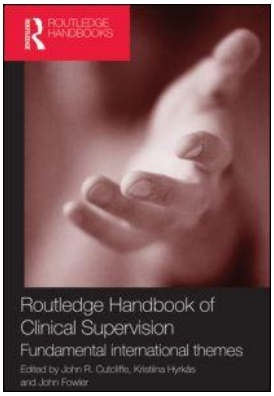

Routledge Handbook of Clinical Supervision Fundamental International Themes

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Clinical supervision

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9780203843437.ch16
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Published online on: 04 Oct 2010

ROUTLEDGE HANDBOOKS

Routledge Handbook of Clinical Supervision

Fundamental international themes

Edited by John R. Cutcliffe, Kristiina Hyrkäs and John Fowler

First published 2011
by Routledge
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

Simultaneously published in the USA and Canada
by Routledge
270 Madison Avenue, New York, NY 10016

Routledge is an imprint of the Taylor & Francis Group, an informa business

This edition published in the Taylor & Francis e-Library, 2010.

To purchase your own copy of this or any of Taylor & Francis or Routledge's collection of thousands of eBooks please go to www.eBookstore.tandf.co.uk.

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging in Publication Data
Routledge handbook of clinical supervision: fundamental international themes/ edited by John Cutcliffe, Kristiina Hyrkäs, and John Fowler.
p. cm.
Other title: Handbook of clinical supervision
Includes bibliographical references.
1. Nurses–Supervision of. I. Cutcliffe, John R., 1966– II. Hyrkäs, Kristiina. III. Fowler, John, RGN. IV. Title: Handbook of clinical supervision.
[DNLM: 1. Administrative Personnel. 2. Organization and Administration. 3. Clinical Competence. 4. Evidence-Based Practice. 5. Internationality. 6. Leadership. W 88 R869 2011]
RT86.45.R68 2011
362.17'3068–dc22 2010010178

ISBN 0-203-84343-6 Master e-book ISBN

ISBN13: 978-0-415-77955-5 (hbk)
ISBN13: 978-0-203-84343-7 (ebk)

16 Clinical supervision

My path towards clinical excellence in mental health nursing

Paul Smith

This chapter focuses on the experiences of a registered mental nurse (RPN) of receiving and engaging in clinical supervision. From early experiences of and exposure to clinical supervision during a formal programme of study, to engaging in clinical supervision as a staff nurse on an inpatient unit and then as a community psychiatric nurse attached to a general practitioner's surgery, this chapter provides a window into the lived world of the supervisee (in various settings and stages of one's career). The chapter advances the argument how engaging in clinical supervision helped the author develop his skills and knowledge, which in turn improved the care he offered to clients and maintained his health and clinical effectiveness. Drawing on specific examples of problems and/or challenges he encountered in his practice, the author shows how these real issues were brought into the supervision sessions and how they were faced, considered and subsequently addressed. The chapter also draws attention to some of the practical disadvantages that can occur if certain principles are overlooked.

While the editors are mindful of the evidence-based movement and the need for evidence to support the widespread introduction of clinical supervision, they are less comfortable with (artificial) so-called hierarchies of evidence and the almost inevitable low 'ranking' of qualitative evidence. Such hierarchies of evidence are by no means universally accepted. An alternative view posits that research methods within quantitative and qualitative paradigms can be regarded as a toolkit; a collection of methods that are purposefully designed to answer specific questions and discover particular types of knowledge. To attempt to place these designs (and the evidence they produce) into some artificial and linear hierarchy only serves to confuse and obfuscate. If what is needed to answer a particular problem (e.g. the comparison of the therapeutic effects of two approaches to the organisation/delivery of CS) is a meta-analysis of the current studies in this area, then for that particular problem, that is clearly the best form of evidence. Concomitantly, if what is required to answer a particular problem (e.g. what are the lived experiences of experiencing effective CS) is deep, thorough, sophisticated understanding, then for that particular problem, qualitative findings are the best form of evidence. Both types of evidence are needed, both types of evidence are valuable: the discovery of both types of evidence should be encouraged.

Introduction

In this chapter I am going to make the argument that clinical supervision (CS) is effective in developing skills and knowledge, improving care delivered to patients/clients and maintaining the clinical effectiveness and health of the supervisee. I achieve this by describing my experience of CS, using specific examples of problems

or challenges I faced in my own clinical practice. I will also draw attention to some of the practical disadvantages that can occur if certain principles are overlooked.

The examples are loosely arranged in three, chronologically correct, stages namely:

1 my introduction to CS while studying for a post-registration diploma titled 'Understanding Therapeutic Relationships' which was run by clinical psychologists and validated by Nottingham Trent University;
2 my experience of CS provided by a nursing colleague as we worked on an inpatient unit for people with enduring mental health problems; and
3 latterly in my role as staff nurse in an acute, general practitioner-attached community mental health team.

While this chapter may not be overly academic and is descriptive and discursive, I believe it is scholarly and persuasive nonetheless. My gratitude goes to my supervisors, who here remain anonymous, for the love, patience and support they have shown me. I hope and believe that they would agree with me when I suggest that at least some of the time spent in providing me supervision has resulted in valuable (and even measurable) gains for the people we claim to care for.

Early experiences of clinical supervision

For the first six years of my nursing career I was not given CS in the form I recognise as relevant and necessary today. As a student nurse (RGN, 1984 syllabus) I was allocated to registered nurses while on clinical placement, some of whom were bemused or threatened by the frequent questions I had, and some were tolerant of my striving to do and know the right way to do things. As a junior staff nurse I was extremely fortunate to have experienced colleagues who forgave me my sometimes insensitive challenges of not only procedures and routines but also their clinical practice. During this time I frequently received critical, balanced feedback about my technical skills, my application of knowledge to clinical situations and developments in my own practice, much of which was helpful and constructive. Indeed it continued through further training which led to me becoming a Registered Nurse (Mental Health) and a staff nurse on a rehabilitation/challenging behaviour/continuing care unit for people with 'severe and enduring' mental health needs. But in all this time I had little guidance to help me examine, analyse, explore the reasons as to why I did what I did, said what I said, and/or behaved the way I behaved. It is reasonable to suggest that I gained insights through reflection upon and within my practice, by discussions with peers and colleagues, and from being exposed to praise, criticism and indifference by others. But I was frequently aware that there was something missing from the picture although, I did not know what.

After nine months of working in the inpatient unit, I commenced a course in 'Understanding Therapeutic Relationships'. An integral part of this was a module that involved receiving CS from a psychologist with the aim of participants learning more of the processes that occur in their interpersonal therapeutic relationships with clients. Throughout the course participants brought issues from their clinical practice to the supervision group. We alternated the sessions between participants, which generally lasted between an hour and ninety minutes. We had received teach-

ing as to the purpose of the sessions, which were not specifically to address issues of technique or clinical knowledge but to gain an understanding about *process*. This meant that our descriptions of interactions between us and our clients were less valuable than the exploration of what we thought were going on while the interaction or events occurred.

Formative group supervision sessions

The issues I brought to the group were to do with the difficulties I was experiencing in developing a therapeutic interpersonal relationship with a resident upon the unit of which I was a staff member. I had been allocated as the key worker to a male resident, Dave, who had been an inpatient for several years within various mental health facilities. The difficulty that I was experiencing was how to stop Dave from interrupting conversations with noisy demands for staff to listen to what he wanted to say about his voices. A nursing care plan had been in force which reflected the general perception of staff that Dave was behaving without reasonable consideration for accepted social norms, as well as a clinical view which did not consider engagement in discussion about the content and meaning of auditory hallucinations as being therapeutic. Dave often became more insistent in his demand to be listened to, leading to mutual frustration, anger on his part and no successful resolution to his requests.

As I described what I thought was a reasonable therapeutic approach, i.e. to reinforce generally accepted social norms in line with the prevailing philosophy of the unit, my supervisor asked me to reflect on what could be happening in the interpersonal dynamics between Dave and members of staff. She asked me directly how I felt while Dave was demanding attention from me. She asked me to speculate how Dave was feeling when he was told he could not talk about something he thought was very, very important. I realised we both felt powerless, angry, ignored, devalued.

I have never forgotten the impact of realising that, for what had seemed good reasons, I was colluding in a system that was resulting in anger and frustration for both Dave and members of staff. *Through these CS sessions I became aware that I had no conceptual justification for refusing to listen to Dave talk at me about his voices other than I did not know what to do to help him if I did.* I also became aware of my emotional response to Dave which was interfering in the therapeutic interpersonal relationship (Peplau 1988). For example, in recognising and admitting to my own sense of irritation, indignation, or anger when Dave confronted me or colleagues, I was able to ask myself whether my response was justified (in the context of being therapeutic). To my discomfort I was able to identify that some of my reaction was because I felt and thought that I, a staff nurse, should be shown more respect, perhaps more gratitude, from this rude, thoughtless, demanding man! I had become an authority figure who Dave was challenging as he had challenged his father since he was a child, although for years I would have espoused the idea that a nurse should work co-operatively with the patient, promoting their sense of independence and challenging passivity and dependence.

Through this CS, I now understood how Dave's expectations of me (and others) were based on experience of previous relationships when he had taken a subordinate but rebellious role. I now had an experience of working with transference and counter-transference (see Brown and Pedder 1991). I had discovered what

transference felt like and, once enlightened, was able to respond to his behaviour in a way that did not confirm unhelpful thoughts and feelings that he had towards authority figures but in a way that empowered him and affirmed him as an individual. For example, when Dave did or threatened to do something which was potentially problematic, such as go to the pub to get drunk, he was no longer told he could not. Instead I discussed with him what his wants were, what the organisational requirements were and together a mutually beneficial solution was reached. What was avoided was an unhelpful reprise of an authoritarian father figure and a rebellious child (Harris 1973). The outcome of this was that Dave reduced the number of assaults he made on staff for the next two years and felt able to arrange sessions when he and I would talk about his voices.

By bringing more examples of my interaction with Dave to CS I was able to gain a deeper understanding of nature and quality of the transactions between us. More importantly I was able to change and adapt my own practice to the benefit of Dave. Instead of attempting to control Dave's demands for attention I began to seek actively opportunities for him to ventilate his frustrations and fears about the voices that caused him distress. It became possible to reject a view, which had not been challenged throughout my training, that voices were symptoms and not to be encouraged and which led me to the developments in Cognitive Behavioural Therapy (Kingdon and Turkington 1991; Alford and Beck 1994; Birchwood and Tarrier 1992; Chadwick *et al.* 1996; Sanju *et al.* 2004) to 'treat' hallucinations and delusions.

My continuing experience of CS has been with my line manager. I agree with the well documented view that difficulties arise when line managers offer CS supervision because the focus of the supervision can easily move from the needs of the supervisee to those of the manager and the employer (see Butterworth and Faugier 1992; Cutcliffe and Proctor 1998a, 1998b; Stevenson 2005). *The truth is that there were some issues I felt unable to take to my formal supervisor for different reasons. One was that in admitting to some thoughts and feelings, I was concerned that this would prejudice my professional standing with my manager. A second reason, closely related to the first, is that there are some issues which practitioners are not comfortable about in exploring even with themselves, and to do so with someone in authority is even more problematic.* In my own case this has included feelings of anger towards a resident of whom I was becoming frightened. Fortunately I was able to take this issue (and others) to someone who I implicitly trusted and who did not feel obligated to inform my employer of our discussion. Because I had a place of safety I was able to express raw feelings, thoughts and emotions without fear of censure. In return I was relieved of the guilt and shame I had for merely experiencing human emotions, and was thereby empowered to change some of my own thoughts and beliefs, change my working practice and to develop strategies for working with the behaviour of the resident involved. This shows that CS allows us to be human and professional. In my case it permitted me to continue working in a homely environment with people who had or were likely to assault or threaten me and to do so in a therapeutic way without resorting to authoritarian attitudes. I believe that this example also illustrates a danger of receiving CS from a line manager, no matter how strong the professional or personal ties are. Regrettably, I could provide testimonies from dozens of colleagues whose 'clinical supervisors' consider CS sessions to be about their own issues, about caseload management or about control. This is not CS and can only be detrimental to patient/client care and the professional development of the nurse being supervised.

While the CS took place over several years there are specific examples that illustrate the effectiveness and value of the supervision I received. One example involved a resident who had recently been admitted to the unit after a period of time on an acute psychiatric admission ward which had followed deterioration in his relationship with his parents. Jack was resentful of not being allowed to live with his parents due to his disturbed and aggressive behaviour. He expressed bizarre ideas about being influenced by aliens and the occult in the past and thought his real mother had been replaced by the present woman who looked like her and sounded like her but could not be her because his mother would have him to live at home. He was disturbed by some of these ideas and even more troubled by the sense of abandonment he felt. Jack was skilled in many activities of daily living although chose not to attend to his hygiene or grooming and was careless with personal possessions.

As an individual I occasionally felt a responsibility for Jack. Through several CS sessions I was able to recognise that I was emotionally responding to Jack's explicit and implicit demands to be mothered, to be nurtured, to be rescued from the consequences of his own choices and actions. My supervisor facilitated this understanding by asking me how I felt or what I thought was being demanded from me by Jack when he behaved in ways which were apparently careless or rebellious. It was not that I was unaware of what Jack was doing, but by exploring the transference and counter-transference I was able to respond with greater self-awareness. I was able to recognise the unhelpfulness of my own unconscious desire to help, to nurture and to parent. Identifying the transference/counter-transference that was present meant that I was able to act in a way that was to eventually result in an increased sense of personal autonomy and responsibility for Jack. I gained a sense of empowerment through CS and felt increasingly able to empower Jack in having an expanding area of choice and responsibility. We were able to revisit parenting issues that he had experienced in ways that were more appropriate to our ages and abilities, and Jack was able to describe these issues as he gained an understanding of them.

Growth of self-awareness

It is not accurate to suppose that I brought all issues to CS knowingly. While I gave thought to what I wanted to talk about beforehand, invariably I would incidentally describe, with some emotion, an event that had occurred, without immediately realising its significance. When I talked of being confused or angry or sad it became apparent that Jack or whoever was experiencing similar or the same emotions. As I became more self-aware I could then reflect back to a client/resident that emotion, albeit in a tentative way, and encourage awareness-raising of their own mood states.

For example, this was particularly helpful in developing my therapeutic relationship with Jack, as he was not skilled in recognising and adapting to rising levels of anger or sadness. One evening Jack had become angry when a member of his family had made comments which Jack had difficulty in 'hearing', and he assaulted his family member. It was distinctly possible that further assaults were going to occur and that Jack was past the point at which he could be talked down or the situation de-escalated (Maier 1996). He was informed of our next response, which would be to 'hold him' until the threat of violence was withdrawn. Jack was also reminded that we recognised that neither he nor the nurses would like this; we had no wish to harm him and would prefer for him not to have to endure the holding. The

situation eventually required a physical intervention that within a minute resulted in Jack saying he was calm and that he would go to his room. (An interpretation of this rapid reduction in Jack's emotional arousal could be that there had been a resolution of the bind he was in. He had been angry but did not have the skill to express this more effectively. Nor was he able to back down in that situation without losing face. Intervention by nursing staff conformed to past interventions he had experienced in previous establishments, including hospital environments, and so he was able to follow the part he had played on numerous occasions. Significantly there was a difference in the part played by the nursing staff, in that throughout the incident dialogue was maintained in a way that did not emphasise a need to control Jack but to manage the situation.)

It was as Jack returned to his room I felt an almost overwhelming sense of sadness and loss and instead of interpreting this as my own personal response to a violent incident I decide to check out with Jack how he felt. A few minutes later, with his permission, I was sitting on his bedroom floor, drinking a cup of tea and describing how I felt to Jack, and speculated that I was not the only one who felt sad. Instead of denying he felt bad and saying he was all right, a habitual shorthand way of avoiding any difficult discussion or realisation, Jack acknowledged sadness and we sat and cried together. He was able to own his emotion in that situation and showed some empathic understanding of others as well. He also was able to appreciate that his actions had resulted in unpleasant consequences for lots of people, and was able to accept responsibility for his part in the incident. A further benefit was that he did not get his revenge on anyone involved in the restraint procedure, which was also a departure from the norm.

Reflecting on critical incidents

I have found that the effectiveness of 'Critical Incident Analysis' (Minghella and Benson 1995) is also increased if carried out in the context of ongoing, skillful CS. That is to say the process(es) by which an incident can be analysed by gathering information to establish what happened, how it happened, why it happened and thereby gaining some insight into any lessons that could be learned from the incident are greatly enhanced if all participants can contribute freely to the process. This premise can be borne out by focusing on two violent incidents in which I was involved. The first involved my mishandling a situation and the second where, even in hindsight, it seems there was nothing that I could reasonably have done differently that would have prevented the assault. The first occurred when I entered, with permission, a resident's bedroom, to discuss something that was causing him some distress and about which he was beginning to get agitated. Missing the danger signals, I overstayed my welcome and had a shoe thrown at me. I was saved from further assault by the timely intervention of another member of staff. Team members provided a debriefing that shift but it was during a CS session I was able to explore my reasons for staying in the bedroom. I am certain without the safety of CS and supervisor that I trusted, I would not have had the opportunity to examine the intrapersonal process I was going through in that bedroom. We were able to identify the technical mistakes I made: e.g. allowing an increasingly agitated patient get between me and the door, not leaving the room earlier. We also explored how I felt at the time, why I did what I did and what I was hoping to achieve by acting the way

I did. The CS did not result in self-condemnation but in self-realisation and the opportunity to change my practice.

The second incident involved a resident who, with no warning, made an aggressive demand that something of his be given to him. Despite following an approach that was the optimum for de-escalating the situation, I was subjected to a bodily assault, which resulted in a period of sick leave. It was CS that enabled me to acknowledge my true thoughts and feelings to the assailant as I prepared to return to work. I had adopted an attitude which was admirable had it been true, that of understanding and forgiveness (as a result of my personal theological views/beliefs and personal philosophy). In addition, I have been exposed to a great deal of nursing literature which uncritically exhorts nurses to have unconditional, positive regard for patients/clients (e.g. Rogers 1952). In truth I did bear feelings of anger, betrayal, sadness and fear. What I was able to do was own up to these feelings in CS, secure in the knowledge that, barring confessions of illegality or gross professional misconduct, I could admit to perceived failure or weakness and not fear censure.

A need for caution

I remain surprised and saddened when I hear of colleagues who are suspicious about the introduction of CS to their practice. I suppose it is with some justification that nurses are cautious or sceptical when they see a hastily developed policy implemented with no consultation and little thought given to the training of supervisors. I have heard many stories of how managers use CS sessions as a management tool; supervisors who appoint themselves, dictate the agenda of the supervision sessions, and who verbalise their belief that it is all a waste of time anyway. I have worked with colleagues who are offended or frightened by the suggestion that they open their practice up to the gaze of anyone else. *But I have experienced how, when done adequately, CS is about growth and development not about censure.* Further, it has enabled me to improve my service to residents/clients and they have directly benefited by changes in my clinical practice.

Towards clinical excellence

When I moved jobs to work as a community psychiatric nurse (CPN) (attached to a general practitioner practice) I experienced a culture shock. While I was used to individual work with clients, I was not fully prepared for the implications of having no one to take over at the end of a shift. The most pressing need is the requirement to carry out assessments as to the risk of suicide, significant self-harm or risk to others within a limited time period. I was also faced with the different demands and opportunities presented by a different client group, and how to apply existing knowledge to different clinical problems. At my job interview I was assured that CS was considered to be part of normal working practice, and this has been the case. I was able to access informal supervision on an ad hoc basis, discussing difficulties and successes as we met coincidentally within the office. Formal CS sessions were planned, noted in our diaries and given priority over other meetings and appointments. As a result of the emphasis given to CS in the CPN team, a culture of support has developed that encourages a sharing of experiences. The team has acknowledged the importance of the opportunities to have colleagues listen to one another, ventilate feelings, help explore and resolve technical or practical difficulties and

also be free to pass their own reflections upon issues raised. It is not a replacement for CS but a helpful addendum.

The issues I bring to CS continue to involve transference and countertransference. It has been of considerable help to bring to CS situations where clients have adopted roles which do not permit therapeutic nursing to occur (Peplau 1988). For example, I have seen numerous clients who are referred not because they themselves want help but because a partner or parent has insisted they see a doctor. However, while I can know this I do not always feel comfortable discharging a client when I believe there is real potential for change. CS gives me the opportunity to express this discomfort and in doing so I usually recognise that my feelings have to do with my agendas, to be seen as effective, to help people whether they want it or not. My supervisor can sometimes enable this process by allowing me to continue talking, sometimes it involves questioning. *My assertion is that in receiving CS from skilful, knowledgeable, compassionate supervisors I was allowed to gain insights into my own practice that had direct benefits to the clients I was working with.*

Similar situations have also occurred when I have mistaken my agenda for the client's need. An example of this was while I was still seeing Bob. He had lost his job as a heavy goods vehicle driver two years previously due to arthritic changes in several joints, which continued to cause him physical discomfort despite the prescription of strong analgesia. He had developed severe depression to the extent he paid no attention to personal hygiene and was at risk of severe neglect without the support of close family. He expressed a sense of hopelessness about the future and a belief there was nothing left to live for. My difficulty was that he was not interested in engaging in a process to challenge the thoughts that were exacerbating the hopelessness and depression. He was only bothered how I could help him get to an outpatient's appointment to see an orthopaedic consultant without him 'cracking up'. I took my frustrations to CS. By being asked what it was that Bob wanted I was able to see my error. I agreed it was not wrong for him to have an agenda that was different to mine. He had to cross a hurdle before he could give attention to the problem he thought I had invented for him. My frustration evaporated as I decided to work with Bob instead of deciding that he needed my nursing care. I subsequently discovered that when our agendas coincided, he quickly came to understand how changing his thinking would enable him to adapt to his changed circumstances. Within a short time he was both depression- and pain-free.

Final thoughts and reflections

My assertion is that in receiving CS from skilful, knowledgeable, compassionate supervisors I was allowed to gain insights into my own practice that had direct benefits to the clients I was working with. It could be argued that as I was someone who habitually reflected upon his own practice, I would have worked much of this out anyway (though I do not agree with that position). My point is that it was especially valuable for the few issues that got under my radar that I needed CS. I have found out that a view from outside oneself is frequently necessary. *The craft of psychiatric/mental health nursing is such an all-embracing human activity that it is too easy to be caught up in the doing and to lose sight temporarily of the processes that we are involved in.*

I also believe that CS has an equally important benefit: I have been able to chart my development. I have had the opportunity for someone I trust to acknowledge

the changes, the successes that have arisen out of my clinical development. I have had a regular opportunity not only to let off steam but also to act constructively as a result. And I remain as hungry to develop myself and clinical services to benefit resident/client care as ever after 22 years of nursing. I do not believe my experience is unique. There are many people who could write persuasive arguments to support the use of CS and I have read many others. The disappointing thing is that the nursing discipline still seems to be deciding whether it is worth the effort. I hope my experience, outlined in this chapter, will help convince nurses that CS is indeed worth the effort.

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