging CS as a means by which nurses might receive support and learning, this description highlights the fact that CS is also expected to protect consumers from unsafe practices. I wondered if such a representation of CS might be guiding clinical supervisors towards closely monitoring their supervisees’ practices.

OPPORTUNITY FOR RESEARCH

CS had been in existence for some time in the Mental Health Directorate (MHD) of the Primary Care Trust where I was employed. The clinical nurse manager (CNM) for the community mental health nursing service introduced CS during 1985. Prior to the director of nursing’s (DN) initial attempts at the widespread implementation throughout the Trust in 1995, CS had not been available to hospital-based mental health nurses or general nurses and health visitors working in other clinical areas. The Trust’s nurse advisor, whose role encompassed primary care nurses as well as mental health nurses, was respon-
sible for the formation of a working group to consider the implementation of CS and to conduct an audit involving all qualified nurses. I was invited onto the working group but relinquished my membership when I commenced psychotherapy training.

The aims of the audit were to identify the current level of knowledge of CS in both hospital and community settings, highlight where CS was taking place and, if so, which models were in use, explore nurses’ views on CS and their perceived advantages and disadvantages, and identify nurses’ preferences on the grade, discipline and choice of clinical supervisors. Around the same time, members of the working group developed a discussion paper concerning CS that was made available to all nurses working within the Trust, a copy being held in every clinical area, ward and team.

Following this, four pilot sites were identified for the introduction of CS. Three of these sites were general nursing contexts and one was an acute admission unit within the MHD. However, this did not motivate other units within the hospital sector of the MHD to follow the initiative. At the commencement of the current study, despite CS being practised in the MHD of the Trust since 1985, no review or evaluation, formal or otherwise, had been conducted.

In 1996, I undertook a postgraduate diploma in cognitive and behavioural psychotherapy, during which I received CS. While I acknowledged the benefits of CS, I was aware that the focus during, and delivery of, CS was particularly valuable. On my return from the course, I began to provide CS to some nurses. I also engaged in much discussion with colleagues regarding the implementation of CS in other areas of the service. The views of those participating in CS were mixed, inconsistent and contradictory, a trend that appeared to resonate in much of the nursing literature.

In acknowledging the contrast between my own experiences of CS and those of colleagues and how it was being described in the nursing literature, I developed an interest in, and wanted to explore, what CS was being used for, how and who was providing it, how it was being practised and what sorts of issues would be discussed during CS. The time was right to undertake the present study.

Chapter 2 provides comprehensive coverage of the issues emanating from the expansive literature on CS and investigates the growing popularity of CS in nursing, benefit and outcome studies, characteristics of the clinical supervisor and interpersonal interactions during CS. Following this review, gaps in current knowledge were apparent. The research questions aimed at addressing these gaps and the methods required for this undertaking are described in Chapter 3. In Chapter 4, Heron’s Six Category Intervention Analysis is described and an argument is presented for its use as an analytic framework, while Peplau’s Theory of Interpersonal Relations is also discussed. Chapter 5 illustrates the study design and methods. Chapter 6 describes how this process was tested during a pilot study. Chapter 7 draws together the main findings and discussion. Finally, Chapter 8 sets out conclusions from the study and
includes the major insights gained, the limitations of the study, its contribution to nursing and some recommendations.

I have been extremely privileged in having the opportunity to observe how others embrace CS. It is hoped that engaging in the research process has been of benefit to all participants and that the insights gained from this investigation are of benefit to those who participate in CS and its continuing development.