

Recognising Supervision

Introduction

Sitting squarely at the crossroads between professional development and professional practice, clinical supervision cries out for study and enhancement. It ensures safe and effective practice (Falender & Shafranske, 2004), maximises the outcomes for clients (Krasner *et al.*, 1998; Holloway & Neufeldt, 1995), offers support for supervisees (Russell & Petrie, 1994) and represents the foremost method (Holloway & Poulin, 1995) and most critical part (Watkins, 1997) of teaching clinical skills to mental health practitioners. Duly perceived as the main influence on clinical practice amongst qualified staff and their trainees (Lucock *et al.*, 2006), it also helps to address the growing emphasis on clinical accountability (Wampold & Holloway, 1997), is required for the accreditation of initial professional training (e.g. British Psychological Society (BPS), 2002), is necessary for continuing professional development and regulation (e.g. British Association of Behavioural and Cognitive Psychotherapists (BABCP), see Latham, 2006), and is an accepted defence against litigation (Knapp & Vandecreek, 1997). Not surprising, then, that the Department of Health (1998) should regard effective staff training that subsumes supervision as one of the 'ten essential shared capabilities' of mental health practitioners (Department of Health, 2004). Although a welcome acknowledgement, this important role has actually been long recognised, as indicated in the Hippocratic oath ('... I will keep this oath and ... him who taught me this art equally dear to me as my parents ...').

Yet, in spite of its critical and highly valued role, the development of supervisors has long been a neglected research area, one that has 'generated only a modicum of research' (Holloway & Poulin, 1995, p.245), research

that has been judged inadequate scientifically (Ellis *et al.*, 1996). Russell and Petrie (1994, p.27) find this neglect 'alarming', and Watkins (1997) noted how this neglect simply 'does not compute' (p.604) with the important role supervision plays in professional life.

It should not be surprising, then, to learn that supervision models do not correspond to the complexities of professional practice (Cleary & Freeman, 2006), and that the adequacy of supervision has been rated as 'very poor' in 20–30 per cent of cases, according to a national enquiry concerning junior doctors in the UK (see Olsen & Neale, 2005). In the presence of such damning views, and in the absence of a well-developed toolkit of psychometrically sound instruments, concerns that the practice of clinical supervision may generally be poor are difficult to dispel (Binder, 1993; Worthington, 1987). To illustrate the validity of such concerns, a rigorous $N=1$ observational analysis of an experienced cognitive-behaviour therapy (CBT) supervisor raised questions about his competence, despite being accredited by at least two organisations (Milne & James, 2002).

The Evidence-based Approach to Supervision

In order to address some of these concerns, and to provide a fresh, systematic and topical approach, the present book describes an evidence-based approach to supervision (EBCS). EBCS is similar to 'Best Evidence Medical Education' (Harden *et al.*, 1999), as both treat professional development in a systematic way, based on the highest-quality, most relevant research. It differs most markedly from intensively personal (humanistic) approaches, which assert, for instance, that 'good supervision, like love ... cannot be taught' (Hawkins & Shohet, 1989, p.157).

The theoretical foundation of EBCS is 'experiential learning', as summarised by Kolb many years ago (1984), but still endorsed within the mental health professions currently (e.g. the BABCP, see Lewis, 2005; British Psychological Society, 2003). This is appropriate as clinical supervision is primarily a form of experiential learning (Carroll, 2007). According to this experiential learning model, supervisees acquire competence by learning from experience, through a necessary combination of four learning modes: reflection; conceptualisation (thinking); planning; and concrete experience (feeling and doing). According to this view, professional competence is achieved most efficiently when the supervisee is given regular opportunities

to use all four modes. Drawing on this theory and on the research literature, it appears that the supervisor needs to use a range of mainly CBT methods to succeed in enabling the learner to utilise these different modes (Milne & James, 2000). To restate this in traditional behavioural terms, supervisors are initially judged competent and effective when their supervision draws on such methods, and when this successively serves the function of facilitating this kind of experiential learning in their supervisees (i.e. a functional definition of competence). Additionally, supervision should also be judged in terms of its influence on the work of the supervisees, characteristically the development of their therapy and its clinical effectiveness. Chapter 8 elaborates this argument. Two studies have indicated the value of this model for the development of supervision, utilising an observational tool called Teachers' PETS (Process Evaluation of Training and Supervision: Milne *et al.*, 2000; Milne & James, 2002). In summary, according to this EBCS model, effective and competent supervision will be characterised by the use of a range of supervision methods (e.g. collaborative goal-setting), ones which increase the supervisees' use of the four learning modes (i.e. a structural and a functional definition of effective supervision, respectively), and consequently their capacity to work competently, safely and effectively.

EBCS is therefore a specialised aspect of evidence-based practice (EBP, see Roth & Fonagy, 1996), now a hot issue in health services, and part of an international effort to ensure that patients have access to the best-available care. For example, in the USA the American Psychological Association has developed a policy for EBP, and international scientific journals that are published there have carried special issues to foster understanding and to promote EBP (e.g. see Thorn, 2007). Figure 3.1 (Chapter 3) sets out the EBP framework, adapted only slightly by replacing 'therapy' with 'supervision'. This framework helps to clarify how the different factors that we should consider in relation to supervision can be brought together successfully (e.g. the relationship between research findings and professional consensus on what represents best practice). The EBS framework underpins this book, as summarised shortly under the 'Aims' section below, and is detailed in Chapter 3.

The Significance of Supervision

The regular media attention to examples of professional misconduct provides a powerful reminder of the importance of supervision within EBP.

The 'Bristol case' is an illustration, a case in which unusually high death rates amongst infants following two types of heart surgery led to doctors being struck off the medical register. The enquiry dramatically highlighted how the traditional trust placed in doctors needs to be replaced by systems for monitoring competence and for providing relevant training, amongst other things (such as effective quality-control procedures within professionals' organisations, Smith, 1998). Supervision would logically form a central part of that training, and should draw on any monitoring data.

Unfortunately for the public's protection, supervision is a neglected research topic, despite considerable investment. In the UK alone, the Department of Health spent about £2 billion per year on the training of clinical staff (Department of Health, 2000). In 2007 the investment was described as 'huge' (Department of Health, 2007, p.3). Although only a small part of this is likely to relate to the training of supervisors, supervision is surely the major form of continuing professional development (CPD) for clinical staff and therefore the greatest investment that health-care providers like the National Health Service (NHS) make in staff support and development. This investment was justified within a modernisation agenda in which the development of the workforce was emphasised (e.g. see *A First Class Service*, Department of Health, 1998). Over time, the UK government's interest in CPD has become increasingly specific, detailing its nature, content and process (see Gray, 2006, for a thorough review of these policy refinements). A case in point is supervision, which needs to be regular and to be available to all staff as it can 'ensure a high quality of practice' and 'will encourage reflective practice', at least in relation to the psychological therapies (Department of Health, 2004, p.35). More generally, 'recognising the importance of supervision and reflective practice' (p.18) became one of 'the ten essential capabilities' (Department of Health, 2004a), and a core national standard was that 'clinical care and treatment are carried out under supervision' (Department of Health, 2004b, p.29). Latterly, the contract specification for training clinical psychologists in the UK (which presumably applies equally to all staff groups) added that this should be 'effective' supervision, developed through CPD (Section 2.1). This is consistent with recent policy guidance on initial training and CPD, which indicates a major shift in contracting and monitoring by stressing, for instance, the need for all training to be 'of high quality' (p.26), within a system that raises the importance of training to be 'core business' (Department of Health, 2007, p.27). As a result of investing heavily, the NHS expects staff to be motivated, confident and skilled, so that they can

provide appropriate care, treatment and support to patients throughout their careers (Department of Health, 2007).

Apart from the explicit functions it serves, such as ensuring safe and effective clinical practice (see the next chapter for a full breakdown of these functions), supervision is also significant in terms of attracting new recruits (Lavender & Thompson, 2000), affording job satisfaction (Milne, 1991), providing status and enhanced pay, helping therapists in managing their caseloads, and as part of the natural career development of professionals (e.g. when the passing on of skills to develop junior colleagues becomes particularly satisfying – the business of generativity). Therefore, although there are concerns about the generally poor quality of research on supervision, there is a markedly greater emphasis on the importance of supervision both in developing initial competence (so that trainees become qualified as independent practitioners), and as a major way to ensure CPD. This book attempts to redress this striking imbalance by highlighting a seam of better research, which, linked to resources such as professional consensus and transferable knowledge (see Chapter 3 for a full rationale), can provide a satisfactory knowledge-base for the current implementation of policy directives. But next I want to try to understand how we got to the present situation: how did supervision become so valued, despite being so poorly understood? How can we make sense of the present significance of supervision, in terms of the past? The next section takes a brief look at the early forms of supervision, based on some literature relating to the mental health field.

The History of Supervision

Given the widespread use of the apprenticeship approach in society, exemplified by the learning of a trade or profession from a more skilled practitioner or employer, it seems likely that supervision has been practised since ancient times. How else would those with the necessary skills and the responsibility for providing specialist services ensure that they had a skilled workforce, one that was doing their work to the required standard? I suspect that certain aspects of this apprenticeship relationship persist to this day. Even such seemingly extreme examples as the training of a monk suggest some continuity across the social spectrum. Consider a historical account of the Zen Buddhist approach to training (Suzuki, 1934). Just like modern trainees, apprentices routinely experienced rejection on first

attempting to gain access to training. Those who persisted were subjected to initial episodes of humiliation and then hard labour, before gaining the requisite experience to graduate. This is eerily like the modern student's experience, with (for example) hundreds of rejected applicants for clinical psychology training (humiliation), then three years of training (labour), not to mention the hard labour entailed in accruing the necessary voluntary work experience, Assistantships, and other arduous aspects of the journey to even stand a chance of commencing the journey to professional 'enlightenment'.

This mystical illustration is perhaps not as perverse as you might imagine, since psychotherapy was traditionally regarded as mystical and therefore not amenable to such practical methods as observation (Baker *et al.*, 1990). It was only in 1957 that Carl Rogers moved training 'out of the realm of the mysterious to the realm of the observable and trainable, by making audio-tape recordings of sessions' (Baker *et al.*, 1990, p.357). This evolved into the systematic approach known as micro-counselling (see Baker *et al.*, 1990, for a summary). Psychoanalytic supervision relied heavily on the apprenticeship system 'from the very beginning' (DeBell, 1963, p.546), and the use of training clinics in psychology in general goes back at least to the late 19th century, when Witmer (1907) utilised case-based instruction. Shakow (2007) dates the emergence of proper psychological clinics from Witmer's time, noting that 'with respect to training, there was a consistent recognition of the importance of providing systematic education in applied psychology and supplying facilities to psychologists, educators, and other students for study in the practical setting. Courses, demonstrations, and practicum facilities in the clinical field for the study of exceptional children were a regular part of the programme' (p.2). Shakow believed that Witmer's early emphasis on training led universities to establish clinics and formal training courses. He noted that, by the time of a survey reported in 1914 (but referring to practices some time prior), there were 26 university clinics, and many related courses, in the USA. However, according to Shakow (2007), training remained generally unsystematic, relying on individual trainees to organise their own programme of professional development. In America, it was not until 1945 that training in clinical psychology was formalised into university-based, four-year PhD programmes. Seemingly for the first time, clinical supervision was a clearly specified requirement within this training programme: students were first to receive teaching, then to acquire clinical skills in diagnosis and therapy under 'close individual supervision' (Shakow, 2007, p.7).

It is not clear from this account whether or not anything like our current conception of supervision was implemented. Therefore, it is often recounted that the first recorded example of supervision in the mental health field occurred with Freud's treatment of Little Hans (Freud, 1909). Hans had developed a fear that one of the large horses he saw pulling coaches past his home might bite him. Freud began to work on Little Hans's phobia through the boy's father, Max Graf. Freud utilised suggestion and didactic instruction in supervising Max Graf, who actually delivered the treatment to Hans (Jacobs *et al.*, 1995). This account is cited by Bernard and Goodyear (2004), who go on to quote Frawley-O'Dea and Sarnat (2001) who noted that 'Freud was the first supervisor and thus represents the archetypal supervisor ... in his model of supervision he combined a positivistic stance ... with a personal insistence on maintaining a position as the ultimate arbiter of truth, knowledge, and power' (p.17). However, this example is problematic, as working clinically through a non-professional like a parent represents consultancy or indirect therapy, rather than supervision (see the Definition section below), so I suggest that we need to look elsewhere for the first recorded example of supervision.

Freud's dogmatism in supervision is reminiscent of primitive psychotherapy and quackery (Lawrence, 1910), to which we now turn for an insight into the true origins of supervision. According to Lawrence's many accounts of quackery, instilling confidence in the healer is an essential first step. Drawing on Lawrence's review of ancient mental health practice, I wish to suggest that Freud was far from being the first mental health supervisor. In ancient Greece, temples were the first hospitals, and priests were the first physicians. Just as Freud used his authority to create the conditions for change, so in ancient Greece various mystic rites took place in order to influence a patient's imagination. With a resemblance to the modern health hydro, ancient Greek temples had a regime of practical therapies (though the details differed, including such things as baths, friction of the skin and a strict diet). This treatment occurred in places carefully chosen for their 'healthful environment' (p.79), just like the ensuing Victorian psychiatric hospital in the UK. The mythological god of healing, Asclepius, like Freud after him, interpreted the dreams of the Grecian pilgrims in search of health, as, at that time, it was believed this afforded the proper cure for an ailment. In turn, 'the interpretation of these dreams and the revelation to the patient of their alleged meaning was entrusted to a priest, who served as an intermediary between Asclepius and the patient' (Lawrence, 1910, p.98). Adding to my supposition that these priests were the first known therapists

and that Asclepius was therefore the first recorded supervisor, Lawrence (1910) records that Asclepius, far from being a god, was in fact an historic personage. He transmitted his professional knowledge to the priests, who were versed in medical understanding. Lawrence records that for centuries the most famous Grecian physicians were members of this order, and that Hippocrates (often considered to be the father of modern medicine) is said to be 17th in direct descent from Asclepius. Other parallels with modern mental healthcare are cited, including how the records of cures were inscribed upon the walls of the temple, perhaps representing the first written case studies? However, my assumption that Asclepius was the first clinical supervisor is challenged by studying Wikipedia (visited on 8 October 2007). According to the information on Greek mythology there, Asclepius in turn apparently acquired the art of healing from Chiron, a kind and great healer who was highly regarded as a tutor. Asclepius was therefore a disciple of Chiron's, and so I now propose that Chiron was the first-ever clinical supervisor.

The significance of a supervisor's personality and general self-presentation is echoed within Jackson's (1999) history of psychological healing. He notes, in a far more favourable vein, how Hippocrates recorded that physicians might use various measures to gain the patient's confidence: 'these included appearance and dress, manner (serious and humane), way of life (regular and reliable), just conduct, control of himself, and social adeptness' (p.40).

To my knowledge, the first clear-cut example of clinical supervision in recent times dates from the 19th century, when social workers guided the work of volunteers within charity organisation societies, where moral treatments were provided to the poor (Harkness & Poertner, 1989). Many decades on, it appears that Freud's formal involvement in supervision began in his Zurich clinic in 1902, when a group of physicians studied analysis with him at regular meetings (Kovacs, 1936). Indeed, it appears that the need for a personal analysis of the therapist began to appear within these study circles. According to Kovacs, Freud 'noted certain disturbing factors, which proved a great hindrance to harmonious co-operation, and he began to surmise that this disharmony was mainly due to the unresolved psychic conflicts of his fellow workers' (p.347). The first international conference took place in 1908, including a report on this Zurich clinic. This had been founded by Bleuler, and was the first place where psychoanalysis was officially taught and practised (Kovacs, 1936). The main methods of supervision at the time were guided reading of the current psychoanalytical literature, plus word association tests, designed to give the trainee analyst a

first-hand experience of the unconscious. It soon became established that, for psychoanalysis to be successful, the therapist first needs to undergo psychoanalysis. By 1922, it was further established that 'only those persons should be authorised to practise psychoanalysis who, as well as taking a theoretical course of training, had submitted to a training analysis conducted by an analyst approved by the Society at the time. A training committee was set up within each Society for the purpose of organising a system of training' (Kovacs, 1936, p.25). The training analysis was based on the supervisee analysing one or two patients, under the supervision of an experienced colleague. This was believed to develop the 'right attitude' towards patients, and to help in the acquisition of techniques.

Therefore, it does appear that the apprentice system has been relied on heavily since the ancient Greek approach. In summary, 'almost from the beginning of organised teaching, supervision has been accorded an important place in the training programme' (DeBell, 1963, p.546). According to DeBell, the essential method of apprenticeship amongst healthcare professionals was to use case material to draw out relationships between theoretical concepts and the specific practicalities of a case. Supervisors reportedly used the methods of feedback, self-disclosure, didactic teaching, encouragement, reflection on material, and the translation of the case into relevant theory. Other methods included confrontation and clarification, in order to formulate the case from the supervisee's written notes of therapy (process notes), and work on the supervisee's account of therapy within the subsequent supervisory hour (especially the use of interpretations, Bibring, 1937). At that time, a total of 150 hours was regarded as the minimum for effective supervision. The goal was to enable a less experienced therapist to become effective in the task of benefiting patients (DeBell, 1963).

To place this in context, research on therapy is dated from the end of the Second World War, with research on supervision appearing in the 1950s (Bernard & Goodyear, 2004). I next bring this review up to date, drawing carefully on the research available at the start of the 21st century to address another important building-block for supervision, its current definition.

The Definition of Clinical Supervision

As a complex intervention, it is not surprising that supervision is defined in a variety of ways. For instance, in the UK it has been defined within the

NHS as: 'A formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex situations' (Department of Health, 1993, p.1). The most widely cited definition of clinical supervision, popular in the USA, is the one provided by Bernard and Goodyear (2004). According to them, supervision is: '... an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional function of the more junior person(s), monitoring the quality of professional services offered to the clients, she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession' (p.8). The evidence that this definition is widely embraced in the USA at least is indicated by its unchallenged use within a consensus statement (Falender *et al.*, 2004) and in the *Handbook of Psychotherapy Supervision* (Watkins, 1997).

However, numerous prior reviews have noted that these definitions of supervision are problematic (e.g. Lyth, 2000; Hansebo & Kihlgren, 2004). Additionally, surveys of practitioners indicate that they are unclear over the nature and purposes of supervision (e.g. Lister & Crisp, 2005). The popular Bernard and Goodyear (2004) definition appears problematic on several counts. In terms of specificity, it is unclear quite what constitutes the 'intervention'; it fails to recognise that supervision may be provided across professional boundaries; and there is no emphasis on the importance of the supervisory relationship. For these kinds of reasons, I conducted a systematic review in order to develop an empirical definition of clinical supervision (Milne, 2007). In the first part of that review I examined the logical requirements of a sound definition, then I looked hard at a carefully selected sample of successful supervision studies. These steps are now summarised.

Logical basis for a definition

According to philosophy and general scientific convention, a definition needs to state the precise, essential meaning for a word or a concept in a way that makes it distinct (*Concise Oxford English Dictionary* (COED), 2004). I refer to this as the 'precision' criterion. Precision can be enhanced by drawing out comparisons and citing examples, in order to distinguish one concept from another. A clear instance in the case of supervision is attempting

to draw out meaningful boundaries between supervision and closely related concepts, such as 'therapy', 'coaching' or 'mentoring'. To illustrate, coaching has been defined as the provision of technical assistance, in order to model, simulate and practise, with corrective feedback, so as to improve the transfer of learning to the workplace (Joyce & Showers, 2002). These features are part of supervision too, so the distinction would appear to be that supervision subsumes coaching, as supervision has additional features and functions. Similarly, there are aspects of therapy and mentoring in supervision, such as the emphasis on the relationship and on reflection, respectively. However, there are important distinctions between these concepts and supervision, in terms of such aspects as the formal authority required to supervise, and the formal evaluative ('summative') function of supervision.

This discussion indicates that we also need 'specification', namely a detailed description of the elements that make up the concept of supervision (COED, 2004). Within research, the term 'hypothesis validity' defines the extent to which a study accurately relates different concepts to the development of hypotheses and to the way that these are tested and the results interpreted (Wampold *et al.*, 1990). That is, according to theory-driven research, the sequence is first to adopt a theoretical model of a concept like supervision, then to specify which panels (also known as boxes or variables) within the model are the subject of a particular investigation, and what relationships are predicted between these panels. The next task is to suitably operationalise the key relationships in the model, so that appropriate forms of measurement are planned. If one applies these steps to the Bernard and Goodyear (2004) definition, one can see the kinds of difficulty that arise. In particular, it is highly possible that we can have what Wampold *et al.* (1990) called 'inconsequential', 'ambiguous', or 'non-congruent' elements within a definition.

To emphasise this point, consider the summary provided in Table 1.1. This sets out the concept of a supervisory 'intervention' following the specification provided within six illustrative texts on clinical supervision. It can be seen that none of these textbooks actually identified the same variables when they came to specify the supervision intervention. That is, although there was precision (different concepts or elements of supervision were noted, such as the basis of supervision being the relationship), there was a lack of consistent specification of such elements of supervision. Such a fundamental lack of consensus makes the whole foundation on which research and practice might be based insecure and indefinite: Just what is 'clinical supervision'?

Table 1.1 Testing some textbook definitions of 'clinical supervision'

Criteria for an empirical definition of supervision	Textbooks					
	1 Bernard & Goodyear (1992)	2 Fall & Sutton (2004)	3 Falender & Shafranske (2004)	4 Hart (1982)	5 Hawkins & Shohet (1989)	6 Loganbill et al. (1982)
A Operationalised?	✓	✓	×	✓	×	✓
1. Senior person	×	×	✓	×	✓	✓
2. Relationship based	×	✓	✓	✓	×	×
3. Educational	✓	×	×	×	×	×
4. Longitudinal	✓	✓	✓	✓	×	×
5. Evaluative	✓	✓	✓	×	×	×
6. Quality control (protects clients, et al.)	✓	✓	×	×	×	×
7. Gate keeping role	×	✓	×	×	×	×
8. Objectivity of role	×	✓	×	×	×	×
9. Supportive	×	×	×	×	×	×
10. Experienced person	×	✓	✓	×	×	×

11. Develops competence	✓	✓	✓	✓	✓	✓	✓	✓
12. Science-informed	×	×	✓	×	×	×	×	×
13. Develops confidence	×	×	✓	×	×	×	×	×
B Measured?								
14. Defined in observable terms	×	×	×	×	×	×	×	×
15. Instrument/s specified/exist	×	×	×	×	×	×	×	×
16. Conducted assessment	×	×	×	×	×	×	×	×
C Supported (by evidence)?								
17. Consensus claimed (e.g. 'widely accepted')	×	×	×	×	×	×	×	×
18. Cites corroborating literature (e.g. a text or review paper)	×	×	×	×	×	×	×	×
19. Notes at least one empirical study as supporting definition	×	×	×	×	×	×	×	×

NB: This assessment is based on the part of the text that explicitly presents the authors' definition of clinical supervision. It is acknowledged that some or all of these criteria may be met elsewhere in the text. Also, criteria judged to be subsumed by the above categories have not been detailed. For example, in Falender and Shafranske (2004) various ways of 'educating' and 'developing confidence' are noted (e.g. instruction and modelling), which are subsumed under these broad categories.

In addition, Table 1.1 presents a disappointing picture in relation to whether or not the variables that each of these six books specified within their definition of supervision were actually capable of being measured, or indeed were actually measured. This brings me to my third logical requirement of a sound definition, called 'operationalisation'. For instance, none of these authors noted an instrument that might measure their definition of supervision. This is unfortunate, as an instrument will tend to limit a concept to some critical parameters, enabling supervisors to see more clearly what is meant when an author uses the term supervision. Also, vague definitions do not enable researchers to manipulate or measure a loosely bounded, murky concept. What is needed is a statement of supervision in a form that enables sensitive measurement to occur. Additionally, an operational definition enables one to state valid hypotheses, and it guides us in manipulating the independent variable (supervision) with fidelity. Reliable manipulation of supervision is then possible, a key element in enabling the intervention to be specified in a manual and administered in a consistent, replicable way (Barker *et al.*, 2002). In turn, such careful operationalisation allows us to determine whether supervision is indeed being delivered as it is specified in a manual (termed variously an adherence, audit, or fidelity check). It also allows the subsequent outcomes to be attributed in a precise way to that intervention, assuming a suitable research design. The concept of intervention fidelity is helpful at this point, as it distinguishes usefully between five aspects of a properly specified intervention (Borelli *et al.*, 2005). This concept will be discussed and illustrated with supervision research in Chapter 8.

In sum, not only is the Bernard and Goodyear (2004) definition problematic in a number of respects, but a representative group of textbooks do nothing to improve this sorry state of affairs. By way of verifying my own position, consider the view reached by Ellis *et al.* (1996). They conducted a systematic review of 144 empirical studies of clinical supervision, concluding that hypothesis validity was not properly specified within this body of literature. They also noted that this poor precision and vague or absent specification meant that supervision cannot be manualised or replicated. In turn, this hampers the interpretation of results from research, and the teasing out of practice implications.

The fourth and last of the necessary conditions for an empirical definition of supervision is that it has received clear support from empirical research: that there exists some persuasive information that helps to justify a given definition. Unfortunately, none of the texts in Table 1.1 satisfied any



of the three evidential criteria. For example, no mention is given to supportive studies. I refer to this as the 'corroboration' criterion: something that confirms or gives support to a concept (COED, 2004). Logically, a definition could in principle meet the earlier three criteria (i.e. be precise, specified and operationalised), yet lack an evidence-base. Systematic reviews like the one by Ellis *et al.* (1996) address this criterion directly. Indeed, this is surely the most firmly established of the four criteria for an operational definition, as it is customary for textbooks and review papers to give systematic attention to the available evidence-base.

If we apply these four tests to Bernard and Goodyear's (2004) definition, it can be seen that it falls short on every count: the intervention is not defined precisely (e.g. is it primarily restorative, formative or normative?), no measurement instrument is indicated, and no evidence is furnished to support their definition. Similarly, other popular definitions fail one or more of these tests. It is surely time to tackle this impediment to good supervisory research and practice.

An improved definition of clinical supervision

However, the texts noted in Table 1.1, together with definitions provided by professional bodies and by the NHS, do give us a full range of concepts with which to fashion an improved definition of supervision. This builds on the Bernard and Goodyear (2004) definition, largely in order to try to maintain continuity with the general consensus on what constitutes supervision. On this basis, the following is an improved definition (the tests of a definition are noted in bold):

The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague/s (**precision**). It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component (**precision by differentiation**) and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisees' performance, teaching, and collaborative goal-setting (**specification**). The objectives of supervision are 'normative' (e.g. case management and quality control issues), 'restorative' (e.g. encouraging emotional experiencing and processing) and 'formative' (e.g. maintaining and facilitating the supervisees' competence,



capability and general effectiveness) (**specification by identifying the functions served**). These objectives could be measured by current instruments (e.g. 'Teachers' PETS': Milne *et al.*, 2002; **operationalisation**).

This definition is supported by recent reviews of the empirical literature (e.g. Watkins, 1997; Falender & Shafranske, 2004), and by a consensus statement (Falender *et al.*, 2004; **corroboration**). This empirical definition not only integrates the main current options (i.e. Bernard & Goodyear, 2004; Department of Health, 1993; Proctor, 1992; Watkins, 1997), but also embraces various supervision formats, professions, therapeutic orientations and stages of provision (pre-qualification and CPD). It excludes staff training, consultancy, performance management, mentoring, coaching, and other variations on the supervision theme that do not satisfy the above definition.

Testing this definition: a systematic review

In order to test the working definition produced above from logical and general scientific criteria, a systematic review was conducted. This adopted the 'best evidence synthesis' approach (Petticrew & Roberts, 2006) to examine a body of literature so as to extract helpful seams of good practice. This stands in stark contrast to reviews that attempt to scrutinise all studies within an area, regardless of considerations like their rigour or effectiveness (e.g. Ellis & Ladany, 1997). In the example that follows, the aim was to test whether this working definition was sufficiently precise to capture the definitions that were used explicitly or implicitly in the selected sample of empirical studies, and was specified and operationalised in ways that also corresponded with these studies (i.e. a carefully selected group of 24 research papers in which clinical supervision was studied within interpretable designs, and where it had proved successful: see Milne, 2007 for details). Lastly, I wanted to see whether the findings from these 24 studies corroborated the working definition. It should be borne in mind that one of the criteria used to select these 24 studies was that the supervision had proved successful (as defined by the authors and supported by the findings: outcomes included the learning of the supervisee, the transfer of that learning to therapy, or other aspects of the supervisee's work). This therefore provided a very practical test of the working definition.

I found that explicit definitions were largely absent within these 24 studies: only six papers specified what they meant by clinical supervision (25 per cent

of the sample). Five of these papers specified at least two methods and one function of the supervision as manipulated in their studies, but none of the authors differentiated this definition from closely related educational activities (like mentoring). It was therefore concluded that this literature corroborated the working definition as far as it went, but was basically inadequate to provide a proper test.

The next test was to examine how this body of scientific literature specified its supervision intervention. It was found that 23 of the 24 studies specified some of the variables making up their supervision manipulation, and these agreed with those in the working definition. There was, however, an absence of any reference to the normative or restorative functions of supervision, and so the working definition above should be amended accordingly to represent a strict empirical definition, at least for research purposes. However, given the slightly broader aims of this book (see below), these functions will be retained for present purposes.

Sixteen (67 per cent) of the 24 studies measured all or most of the variables specified within their application of supervision. The measures used were consistent with the outline in the working definition. For example, Fleming *et al.* (1996) measured the competence of the four supervisors in their study using a nine-item observational checklist (e.g. assessing 'participative goal-setting' and 'provides feedback').

Lastly, in order to assess corroboration for the working definition, a simple, seven-point, summary rating was made across all 24 studies, in order to gain a general sense of their effectiveness. A value of 2.4 for supervisees (i.e. the amount of learning for the therapist) and 2.3 for patients (clinical outcomes) indicated that these studies were generally very successful, equivalent to an 80 per cent and 77 per cent effectiveness of supervision score, respectively. Overall, these systematic review data indicate that supervision, as per the working definition, is associated with positive outcomes, giving it empirical support. In conclusion, having passed these various tests, the working definition will be accepted as the definition of clinical supervision used within this book.

Aims of This Book

In order to build on this empirical definition and to redress the imbalance between research and policy noted earlier, this book will collate the best

available evidence on clinical supervision (referred to simply as ‘supervision’ from now on) in order to aid our understanding of what it is and how it works, so that research and practice can benefit, and so that policy can be translated into practical intervention. Unlike prior reviews, I add original material (e.g. instruments for measuring key aspects of supervision, and a manual for training supervisors), and, unlike most other textbooks, this book will provide a critical, scholarly and evidence-based review of this vital activity as it stands at the start of the 21st century. As a result, the basic psychological principles and practices will be clarified in a searching yet constructive way, so that we can understand and apply CBT and related forms of supervision more effectively. Although the focus is on 1:1 supervision, other formats will be discussed, such as group and peer-consultation arrangements. Also, the prime emphasis is on the supervision of the clinician’s caseload, although I also attend to the traditional concern with the clinician’s wellbeing. This foundation for improved supervision practice is fostered by presenting and elaborating some supervision guidelines, part of that manual for training new supervisors (Milne, 2007a). Another neglected aspect of the training of supervisors, and of routine supervision, is the emotional dimension. There is a ‘tyranny of niceness’ (Fleming *et al.*, 2007) that can suffocate supervision, dampening down in particular the exploration and effective use of emotional experiences in supervision. Therefore, due weight will be given to developing supervision by attending to the relevant thoughts, feelings and behaviours.

Although you may already sense that psychological emphasis coming through, this book is written for all those involved in supervision, not just psychologists, and not just supervisees or those who train supervisors. The emphasis is on isolating the basic, essential ingredients of effective supervision, drawing primarily from the relevant research literatures, so as to provide a useful account of supervision. This information should therefore be relevant to everyone involved in supervision (and not just to supervisors in the mental health field, though that is the assumption). As a result, there are also implications for supervisees, researchers, commissioners, programme reviewers, patients and others with an interest in supervision. Reflecting these stakeholders, and using the evidence-based practice framework, the material in this book will also be influenced by professional consensus, my personal training experiences, national guidelines and local audits, not to mention my regular involvement in supervision for the past 25 years, most of it within a major training programme. Relevant neighbouring literatures will also be used to strengthen the evidence-base and the theoretical

awareness, particularly material from the staff training and psychotherapy fields. This, then, is psychologically informed supervision for the evidence-based practitioner and for the modern healthcare organisation. Supervision will be regarded as a complex intervention and treated with long-overdue rigour, as a core part of the business of delivering high-quality health services.

Plan for the Book

The remaining eight chapters are suitably businesslike, stressing informed action within a coherently structured, logical approach. To summarise, Chapter 2 outlines a basic, evidence-based model of the factors that govern supervision, and Chapter 3 goes on to reconstruct an experiential model. Recognising the importance of the relationship between the supervisor and the supervisee (typically a therapist) is far from novel, but it merits serious attention. Therefore, I review recent work on this interpersonal professional ‘alliance’ in Chapter 4, where I introduce the first of four guidelines. These early chapters prepare us to address the technical tasks faced by supervisors, and Chapter 5 sets these out as the ‘supervision cycle’. Drawing on the staff training literature, supervision is regarded as a closely related series of activities: assessment of the supervisee’s learning needs; collaborative goal-setting; applying methods to facilitate learning; and evaluation. Further guidelines on these topics are introduced. Chapter 6 then mirrors this emphasis on the supervisor by giving attention to the part played by the supervisee, a strangely neglected player in most published accounts of supervision. I detail how supervisees can be understood to learn from their experience through supervision, affording a psychological map of the unfolding journey of professional development. Related to this understanding, some instruments with which to capture this process are noted (to be discussed in Chapter 8, alongside a wider summary of the available tools and associated issues). Chapter 7 notes the need to ensure that professionals are properly supported in their emotionally demanding work. This aspect of supervision has been called the ‘restorative’ or ‘supportive’ function, complementing the ‘formative’ focus of Chapters 5 and 6. Here I will deal with the various practical arrangements that need to be addressed by those who appoint, support and guide supervisors, such as regular peer support groups and training workshops. The final chapter (9) draws together the essential principles and implied practices covered above. This summary

provides the basis to relate supervision (as discussed in the preceding chapters) to the wider workplace and to the professional context. Similarly, the professional affiliation of the supervisor (and other factors) will be considered, including how supervision needs to change through the professional's career.

In summary, this book offers you an experienced guide's version of supervision as an applied science, in a way that is intended to show how supervisors can integrate theory and practice in this vital professional activity, within the current healthcare context (especially the NHS).

Summary

Supervision is belatedly receiving the attention it deserves, given its pivotal role in professional development and in the maintenance of competent, ethical practice. But there is an awkward gulf between the aspirations that are expressed in the policies of national bodies such as the BABCP and the material that is available to develop supervision. Therefore, this book draws on the evidence-based practice framework to set out a systematic, scholarly and constructive approach, called evidence-based clinical supervision (EBCS). Using techniques such as the 'best evidence synthesis' to review the core literature and the results of professional consensus building, EBCS affords a contemporary approach to competent supervision practice, a stimulus to research, and a promising way to bridge the theory–practice gulf.

An illustration of this scholarly, constructive style was the critical attention given to how we define supervision. It was argued that the most popular definition is seriously flawed, and a more logically coherent and evidence-based revision was provided. This specifies what supervision entails, how it can be measured and what it is known to achieve. A brief glimpse of the available history of supervision, aided by some speculation regarding ancient history, suggested that the apprenticeship model has a considerable pedigree.