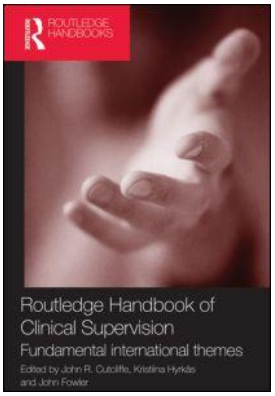

Routledge Handbook of Clinical Supervision Fundamental International Themes

John R. Cutcliffe, Kristiina Hyrkäs, John Fowler

A comparison of us and european conceptualisations of clinical supervision

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John R. Cutcliffe
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32 A comparison of US and European conceptualisations of clinical supervision

John R. Cutcliffe

This chapter compares the extent of United States and European nursing literature that focuses on substantive clinical supervision (CS) matters. Examination of this body of work indicates (at least) two principal, differing conceptualisations of the purpose and resultant practice of CS. The chapter points out how the US conceptualisation creates the need for all supervisors to be more 'expert' in the particular specialty of nursing than the supervisee; the European conceptualisation posits supervision as a forum for considering the personal, interpersonal and clinical aspects of care so as to develop and maintain nurses who are skilled and reflective practitioners. In such a conceptualisation, this creates the need for supervisors to be effective at supporting nurses in self-monitoring, identifying difficulties in practice and finding the proper place to make good the deficit, not necessarily to be more expert in the particular nursing speciality. The chapter concludes by highlighting and discussing two key issues that emerged from this comparison: does the clinical supervisor of a nurse have to share the same specialty background as the supervisee (the recipient of the CS) and, what are the advantages of cross-discipline supervision?

The editors note how this chapter draws attention to several important points/questions. Clearly, there are multiple interpretations and/or versions of CS; in different parts of the world, the same term has very different meanings. The resultant confusion and difficulty in international, translation (or exporting) of CS should not come as a surprise. The persistent confusion surrounding the term continues to bedevil our academe's research efforts; it inhibits clinicians' attempts to grapple with and subsequently embrace CS; it enables a variety of practices which bear little passing resemblance to the original conceptualisations of CS to be 'passed off' as CS. Movement towards an agreed (and, the editors would argue, international) shared conceptualisation of CS (and an associated nomenclature) can then be regarded as one of the most pressing issues facing the CS academe.

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Introduction

Anyone who is conversant with the significant developments within psychiatric/mental health (P/MH) nurse education and practice over recent decades will have a familiarity with clinical supervision (CS). The importance of P/MH nurses engaging in CS has been formalised in a number of United Kingdom (UK) policy documents. The 1994 review of P/MH nursing *Working in Partnership* (Department of

Health 1994) explicitly stated the need for all P/MH nurses to receive regular CS. The Department of Health documents, *The New NHS* (National Health Service) and *A First Class Service* (Department of Health 1997, 1998) both highlight how engaging in CS must be a career-long activity. Further, the then governing body of United Kingdom nurses, the United Kingdom Central Council (now re-formed into the Nursing Midwifery Council) issued a position statement on CS in 1996 and added their support to the principle of P/MH nurses entering into CS throughout the duration of their career. Most recently, the Chief Nursing Officer's review of P/MH nursing once more highlighted the centrality of clinical supervision to practice stating: 'Clinical supervision was seen as being essential to underpin good practice' (Department of Health: Chief Nursing Officer 2006: 2).

Indeed, it is heartening to see that within the UK, more than any other specialty of nursing, P/MH nursing has embraced CS (Bishop 1998; Bulmer 1997; Butterworth 1997). Bishop's (1998) nationwide survey determined that, of all the nursing specialties, P/MH nurses had the highest level of engagement in CS. More recent studies repeatedly verify that a very high proportion of P/MH nurses continue to view CS as important, valuable and highly beneficial, and not surprisingly they continue to engage in CS (Kelly *et al.* 2001).

Despite the well-established interest in and continuing practice of CS that P/MH nurses have shown, the conceptualisations and resultant operationalisation of CS across different groups of P/MH are far from consistent. Indeed, such is the extent of the lack of unanimity that what one group might recognise and call CS, another group might not. Pivotal differences in conceptualisation can be seen between US and European perspectives on CS. As a result, this chapter focuses on some of the key differences in conceptualisation (and resultant operationalisation) of CS between Europe and the US. In so doing, it draws attention to the particular issues that arise out of such conceptualisations and asks a number of questions (see Box 32.1).

A US conceptualisation of clinical supervision

According to Rounds (2001), in the main, the term clinical supervision is used in nursing in the United States to refer to relationships between an administrator or superior and a more junior 'other' (the supervisee). The term implies the idea of the supervisor having a 'supervisory responsibility' for the performance of the supervisee. The term is not synonymous with equity within the relationship, nor is it

Box 32.1 Key questions arising out of a comparison of European and United States conceptualisations of clinical supervision

1a Does the clinical supervisor of a nurse have to share the same specialty background as the supervisee (the recipient of the CS)?
1b Does the clinical supervisor of a nurse have to be more experienced than the supervisee (the recipient of the CS)?
1c Does the clinical supervisor of a nurse even have to be a nurse at all?
2 Are there advantages to cross-discipline clinical supervision?

necessarily indicative of a relationship between peers or colleagues. Rounds (2001) offers the example of how the nurses who care for patients in a formal care setting will report problems or concerns to 'their supervisor', seek guidance in administrative matters, and receive performance evaluations from 'their supervisor'. Interestingly, many of the dynamics and principles of 'European' conceptualisations of CS can be found in both the education and practice of nurses in the US but, most often, these exist under the banner of a different title. The procedure of assigning a preceptor to undergraduate nursing students for the clinical placements that occur during the later stages of a programme is common (Hagopian *et al.* 1992; Meng and Morris 1995). The preceptor–student relationship is a formal one, it can have a one-on-one format; it is driven by the principle that working closely with the preceptor will give the student the opportunity to function more fully in the nursing role. It should be pointed out, though, that often the relationship has an inherent power imbalance, with the preceptor being partly responsible for assigning grades to the student.

Another recent development in some parts of the US, that similarly echoes the 'European' model of CS, involves assigning preceptors and 'mentors' to new graduates, in order to help them adjust to the realities of practice. Rounds (2001) points out that this can also involve a one-on-one relationship, most often with a more experienced (and often more senior) nurse who provides guidance, support, and instruction as needed. Such developments have been expanded to advanced nursing practice programmes, most notably, nurse practitioner programmes. The above-mentioned notions of performance appraisal remain very much evident in Stuart's (2001) conceptualisation of CS; and Varcarolis tenders a conceptualisation of CS that is highly congruent with Stuart's. She states that CS involves: 'validation of performance quality through regularly scheduled supervisory sessions' (Varcarolis 2002: 231). In scenarios such as those depicted by Stuart (2001) and Varcarolis (2002) CS is conducted either by a more experienced clinician or through discussion with the nurse's peers in professionally conducted supervisory session.

Very few voices within the US nursing CS literature could be located that offer a different view to the one outlined above; a notable exception being Billings' (1998) opinion piece.[1] Billings suggests that in addition to reviewing (and appraising) the supervisee's clinical care, CS can also be used as a support system. Billings' insightful comments regarding the need for P/MH nurses to take care or look after themselves before they are capable to care for others adds an important dimension to CS, and one which is relatively absent in US conceptualisations of CS.

A European conceptualisation of clinical supervision

The European CS literature is replete with multiple definitions and conceptualisations of CS; consequently it is extremely difficult to find one definition/conceptualisation that captures all of the key elements of CS. Nevertheless, much of this literature shares commonality and congruence and there remain pivotal differences with the US conceptualisations of CS. In *Fundamental Themes in Clinical Supervision*, Cutcliffe *et al.* (2001: 3–4) produced and put forward a comprehensive list of parameters that, when considered collectively, could be seen to underpin the 'European' conceptualisation of CS. These parameters can be found in Chapter 1 of the current volume.

In the largest review of CS literature undertaken in the United Kingdom to date, Gilmore's (2001) summary of the nature (and purpose) of CS adds credibility to the parameters proffered by Cutcliffe *et al.* (2001). Gilmore found that the main purposes of CS are professional development and support for the practitioner. Some European conceptualisations of CS focus primarily on case reviews, caseload issues and treatment/care delivery (Gilmore 2001). There are some obvious similarities here with some US conceptualisations such as Stuart's (2001). More prominent within Gilmore's review is the conceptualisation of CS that focuses on supervisee-led issues. Rather than having to be case specific, the range of issues to be considered is much broader, e.g. conflict with colleagues and how this impacts on care; issues arising from interactions with clients and/or relatives; or how to deal with the 'emotional baggage' that results from engaging in demanding interpersonal work.

An important difference between European and US conceptualisations of CS goes to the issue of the supervisor occupying a position of power and authority over the supervisee. Original conceptualisations of CS for nurses in Europe highlighted that the roles of 'line manager' and 'clinical supervisor' should not be blurred. In his seminal work with Faugier, Butterworth was quick to allude to the problems that would ensue if CS were conflated with managerial supervision. Indeed, he was eager to disassociate CS with ideas of authority and power, and declared:

> People at work tend to think of their supervisor as authoritarian and that the whole concept of supervision is linked conceptually to an authority figure. This is a pity, because CS is much wider and more generous in its intention.
>
> (Butterworth 1992: 9)

He continued:

> Supervision is often negatively associated with more traditional disciplinary dealings between managers and their staff … this is a narrow definition and more generous interpretations are available.
>
> (Butterworth 1992: 9)

When CS is conflated with managerial supervision, it ceases to be an emancipatory process and becomes analogous to Bentham's 'Panopticon'; a process more concerned with surveillance (Clouder and Sellars 2004) and Foucault's (1980) notion of 'the gaze.' Given these original conceptualisations it is not entirely surprising that for some there is continued resistance to CS when it is conflated with managerial supervision (Cutcliffe and Proctor 1998; Malin 2000).

Key questions and matters for discussion 1: does the clinical supervisor of a nurse have to share the same specialty background as the supervisee (the recipient of the CS)?

Issues relating to disciplinary congruence within CS relationships are prefaced by a preliminary question, namely: is the supervisee afforded the option of choosing his/her supervisor? The consensus within the European CS literature appears to be that wherever possible, the supervisee should have the chance to choose

his/her own supervisor. Yet the limited availability of suitable, qualified and trained supervisors, logistical difficulties and to some extent, the conflation of the nature/purposes of CS with another form of management-led surveillance systems (Yegdich 1999; Kelly *et al.* 2001; Clouder and Sellars 2004), has led to the situation where many supervisees do not get the opportunity to choose their own supervisors. Dictating the identity and at the same time, the discipline (or profession) of the supervisor, sets the tone and establishes the dynamic of the supervision relationship. Such impositions reflect the power dynamic whereby the supervisee has less (or no) control of what happens in his/her own supervision. The selection of a supervisor and imposing this person on the supervisee as a fait accompli communicates a clear message that CS is something that is done unto the supervisee, whether he/she wants it or not. Impositions such as these are a direct contradiction of the emancipatory and enabling ethos that drove the introduction of CS into European nursing; after all: 'Clinical supervision is about empowerment – not control!' (Smith 1995: 1030).

The issues concerning choice/no choice of supervisor notwithstanding, the matter of disciplinary congruence between the supervisor and supervisee requires attention. An examination of the extant literature shows that, for some, the supervisor and supervisee should both belong to the same discipline. Power (1999: 36) purports that 'no nurse who has never had experience in your area of clinical practice' should supervise nurses.

Interestingly, no evidence is provided to substantiate this position. Furthermore, such a position appears not to take account of the historical inception of CS in nursing, wherein given the paucity of trained supervisors with a nursing background, the common model was cross-discipline (Gilmore 1973; Hadfield 2001; Proctor 2001). A less concrete position is asserted by Bond and Holland (1998: 18), who argue that supervisors 'should usually (although not always) be from the same clinical area or with sufficient recent experience of relevant clinical practice'. They continue: 'These clinical supervisors need to undergo further training in order to equip them for this role'.

What begins to become clear here is that is a relationship between one's particular conceptualisation of CS and supervisor/supervisee disciplinary congruence. If one holds the view that CS should focus *only or exclusively* on clinical performance evaluation, case reviews, and critique of treatment/care delivery choices (the orthodox conceptualisation within the US), then it becomes clear that one's supervisor will need to be more experienced (and knowledgeable) about the supervisee's substantive clinical area. Ergo – the supervisor needs inevitably to be from the same discipline. However, if one holds the perception that CS goes beyond such narrow, restricted views and is an opportunity to help and support nurses (practitioners) reflect on their dilemmas, difficulties and successes; a chance to explore how they reacted to, solved or achieved them; a forum for considering the personal, interpersonal and practical aspects of care so as to develop and maintain nurses who are skilled, reflective and healthy practitioners (Cutcliffe and Proctor 1998), then the choice of supervisor is predicated by wishing to work with an effective supervisor – not by supervisor/supervisee disciplinary congruence.

Accordingly, there is a need for aspirant supervisees to give some thought to their own conceptualisation of CS, as this is likely to influence their ultimate choice of supervisor. Epling and Cassedy (2001: 200) state:

> It is the authors' experience from running training courses in CS that when first embarking on the concept, the supervisee initially wants someone from the same discipline and background to supervise him or her.

Findings from Kelly *et al.*'s (2001) study lend support to these views. Up to 40 per cent of their sample strongly disagreed/disagreed with the statement 'other disciplines can give supervision'. Given the range of conceptualisations of CS that exist, and the well-documented confusion that many practitioners have concerning the nature/purpose of CS (Clouder and Sellars 2004; Gilmore 2001), it is not unforeseen or unexpected that many supervisees hold the belief that only another individual with the same disciplinary background could supervise them. There is certainly some merit in sharing disciplinary congruence with one's supervisor; the familiarity with certain scenarios and dynamics can help the supervisee feel listened to and understood (Butterworth *et al.* 1997; Cutcliffe and Burns 1998). Having a supervisor from the same discipline would give the supervisee access to valuable experiential material and sometimes supervisees gain immense support in knowing that they are experiencing common, normal processes and reactions; an awareness they can gain through appropriate self-disclosure on the part of the supervisor (Butterworth *et al.* 1997; Cutcliffe and Burns 1998). It has been shown that increased technical competence can be an outcome of supervision where there is supervisor/supervisee disciplinary congruence (Paunonen 1991; Hyrkäs 2005).

An important element of this argument, and one that is rarely examined, is that of the theoretical (and practical) orientation of the supervisor and supervisee. While the supervision dyad may have the supervisor/supervisee disciplinary congruence this in no way guarantees congruence in theoretical/practical orientation. Accordingly, the supervisory direction will undoubtedly reflect theoretical orientation of the supervisor, which begs questions about, for example, how would a P/MH nurse help/guide a supervisee who has a completely different theoretical background, personal philosophy and/or orientation? Inevitably, the supervisee would be given 'fixes' and/or advice to client-based problems that are based in the particular theoretical orientation of the supervisor not that of the supervisee. For example, what would a P/MH nurse supervisee who, for want of a simplistic comparison, holds a humanistic view of P/MH nursing do with advice given to him/her by a supervisor with a biomedical or cognitive behavioural orientation?

In addition, considerations around supervisor/supervisee disciplinary congruence would be incomplete without giving attention to the issue of experiential congruence. If one accepts the view that CS should focus on clinical performance evaluation, case reviews, and critique of treatment/care delivery choices, then it is difficult to imagine an effective CS relationship where the supervisor/supervisee have no experiential congruence. Questions need to be asked about the veracity and accuracy of any performance evaluation, case review or treatment choice undertaken by a superivisor who has no experience of the clinical scenario being considered. For example, the supervisee wishes to receive performance evaluation on how he managed a violent client. Yet, the clinical supervisor has never had the experience of having to de-escalate a potentially violent situation or restrain a violent client. Such incongruity in experiential background is likely to impede, if not thwart, the supervisory process.

Matters for discussion 2: the advantages of cross-discipline supervision

Any argument about cross-discipline approaches to CS is prefaced by the need to acknowledge that during the formative years of introducing CS into nursing in Europe, this was the norm. Drawing on her experience of providing CS to a variety of health care professionals during the 1970s and 1980s, Proctor (2001: 27) declares:

> Supervisors seldom had experience in the core work and contexts of the practitioners they were working with, only usually in the interpersonal aspects of their work.

There simply were too few nurses who had received any training in CS to meet the needs of the workforce. Accordingly, the majority of CS of nurses was carried out by people with a psychology, psychotherapy and/or counselling background (Gilmore 1973; Proctor 2001). The body of empirical evidence which illustrates a wide variety of positive outcomes arising out of high quality CS continues to grow (for recent reviews see Gilmore 2001; Hyrkäs 2005), though it should be noted that, as yet, no comparisons between cross and uni-disciplinary CS outcomes could be located in the extant literature. There are, however, findings embedded within the literature emanating from empirical studies which underscore the positive outcomes that occur from cross-discipline CS (see Hyrkäs 2005). Furthermore, there is some evidence to indicate that cross-disciplinary approaches to CS are by their inherent nature more conducive to enabling supervisee-led rather than supervisor-led CS. The tendency of some supervisors to default to offering 'expert opinion and advice'; to default to traditional teacher-student power dynamics is well documented (see Epling and Cassedy 2001; Holloway and Poulin 1995). Such relationships maintain the supervisor in the position of the 'dominant knower' and the supervisee in the subservient position. However, if a potential supervisor lacks the expert knowledge specific to the discipline of the supervisee then clearly, he/she is less (un)able to act in the role of 'disciplinary expert' or 'dominant knower':

> … it has been frequently reported by Supervisors that the tendency to act in the role of expert advisor diminishes when their own orientation and experience is different from that of the Supervisee … some of the Supervisors have reported that the role of being an expert can get in the way of supervision. The tendency to encourage a more reflective style of supervision is almost forced by the virtue of not having a similar orientation to that of the supervisee.
>
> (Epling and Cassedy 2001: 77)

A further element of this argument is situated within the educational component of CS. Examination of the CS literature emanating from both sides of the Atlantic indicates that there is widespread agreement that CS, in whatever form it is manifest, inevitably contains an educational component. The pedagogical ideologies of emancipatory learning (van Manen 1997), which are in keeping with the nature and purpose of (European) CS, are epitomised by encouraging learners to find their own solutions and thus develop in a number of ways. The learning scenario becomes one less concerned with imparting knowledge from the expert to the learner, and

more concerned with facilitating the (holistic) development of the learner. The author would argue that there is obvious and transferable utility in embracing the same (similar) emancipatory models of development in our CS, that we appear to embrace and uphold within our education/training systems. Moving from the position of expert knower to one of facilitator, in CS, requires a radical shift in philosophy and CS style. Engaging in CS in this manner (or approach) has a specific skill set, and while some interpersonal skills may well be transferable from nursing and/or psychotherapeutic education/training these would serve only as the foundation. Now while the precise nature and composition of this skill set (or more likely sets) remains a matter of debate (see Kilminster and Jolly 2000), the accepted wisdom is that some additional training/education is needed; particularly if one wishes to engage to move from the conceptualisations and practices of US CS to a more 'European' approach.

Conclusion

Examination of the extant substantive CS literature highlights the existence (broadly speaking) of two separate perspectives on the purpose of CS. One view, perhaps more commonly associated with US CS literature, appears to conceptualise CS as an opportunity for a more experienced nurse to monitor, educate and support a less experienced nurse in how they do clinical skills. Such a conceptualisation clearly creates the need for all supervisors to be more 'expert' in the particular specialty of nursing than the supervisee. Further, it requires a significant degree of experiential and theoretical supervisor/supervisee congruence. Alternatively, there is another view, perhaps more commonly associated with European CS literature, that appears to conceptualise CS as an opportunity to help and support nurses reflect on their dilemmas, difficulties and successes, and to explore how they reacted to, solved or achieved them. This view posits supervision as a forum for considering the personal, interpersonal and practical aspects of care so as to develop and maintain nurses who are skilled and reflective practitioners (Cutcliffe and Proctor 1998). This situation creates the need for supervisors to be effective at supporting nurses in self-monitoring, identifying difficulties in practice and finding the proper place to make good the deficit, not necessarily to be more expert in the particular nursing specialty.

Note

1 It is also worthy of note that outside of the nursing literature, in related disciplines, alternative views can quite easily be located, see for example the journal *The Clinical Supervisor: A Journal of Interdisciplinary Research, Theory, and Practice.*

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