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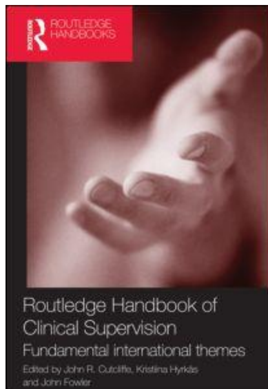

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John R. Cutcliffe, Kristiina Hyrkäs, John Fowler

Postmodernising clinical supervision in nursing

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8 Postmodernising clinical supervision in nursing

Chris Stevenson

This chapter adopts an approach that has infrequently been used to frame the discourse around clinical supervision; it attempts to reconstruct clinical supervision from a postmodern perspective. After providing a useful and succinct overview of (one view of) postmodernism in nursing, Chris then used a postmodern critique to enable a re-visioning of clinical supervision using some of her earlier published work (Stevenson and Jackson 2000) in which clinical supervision is reconstructed as 'egalitarian consultation meetings'. Case study extracts of group clinical supervision with 'G' grade community psychiatric nurses are then used to illustrate how the supervisors divested themselves of the role of 'expert' by inducting the attendees into the postmodern approach.

The chapter draws the editors' attention to an important issue: should we as an academe (and/or collection of health-focused clinicians, educators, researchers and managers) strive for one best approach to operationalising clinical supervision, or should we embrace multiple approaches? Clearly this issue is inextricably tied to that of common or core competencies for clinical supervision and perhaps as a result of such an association, parallels might be drawn. Drawing on Barney Glaser's (2001) work, it seems to the editors that 'shared' psychosocial processes exist within the (social) world of clinical supervision and that these transcend individual substantive areas. Notwithstanding the possible existence of a formal level theory of an approach to clinical supervision, this would still clearly allow room for substantive level particularised approaches (and interventions) that are idiosyncratic to various substantive areas of psychiatric and mental health nursing care.

Introduction

High profile individuals/organisations have identified that clinical supervision (CS) is not a homogeneous practice (Cutcliffe *et al.* 2001; Department of Health 1994; Fowler 1996; Paunonen 1991) or located in a single 'correct' model. Indeed, there has been a proliferation of models that claim to be tailored to the needs of specific nursing groups (for example Hawkins and Shohet 1989; Johns 1998; Page and Wosket 1994; Proctor 1986). Despite this, much CS has been organised around five core principles, implying that there is a reality of what constitutes good clinical supervision practice. These principles are themselves grounded in modernist assumptions, such as:

- there are real mental health problems (otherwise described as diagnoses, signs, imbalances, illnesses, etc.) that are lodged within people and/or their social networks;

- the problems can be treated (by bio/psycho/social approaches) by professionals;
- it is possible for an external, expert supervisor to spot the problem, even if it has been missed by the involved practitioner, and identify treatment solutions when the practitioner cannot;
- that the ability to practice and supervise grows with grade, so that it is only appropriate to have a hierarchy of supervision, where senior nurses (referred to as 'I' grades in the United Kingdom) accordingly supervise less senior nurses (referred to 'H' grades in the United Kingdom) and so on down the 'command chain', implicitly (if not explicitly) a management function. This applies across different supervision structures, for example individual, triadic or group; and
- that there is a 'form' of supervision based on Proctor's triad of functions – normative, formative and restorative (see Butterworth 1994, 1996; Kipping 1998; Sloan and Watson 2002) – that shapes the supervisee through promoting self-awareness (Cutcliffe and Epling 1997) or reflection, but without being psychotherapeutic (Faugier 1998; Severinsson 1995). This implies that there is linear progress towards the practically perfect practitioner.

There is an abundance of existing literature that supports, picks over, or is based in the principles, and some references is made to it below. However, this chapter does not seek to review comprehensively but to reconstruct CS from a postmodern perspective.

Postmodernism in nursing

Stevenson and Beech (2001), drawing on Lyotard (1984), take postmodernism as a rejection of 'grand' theories in relation to how we make sense of our worlds. Rather, we tend to know from 'being in' situations. Knowledge is inseparable from the context in which it comes into existence. Taking a social constructionist stance within postmodernism, language is the means by which we construct our world. We create 'stories' together, which we treat as realities and which we base our practices on. Of course, this means that there are multiple realities rather than a single truth.

Turning to CS, we can re-evaluate the principles outlined above. Firstly, we have to question the idea that there are real mental health problems that are anchored in some kind of biological or psychological or social pathology that can be remedied by clever professionals. While we are, undoubtedly, biologically based beings, how we talk about our bio-psycho-social functioning seems to be critical in getting on, or not getting on, with our lives. For example, in working with families, I have been struck by how often there is a family story about what is wrong with a member. The story serves to organise the family in relation to every aspect of their lives – who has to be at home, what level of achievement is possible at work, and so on. By using a process that invites dialogue (Seikkula *et al.* 1995) or trialogue (Amerling *et al.* 2002) it is possible to loosen the dominant family story and open up possibilities to construct other stories and allow the family members more scope to function. Seikkula *et al.* (1995) present convincing case summaries that describe less reliance on medication, less hospitalisation, and less re-presentation of psychotic symptoms when a different, shared vision is available.

Once we surrender the idea of broken machines that need fixing, the function of the expert clinical supervisor, reaching conclusions that other professionals cannot

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reach, becomes extinct. If knowledge is joined into the situation, then the person who is expert is the person most closely connected to that situation. In relation to CS, the practitioner who is working with the person in distress must be more knowledgeable than the detached supervisor. The practitioner and person in mental health difficulties co-create a narrative about the problem situation. Thus, by definition, it will be the practitioner most intimately involved with the person-in-context who will be the co-constructor and relayer of stories. Any 'stuckness' may be attributed to the practitioner (and person) becoming organised by their dominant story rather than that the practitioner has failed to detect the real problem. The new description of stuckness as an unhelpful story means that the supervisor only needs to help create different stories, a point I return to below. Finally, the whole hierarchy of supervision, and its assumed form, comes tumbling down when we admit that we are all creators and tellers of stories; that each of us is steeped in the expertise of living and can contribute to an ecology of stories or narratives in a clinical setting.

The above critique may be a welcome alternative to some authors who have begun to challenge the processes of CS from *without* the postmodern turn. For example Van Ooijen (1994) sees CS as punitive for some nurses and Jones (1995) notes that it can involve criticism and discipline. Yegdich (1998) suggests that the supervisor can cruelly exploit a supervisee's 'blind spots' towards supposedly increasing self-awareness. Clouder and Sellars (2004) question whether the reflection-on-action, often explicit within CS, actually improves learning and practice. Bulmer (1997) in a study of 136 'F' grade nurses (junior charge nurses/ward sisters) who were receiving regular supervision found that the supervisees did not think that their supervisors necessarily needed more knowledge or higher clinical grade. In the same vein, Chambers (1995) and Bowles and Young (1998) want to dismantle hierarchical CS, although they continue to make a distinction between the educated and practiced supervisor and the supervisee who is seen as gaining insight through the CS process away from her/his novice state. Thus, there is a critique without the postmodern turn, but it lacks the radical edge that this chapter provides.

So what does the new clinical supervision look like?

Drawing on the postmodern critique outlined above, I offer a re-visioning of CS using and developing earlier work (Stevenson and Jackson 2000: 493) which re-constructed CS as 'egalitarian consultation meetings'.

Egalitarian consultation meetings (ECMs)

ECMs were an approach to CS that grew out of the desire of Stevenson and Jackson (2000) to take the 'super' out of supervision. As researchers and practitioners, they favoured a postmodern stance that provided the underpinning philosophy for the ECMs (adapted from Stevenson and Jackson 2000):

- Imposed structure/content is problematic. It creates an illusion of CS as a homogeneous process and practice, with right and wrong approaches to care (the 'reality' of diagnosis and treatment). For example, much CS begins with a description of 'the case', structured around categorical information – gender, age, class,

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occupation, diagnosis, number of treatment sessions and kinds of interventions. The personal narrative, the person's story, is less prominent. The task is to dig into the information in order that the CS can discover a) the real problem; b) the weaknesses in the supervisee's approach to date; and c) the correct intervention. This may limit the creativity needed to promote excellent care and, instead, be a conservatising force. For example, the quality of CS may be dependent on the degree to which the individual supervisor can step outside existing understandings rather than recycling them to fit the new case (Ekstein and Wallerstein 1972).

- Clinical supervision should be separate from line management. When there is a hierarchical structure, innocent questions asked by the supervisor, e.g., 'How is the case going?' can be interpreted as surveillance and imbued with coercive connotations to induce a 'confession' (Clouder and Sellars 2004). This leads to a cycle of power and resistance in which supervisees moderate what they take to supervision (op. cit.) in order to avoid close scrutiny, but supervisors only become more intrusive wondering whether they are being consulted only on cases that are not particularly stuck. Alternatively, the expert supervisor/manager creates dependency in supervisees.
- CS should be democratic. The all-seeing, all knowing, all-powerful, ever-present clinical supervisor is mythical (Farrington 1995). Indeed, Bobele *et al.* (1997) note that practiced expertise can close down the possibility for new meanings to arise in CS. One implication might be convergence on a limited number of interventions, or even on the best evidence-based treatment. Yet, evidence-based practice is notoriously difficult to enact (McSherry *et al.* 2002). It frequently does not take account of the specific context – the person, her/his existing illness narratives. For those who embrace postmodernism, the construction of an intervention is a conjoint dialogical process. Without a shared narrative, it is likely that the evidence-based approach will not be a difference that makes a difference. In a democratic system, there are multiple knowledges (plural rather than singular), as there are multiple sources of expertise. Such ecology can help both the supervisor and supervisee to 'move beyond their present knowledge states' (Hawes 1993: 4). More importantly, the multiple versions can be processed by the expert practitioner in relation to what s/he understands might be a story of interest for the person experiencing mental health difficulties.

Participants' constructs of 'real' group supervision based in the ECM approach

Chris Stevenson and Barry Jackson (BJ) (2000) were also interested in how 'real' group supervision based in the above philosophy might be constructed by participants. Accordingly, they engaged a group of 'G' grade community psychiatric nurses (CPNs) for a series of six ECMs within which they divested themselves of the role of 'expert'[1] by inducting the attendees into the postmodern approach. So that, in Session 1, Lesley[2] stated:

> I came in here this morning with the old view, and I've had a realisation since I came in about supervision, and I've done all these classic things where I think BJ's the expert. If I have a problem I will take it to BJ to help sort it out.
>
> (Stevenson and Jackson 2000: 495)

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The group constructed a meaning of egalitarian consultation as liberating. They found benefit in having a space created by the reworking of the 'rules' of supervision (which they could further recreate at will). Losing the omnipotent supervisor appealed to Claire:

> I don't mind taking away people's ideas, but I don't like people saying you must do this when you're your own person ... That whole feeling of being an expert is taken away from us because everybody has their own little idea of what we should be working from. What they think you should do with that person.
>
> (Stevenson and Jackson 2000: 497)

While Jean was aware that being seen as an expert was validating in relation to putting ideas into practice:

> I think that some of the paranoia (amongst staff) comes from the word supervision. I have certainly found in my previous job that supervision has a punitive feel to it. We're all individuals and we all work as different personalities, and we interpret whatever we learn in different ways and use it differently with each client. I think it's just validations and accepting that.
>
> (Stevenson and Jackson 2000: 497)

The group members were pleased to move away from existing patterns of case presentation in favour of relaying people's narratives, elaborating cases rather than reducing them. As Lesley described it:

> I can't remember information from the top of my head like dates of birth, etc. I can remember the things to his life story, and that's the things that interest me.
>
> (Stevenson and Jackson 2000: 497)

When a multiplicity of truths about the world is allowed, stories breed stories. Storytelling often concerned the interpersonal relationship between the person defined as in psychiatric distress and the professional. The stories rarely concerned personal characteristics of the CPN and how s/he needed to use self-awareness to adapt her/himself to be a better practitioner. Deborah's version stated:

> I think there was an incredible benefit in bringing it [a case] here. I took a lot of the things I discussed here back to M when I was talking to her. I was doing a lot of thinking about what we'd been talking about here when I was talking to her...
>
> (Stevenson and Jackson 2000: 497)

The group had a sense of cohesion that does not necessarily occur in more hierarchical arrangements for the reasons outlined above. As Tom described it:

> If there's some cohesion and some value amongst us ... and we're actually talking openly about the professional roles we have, then maybe ... we're almost in a separate world to our colleagues...
>
> (Stevenson and Jackson 2000: 498)

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This led to more radical thought that questioned practice of colleagues. For example, Keith responded to the idea of blacklisting a General Practitioner (GP, physician) who had put a CPN at risk:

> I would find that quite a difficult thing if I'd gone through doing that myself ... I would rather appreciate that would come as a collective thing because that could be more powerful.
>
> (Stevenson and Jackson 2000: 499)

However, the group members were still cautious in relation to the potential for surveillance from without the group, or from self-surveillance. Talking about a group that was organised in a way similar to the ECMs, Lesley said:

> We have these very formal staff meetings once a fortnight and the alternating weeks we have seminars. We invite speakers down. It's all very formal. Everybody has their supervision through the hierarchical structure. So, what we [Community Psychiatric Nursing Group] thought that we would have a group meeting once a month where nobody took minutes. There was no agenda written down anywhere and that we would literally just meet. If people just sit and they don't say anything that's fair enough. We've had one of these meetings so far and everybody talked non-stop. There were no awkward silences or anything and we are more relaxed. I suppose it's similar to this ... but we all felt really, really guilty as if we were skiving doing this. After the first one everyone went away feeling positive ... it was really good ... but the interesting thing is that we felt that we couldn't broadcast it to the outside world, because there was no agenda there, there was no name for it.
>
> (Stevenson and Jackson 2000: 500)

Whilst Tom and Jean were aware of how they retreated from a political agenda:

> Tom: We always feel safer talking about patients.
>
> Jean: ... by saying that [we] talk about patients we're getting paid for that, you know dealing with patients and making yourself feel a bit more comfortable if you discuss cases.
>
> (Stevenson and Jackson 2000: 500)

Discussion

Modernist, hierarchical supervision has a stranglehold on CS practice, yet, it can hardly be said to be unproblematic; it is heavily critiqued from both outside and within the post-modern turn. Although CS is apparently sustaining for practitioners (Butterworth *et al.* 1997), it is well known that CS is often a casualty in busy clinical environments. Given the experience of some in relation to the critical, punitive and deskilling aspects of CS, it is unsurprising that it is shunted to the bottom of the clinical agenda. Reconstructing CS from a postmodern position might well address some of the existing problems. ECMs are one example. In the case of ECMs, when the assumptions of traditional supervisory practice are set aside, practitioners have

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the opportunity to construct their own meanings in relation to CS. Having a negotiated meaning is experienced as liberation, as hoped for by Chambers (1995).

The supervision group members preferred thinking of themselves as experts by experience in relation to the people they were working with. From a postmodern stance, the actions that a practitioner reports cannot be judged out of context. The alternative of being scrutinised, criticised and corrected is, understandably, unattractive. In a situation where the supervisee feels the need to be defensive, it is unlikely that supervision will be a site where complex challenging practice issues are viewed as opportunities as Cutcliffe and Proctor (1998) propose.

The postmodern ambience facilitated the production of an ecology of stories. These stories were a response to the story relayed by the practitioner as the expert on the person in context. Stories were offered spontaneously. This contradicts work that suggests that CS proceeds best when there is a clear contract in respect of content and process (Oxley 1995; Porter 1997). In traditional dyadic supervision there is the potential for non-connecting monologues. The supervisee tells the case history, following an accepted format. S/he may have the information elicited by a challenging or confronting interventions model like Heron's (1990) approach. The supervisor responds by offering an expert monologue consisting in a formulation of the person's diagnosis or illness or problem and the preferred intervention. Conversely, in ECMs, stories were rich, personal and meaningful. They were presented as tentative suggestions, rather than exemplars. They invited dialogue, which, in turn, aided new narratives to emerge. The external dialogue created the opportunity for internal dialogue as the supervisee explored the relevance of the supervision stories for the person 'in view'.

Hawes (1993: 4) has provided an excellent summary of the above points:

> Collaboration in the supervisory process can be understood to include at least three defining characteristics: bidirectionality, non centrality of expertise, and circularity in modelling practices. These characteristics speak to the reciprocity of interpersonal obligations, the absences of rigidly enacted hierarchy in a working relationship, and an outcome or object that is a shared construction of every participant.

ECMs were a place where radical talk could occur in relation to how practice might be better organised. The group members drew strength from being together physically and emotionally in relation to the macho practice environment. As Cutcliffe and Proctor (1998) note, comradeship and cohesion between peers can protect against a culture of divide and rule. However, the participants were nervous about the extent to which they could share and create stories about the organisation which paid them, and which promoted hierarchical supervision. Narrow definitions of what constitutes work weighed heavily on the group members.

Conclusion

The chapter has sought to challenge existing ideas about CS and to construct an alternative approach. In the postmodern spirit, there is no 'truth claim' about the effectiveness of ECMs. Rather, practitioner narratives have been presented as descriptors and testimonials to the experience of ECMs. However, one reading is

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that ECMs were a site where practitioners began to feel 'powered up' in relation to casework and the system. Being part of a polyvocal community, that is a group where different narratives were valued and people are valued beyond a diagnostic label, appeared to be important. However, no approach is without a political dimension and the group was not immune to the broader, modernist culture. Thus, change in CS practices needs to be at multiple levels of the system.

Notes

1 As far as it is ever possible to do so.
2 Pseudonyms are used to protect confidentiality.

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