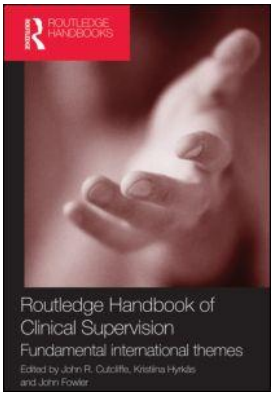

Routledge Handbook of Clinical Supervision Fundamental International Themes

John R. Cutcliffe, Kristiina Hyrkäs, John Fowler

Providing cross-discipline group supervision to new supervisors

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19 Providing cross-discipline group supervision to new supervisors

Challenging some common apprehensions and myths

Paul Cassedy, Mike Epling, Liz Williamson and Gale Harvey

This chapter was originally presented in *Fundamental Themes in Clinical Supervision* (Cassedy *et al.* 2001: 198–209). Due to the importance of the topic and the timelessness of the content, the editors have chosen to include the chapter in this book as well. The authors focus on discussing cross-discipline group supervision. They describe how, at the request of their local NHS Trust, two mental health nursing tutors provided a series of group supervision sessions to general registered nurses who were about to take on the role of clinical supervisor for the first time. They show how the groups were established, illustrate some of the experiences of being in these groups, and identify some of the issues that arose, primarily during the early stages. The chapter draws attention to one particularly important issue, which is that some novice supervisees may be discouraged from participating in supervision if their supervisor is from a different discipline. However, exposure to and experience of supervision provides such novices with an awareness that the supervisor's skill in providing supportive, reflective and challenging supervision is more important than sharing the same discipline.

This chapter is particularly useful for supervisors and supervisees. It is a classic piece of work and, therefore, important for educators, administrators and researchers. Because this supervision was successful, it can provide valuable information for those endeavouring to develop cross-disciplinary supervision and, potentially, also for those interested in the growing field of interdisciplinary and interprofessional collaborations.

Setting up the supervision groups

Back in 1997 clinical supervision was a new concept for the majority of the 1,500 registered nurses in the large teaching hospital where two of the authors were employed. They had the task of implementing a pilot project to introduce supervision within the Trust. Volunteers were asked to be trained as supervisors and 18 registered nurses came forward. The supervisees were drawn from six areas which volunteered for the pilot project, but the supervisors came from all across the hospital.

Purposeful time had been spent by a working party to consider and provide a framework for implementation that would be carefully planned, covering as many aspects as possible to establish a culture and provide high quality clinical supervision. In keeping with the structures suggested in the relevant literature (Hawkins and Shohet 1989; Butterworth 1992; Bond and Holland 1998), and since this was to

be a new experience, supervision for the supervisors was identified as essential within this framework, providing the much-needed support.

Links had been established with the local education provider in particular through the supervision course that was offered to the Trust. As the facilitators of that course, the first two authors were therefore approached by the second two authors to facilitate group supervision to these new supervisors for the duration of the pilot study (six months).

In addition to providing this learning experience, the group was viewed as valuable for the new supervisors in providing an experience of what it feels like to be a supervisee. Participation in the group offered a unique means of learning, enabling empathic qualities to develop as more insight and respect can be gained as one begins to value the whole process of supervision.

The first two authors accepted this invitation with a mixture of enthusiasm and anxiety. Although both these authors have many years of experience facilitating groups in practice and educational settings, this was the first time they would be formally supervising general nurses in a setting and environment that is alien to their own. Both these authors have a background in mental health, human relations, counselling and training. Each of these subjects can be regarded as somewhat 'mystical' to those unfamiliar with the idiosyncrasies of the subject and as a result, may have caused a degree of caution in the potential group members. These anxieties existed on several levels. First, there was the initial anxiety of the supervision itself. The authors felt that they would be focusing on their role of supervisor rather than the role of general nurse, but concerns existed regarding the possibility that issues could arise about practice that was beyond their understanding and experience. Second, the authors had anxieties that mental health backgrounds might prove to be an issue in facilitating group supervision for general nurses.

Supervisors and supervisees sharing the same discipline

It is the authors' experience from running training courses in clinical supervision that when first embarking on the concept, the supervisee initially wants someone from the same discipline and background to supervise him or her. There is probably an element of safety here, in that potential supervisees do not want to feel vulnerable and exposed and they have always previously gone to a colleague for support. *However, as knowledge and experience is gained supervisees gradually realise that there is a greater opportunity for development in choosing someone, irrespective of his or her background, who will stretch them and be more challenging.*

The fact that the facilitators were from different backgrounds did not manifest itself as a significant issue for the group members. When the initial arrangements were being formulated and during the preliminary sessions, the new supervisors welcomed the opportunity of working with someone with more experience in supervision. The potential supervisors suggested that they were concerned with the skills the facilitators exhibited as supervisors rather than their clinical backgrounds. *It is the authors' belief that it is more important for the supervisor to be competent in and understand the process of supervision, than it is to share the same clinical background as the supervisee.*

The new supervisors were divided into three groups of six members each; there was a considerable range of specialties and grades within each group. Only

two had received supervision before and there was an even mix of those who knew one another and those who did not. There was apprehension about taking part in group supervision alongside the anxiety of taking on the role supervisor for the first time. Page and Wosket (1994) allude to the notion that becoming a supervisor is rather like learning to swim. Although the new supervisors would be getting their feet wet by going in at the shallow end there was also the opportunity of taking lessons and learning alongside a more experienced swimmer. The facilitators felt qualified to take on the role of group supervisor as Carroll (1996) and Scanlon (1980) suggest, having previous supervision experience and the transferable skills of teaching and facilitating, so this was about to be put to the test.

The group experience

There were no pre-conceived ideas or guidelines about how to use the sessions, only that these supervisors would need considerable support as this new role was in its infancy. As in any new role or setting the nurse may find herself in, there needs to be a period of mentorship and nurturing. To help safeguard this new journey, it was considered important to create a contract for the supervision group to enable some degree of control over the experience. A good starting point for encouraging empowerment and ownership is to discuss the very issues that may cause concern to the individuals involved (Hawkins and Shohet 1989; Bond and Holland 1998). Airing these anxieties provided a forum to share and explore a range of issues which are not only important to the supervisor in the group, but may also parallel the very same concerns of the supervisee in the work setting.

The group decided that the time allowed for each member would be divided equally but urgent matters would take precedence. As status within the group was diverse, it was considered to be important to address this and the group wanted to ensure that it was put to one side to create an egalitarian approach. The authors attempted to create a level playing field to provide supportive challenge that would avoid competitiveness and encourage reflection, exploration and sharing. Each member agreed to be prepared for supervision, and the group would decide the agenda on the day.

Confidentiality was discussed; the decisions reached were analogous to the agreements that were stated between supervisors and supervisees. Revisiting the United Kingdom Central Council guidelines for professional practice (UKCC 1992) proved to be a good starting point. A breach of this code, a breach of law or serious exploitation or endangerment to others would normally be occasions to disclose information to another source (Morton-Cooper and Palmer 2000).

Concerns of disclosure, which would involve reporting serious malpractice and how these could be dealt with in the supervisory alliance, were aired, but also what-if scenarios were brought to the fore (see Cutcliffe *et al.* 1998a, 1998b). Many issues are not easily answered; reminding the group that they were also in a supportive relationship and would not be left isolated calmed anxiety about the possibility of serious disclosure. An issue that was related to confidentiality emerged in one group and had an effect on both the attendance and dynamics. Feltham and Dryden (1994) point out that group supervision does have its drawbacks; notably the group dynamics can be a complicating factor.

Blurring of relationship boundaries

A member of the group had a close friendship with another group member's supervisee. This was not disclosed or picked up by the facilitator at first, but there was some absenteeism and when all were present some hesitance and holding back of material. A group member finally revealed this in a group evaluation round. Although the names of the supervisees were not used in the group, identities in this small world can be recognised so anonymity cannot be maintained, only the conditions of confidentiality can be provided. This was explored and discussed with the group with the conclusion that it would be more therapeutic to be open and honest about such matters and that we as a group needed to establish strategies to overcome such issues. Many staff, even within large hospitals, are going to have some awareness or acknowledgement of one another. Even if not, certain persons still may be able to be identified from the material the supervisor is working on. The issue here for the group and subsequent supervision arrangements is to maintain the boundaries and responsibilities of clinical supervision. Some group members will know one another and their supervisees; a group member may have a different role over another member's supervisee, which could cause a blurring of boundaries or conflict of roles.

Power (1999) argues that a supervisor should not agree to supervise anyone that he or she has a close relationship with. Bond and Holland (1998) state that it is the responsibility of the supervisor to hold tight boundaries and keep any other role outside the supervision sessions. Perhaps both of these views can be substantiated, but when a supervision group finds itself with such issues, practical measures may be needed. One such method would be for group members to disclose a supervisee's first name and then perhaps his or her area of work. If any group member recognises the supervisee as someone well known to him or her, he or she should acknowledge this and leave the room whilst this supervision work is being presented. Another method would be, following negotiation with the group, to have the last ten minutes of session for an individual to work alone with the supervisor if his or her supervisee was well known to another in the group. By making every effort to respect confidentiality, this would help maintain objectivity and avoid potential damages of avoidance or collusion.

The early stages: finding our feet

Attendance of one group was spasmodic in the early stages, which could have had a number of contributing factors. Some will always drop out for unplanned unexpected reasons, e.g. leaving the area. There is also the notion that in the initial stages of implementing supervision, anxiety levels of staff will be raised, in particular if it is to be group supervision (Hawkins and Shohet 1989). This could result in absenteeism either from the supervision sessions or from work itself, as staff are apprehensive and uncertain of attending. It is well documented that receiving supervision can reduce stress levels in the supervisee (Butterworth *et al.* 1997). However, undertaking the role of supervisor for the first time can have the opposite effect and increase the supervisor's level of stress.

This, in some small way, seemed to be the case here. In the pilot evaluation supervisors did admit to some anxiety about the size of the group and they felt

uncomfortable with self-disclosure, which affected levels of reflection. A few supervisors found the whole process too much and opted out while for some others the group size created some reticence. One supervisor during the evaluation stated that 'it wasn't until my group reduced to three supervisors that I really felt comfortable and was really able to reflect on my performance.' Another mentioned that 'it wasn't that I didn't trust all the group members, although I did feel some concern about the makeup of the group and possible impact on outside working relationships. The group felt too big and a little intimidating,' then went on to add, 'I never felt sufficiently at ease to want to address important issues, especially due to the fragmented nature of the group in the early sessions.'

A delicate balance is needed here, as Charleton (1996) points out that supervision is approached with a mixture of anxiety and relief: anxiety at the thought of exposing their clinical practice and relief that there is someone who will really listen and provide support. It can be a problem to maintain attendance and keep commitment and motivation high, in particular in the early stages of the group when only meeting once a month in what can be a disquieting experience. Support and encouragement is certainly needed but what also needs to be built in is a professional approach to value the whole process of supervision, and a responsibility to make and keep that commitment. If we do not take that personal responsibility, then we are not only letting ourselves and our profession down, but arguably our patients or clients as well.

The supervision sessions themselves were also fragmented at the start of the pilot in the work setting. Some found it hard to meet regularly; there were cancelled appointments and when some meetings did occur, there were perceived to be no major issues to discuss or explore. So for some new supervisors the relationship with the supervisee was difficult to get going and the alliance slow to develop. This meant that those supervisors who had not met with their supervisees felt inhibited or even embarrassed about attending the group sessions. Further exploration with the group revealed that some form of parallel process might have been occurring. Although this is a very complex phenomenon, a simple definition would be that at times the dynamics of the relationship between client and nurse become paralleled or mirrored in the relationship between nurse and supervisor. Carroll (1996) gives a comprehensive overview of this phenomenon from a psychoanalytical and counselling perspective, while Power (1999) goes into some detail from a nursing perspective. Therapeutic relationships do take time to grow and develop, even more so when the meeting is only for one hour a month. So the rather fragmented start to the supervision process for some in the work setting appeared to mirror that of one of the supervision groups in the pilot project. Perseverance, commitment and enthusiasm were needed by all those concerned in the process as well as the full backing and co-operation of those on the periphery. The supervision group needed to become aware of this so that they could address the issue and work on their own group co-operation.

An advantage of group supervision over individual supervision is that participants can share their abilities and resources for a common purpose. Listening to other group members presenting their supervision work can help others in the group to identify and express issues in their work setting. This is particularly valuable, as new supervisors may well experience similar difficulties (Bond and Holland 1998). There are developmental opportunities as each member can be a co-supervisor for one

another, enabling reflection and supervision skills to develop. Creativity has an opportunity to be rediscovered and developed for the task in hand. The authors needed to remind themselves to take risks and were eventually rewarded with a greater richness of learning and experience. Tuckman's model (1965) of group development suggests there will be confusion and conflict in the early stages but if successfully managed, it will lead to a successful performance of the task.

Themes arising from the group

There were common themes of material that emerged from the group supervision sessions. Rather than the supervisee focusing on his or her clinical practice, it tended to be relationships with other members of staff or his or her own personal development issues. It seemed that at least initially most supervisees needed to focus on the formative and restorative aspects of supervision rather than on the normative function. There could be several reasons for this; it would seem that there is little already available in terms of support systems to focus on personal issues related to teamwork and professional development. *Such issues may therefore have been stored away or built up over a period of time leading to a backlog of concerns or issues needing to be addressed before the supervisees could move on to examining their own practice in more depth.* This is not to suggest that there is no need for supervision in the normative function for general nurses.

Bond and Holland (1998) propose that the focus of supervision leads from the restorative to the formative and finally to the normative when safety in relationship and process has been established. The experiences the group reported in the nature of the material brought to supervision can therefore be viewed as following such a pattern and process, which needs to be worked through in the development of the supervisory relationship. Progressing onto exploring issues relating to practice would be the next phase of the process.

It is possible that initially the supervisees need to feel fully supported to reflect more in depth on their care and relationships with patients. There is a misconception that it is only when nurses are working with patients intensively over a long period that there is need to reflect on that work and the relationship. Nurses working in areas with a rapid turnover of patients often underestimate the significance of their relationship with patients and families for the patients and themselves. Even brief relationships may leave unresolved issues for the nurse, which could be explored in supervision. The supervisors new to their role may have allowed some supervisees to keep their focus on familiar issues as this gave them an opportunity to build up their own confidence in their role before having to face more demanding situations that may raise anxiety, e.g. dealing with uncertainty.

A common theme also emerged in how the supervisors tackled these issues and the types of interventions they used. Perhaps because the supervisors were apprehensive of this new role and of being viewed in a position of responsibility, they tended to be rather prescriptive and solution-focused in their interventions. This tendency to focus on the actions and activities of the supervisee with problem solving in mind was seen to be a measure of success. There was also the misconception on the supervisors' part that solutions to problems identified in supervision could be written up for the evaluation in order to demonstrate its value to the organisation. Indeed, following the pilot and evaluation a number of supervisors

reflected that this was primarily a symptom of their lack of experience with supervision and that it fitted more comfortably with their more familiar nursing role.

What emerged from the group sessions and proved to be valuable learning were the ways the new supervisors perceived their authority and how comfortable they felt with it. Pickvance (1997) states that new supervisors will bring to the role their own feelings and experiences regarding authority. The facilitators felt that it was paramount that the supervisors did not over-identify with an authoritarian role by being too prescriptive and being seen to have all the answers. Conversely there should not be denial of the role by an avoidance of challenging supervisees and leaving sessions without clarity or focus. Both these characteristics appeared in the supervision sessions as some supervisors found it easier to stay purely supportive while others wanted to focus intently on outcomes. This will have the effect of undermining the supervisee and the whole purpose and process of supervision. What needed to be established in the supervision relationship was a genuine space for reflection, thinking and development, not only for the supervisee but also the supervisor.

Seeing the big picture

This ability did develop during group supervision and the supervisors were able to work with their supervisees in a different style from any previously experienced. This was not only to be more facilitative in their approach but also to have a wider vision. Hawkins and Shohet (1989) refer to this as helicopter vision, which is the ability of the worker to switch perspectives at various times. The purpose is to help the supervisor to take a broader perspective on the supervisee. This is not only to focus on their practice and work setting but also to consider their (the supervisors') own behaviour and experience and the reasons for acting as they do.

One supervisor presented a case where the supervisee felt left out and not part of the ward team. What they both initially began to explore was to find a solution to the problem and how to resolve it. This was in part due to the supervisor's desire to problem solve as this was her usual way of working. During group supervision this was processed and other possible interventions and ideas reflected upon. Following this exploration, the supervisor felt more able and thus competent to utilise facilitation skills and help the supervisee to reflect more deeply. When the case was next presented in supervision, it surfaced that the supervisee felt more isolated with herself rather than with others and a broader picture emerged. She worked part-time, was caring for an elderly relative and had just returned to practice following maternity leave. She now lacked confidence in herself and questioned her ability in a changing ward environment.

The supervisor had helped the supervisee to focus more on how to build up her self-esteem and confidence, what she actually wanted for herself and how to develop more supportive relationships in her team. Eventually there was more insight and understanding and the supervisee felt more able to disclose her feelings to others. She began to update herself with practice issues which enabled her once again to feel involved. Hawkins and Shohet (1989) point out that the skill of seeing things in a wider context is difficult at first and can only fully be developed during the actual supervision process. This was also our experience as the skills began to emerge and then develop during the life of the group.

Moving towards supervisee-centred skills

Perhaps also due to a lack of skill or experience, there was some initial anxiety of utilising more the catalytic or facilitative type of intervention and its links to helping in a counselling type of role. Supervision is not counselling, although many of the skills and certainly the qualities that make the working alliance are transferable. The overall intention and purpose of each is different: counselling is focused solely on the person being counselled while the focus of supervision is primarily on issues that ultimately affect the supervisee's practice. However, this should not discount the need for support for the supervisee as a person and in his or her emotional and psychological development. As Bond and Holland (1998) argue, support is open-ended. Good supervisors need to develop their use of counselling skills as well as feeling confident and comfortable with that process. There needs to be an ability to be aware of their appropriate and inappropriate use as well as to recognise when they may need to refer elsewhere. The supervisor needs at least to be able to contain any emotional material the supervisee brings to supervision and have at least some understanding of the psychological processes that may be occurring. A fear that new supervisors may often have is saying the wrong thing or not wanting to put their foot in it. However, if they truly are actively listening and communicating their empathic understanding there needs to be no such fear. Communication skills such as paraphrasing and reflecting back key words or feelings are very powerful in enabling the supervisee to be really heard and understood. But what the new supervisor will need is to feel supported in this different way of working and have a forum, such as their own supervision, to explore any issues that may arise.

The essential ingredients of good communication, learning and supervision are Rogers' core conditions of warmth, genuineness and empathy (Rogers 1962). It is important for us all to re-establish this at times, in particular when the relationship is difficult or demanding and when rapport is hard to establish. We endeavoured to create these conditions in the group to create a climate and culture to serve as a good model for relationships.

Final reflections

Overall, the involvement in group supervision for the new supervisors was a positive experience. Although it took some time for trust to develop with the facilitators we all felt the benefits by the end of the pilot project. The facilitators have learned that there is a fine balance of support and challenge needed at the start of a group, alongside being able to keep the balance of commitment, enthusiasm and responsibility to the task. Perhaps the facilitators did not successfully juggle all the aspects together at the beginning. The facilitators have also gained a wider experience in group facilitation and felt it is successful to supervise others of a different discipline in this capacity. We are also indebted to the various group members for providing us with material and valuable learning that we can take back into our educational setting and the supervision course.

The group members report that they will take away the experience of being supervised, in that levels of self-awareness regarding the role of supervisor have increased significantly. The development of facilitation skills and the ability to view the supervisees' work in a wider perspective have also been fostered. The

supervisors reported that it was important that they were supported and nurtured through this beginning process of being a guardian to another (their supervisees). The analogy of parent and grandparent that Page and Wosket (1994) refer to is a useful one to use here. If the supervisor is acting as a 'parent-type figure' to the supervisee then the supervisor of the supervisor is similar to a 'grandparent figure'. The supervisor who is new to the role will need fostering for some time while he or she becomes more effective and competent in that role. This analogy also addresses the question of where the continuous line of supervision ceases. The supervisor of the supervisor (grandparent) can eventually withdraw as they place more trust in their supervisors. However, they can be a reassuring figure in the background for welcome support when needed or at times of emergency. Grandparents will occasionally seek out help and support from other adults or peers in a similar role; the facilitators certainly did this at times, with certain colleagues and ourselves. They would share some of our ideas or findings or check out with one another some small detail.

Through their development and learning most group members felt they had now reached a stage where they could function more autonomously as a supervisor. Some have arranged to meet in small peer groups while others can utilise their own clinical supervision at times to reflect on their supervision role. The arrangements for providing support for the supervisors will inevitably vary. This will depend on the overall amount of supervision work the nurse is undertaking, but will need to be monitored. All the supervisors will however, continue with their own clinical supervision. As the UKCC (1996) position statement proposes, this will assist lifelong learning, as indeed, some will eventually step into the role of 'grandparent' and become a supervisor of supervisors themselves.

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