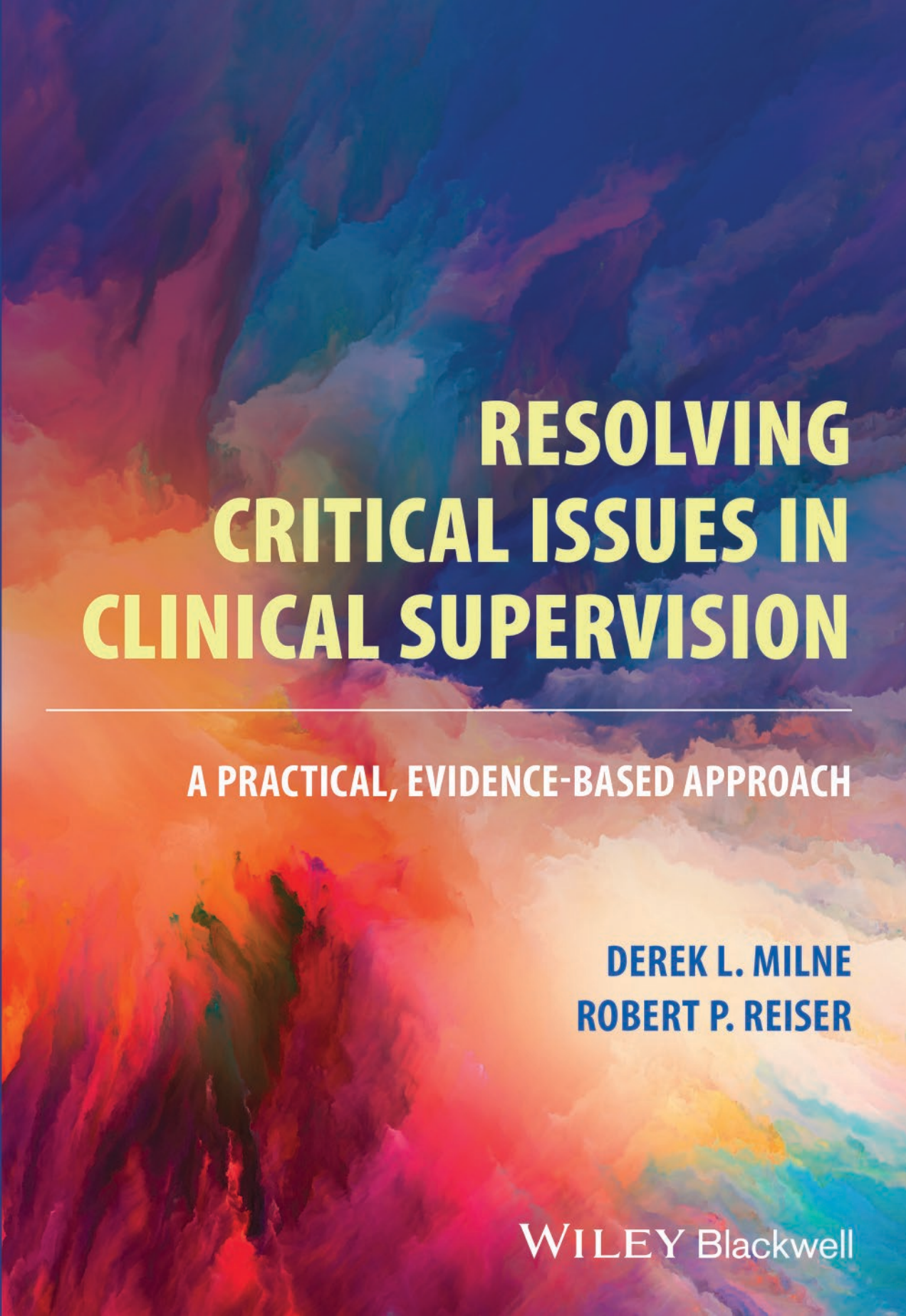
RESOLVING
CRITICAL ISSUES IN
CLINICAL SUPERVISION
A PRACTICAL, EVIDENCE-BASED APPROACH
DEREK L. MILNE
ROBERT P. REISER
WILEY Blackwell

Resolving Critical Issues in Clinical Supervision

Resolving Critical Issues in Clinical Supervision

A Practical, Evidence-based Approach

Derek L. Milne, PhD
Retired Scholar
Northumberland, England

Robert P. Reiser, PhD
Adjunct Faculty Member
Beck Institute for Cognitive Behavior Therapy
Kentfield, CA

WILEY Blackwell

This edition first published 2023

Registered Office
John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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Library of Congress Cataloging-in-Publication Data
Names: Milne, Derek, 1949- author. | Reiser, Robert P., author.
Title: Resolving critical issues in clinical supervision : a practical, evidence-based approach.
Description: Chichester, West Sussex : Wiley-Blackwell, 2023. | Includes bibliographical references and index.
Identifiers: LCCN 2022055940 (print) | LCCN 2022055941 (ebook) | ISBN 9781119812456 (paperback) | ISBN 9781119812487 (adobe pdf) | ISBN 9781119812463 (epub) | ISBN 9781119812470 (ebook)
Subjects: LCSH: Medical personnel--Supervision of. | Health facilities--Personnel management. | Clinical competence. | Medical care--Quality control.
Classification: LCC RA971.35 .M56 2023 (print) | LCC RA971.35 (ebook) | DDC 362.11068/3--dc23/eng/20230125
LC record available at https://lccn.loc.gov/2022055940
LC ebook record available at https://lccn.loc.gov/2022055941

Cover image: © agsandrew/Shutterstock
Cover design by Wiley

Set in 9.5/12.5pt STIXTwoText by Integra Software Services Pvt. Ltd, Pondicherry, India

This book represents the completion of a 40-year research and development programme, made possible by many hundreds of people who, since the 1980's, have helped us to research, develop, and implement evidence-based clinical supervision (EBCS). This includes close collaboration with dozens of co-authors, clinical tutors, health service managers, service users, clinical supervisors, supervisees, and others (including hundreds of supervisors who participated in our many workshops). We would like to dedicate this book to them all.

Contents

About the Authors

Derek L. Milne (Ph.D., FBPS) is a retired clinical psychologist and visiting professor who worked in England's National Health Service (NHS) for 33 years, specialising in staff development. This included a decade as Director of the Doctorate in Clinical Psychology at Newcastle University, preceded by 12 years as a clinical tutor at Leeds and then Newcastle Universities. Clinical supervision was a significant focus for this work, including the organisation and management of placements/practicums for trainee clinical psychologists, together with workshops for clinical supervisors of all mental health disciplines. Since 1979, Derek Milne has published several books on clinical supervision, and over 100 papers in peer-reviewed scientific journals. Many of these addressed practical issues in enhancing clinical supervision, such as clarifying conceptual models, improving measurement (especially through direct observation), conducting single-subject ($n = 1$) and other evaluations, and developing supervisor training. This activity has been guided by a commitment to evidence-based practice, drawing on a scientist–practitioner orientation.

Robert P. Reiser (Ph.D.) maintains an active clinical practice as a licensed clinical psychologist in California and provides training to clinicians as an Adjunct Faculty member at the Beck Institute for Cognitive Behavior Therapy. Since 2006, he has been delighted to collaborate with Derek Milne on a series of research projects including a manualized account of evidence-based CBT supervision in 2017. He has written and co-authored journal articles and has contributed book chapters focusing on evidence-based approaches to clinical supervision in conjunction with Derek Milne. He has provided CBT training to VA clinicians within the CBT-D national training program with the Veterans Administration over several years. Dr. Reiser also leads workshops focused on improving supervision and training through the use of empirically supported practices. Currently, he trains psychiatric residents at the University of California, San Francisco, in the Department of Psychiatry.

Acknowledgements

Derek Milne would like to acknowledge all those who have helped to develop EBCS over four decades. Prominent latterly are the enthusiastic and committed members of National Education Scotland, who gave us priceless support, direction and validation. Particular thanks go to my long-standing (and long-suffering) co-author Robert Reiser, who has since 2006 collaborated closely with me on supervision research, training, and publications. His companionship, energy, and positivity have played a huge part in building EBCS to this stage. Such collaboration has also provided enormous satisfaction, and hopefully this book will contribute to further work on EBCS, and to related improvements in clinical supervision.

Robert Reiser would like to acknowledge the stimulating but sometimes painful journey in moving forward and adopting EBCS in his own practice. Apologies to my students and trainees, as this required many years of probably imperfect supervision. At least one student in his evaluation commented to the effect that I was experimenting with a new form of supervision, and that 'it would probably be quite useful when he eventually gets it right'! The best part of working with Derek has been the many and constant opportunities to review my practice, reflect on challenges and difficulties, formulate how the issues might be tackled, and then plan and deliberately practise how to incorporate this into the body of our work together. This entailed many trips around this experiential learning cycle based especially on our 11-month study of tapes from my supervision (Milne, et al., 2013), so central to our conceptualization of supervision. This book exemplifies this experiential emphasis, and is a fitting milestone on our EBCS journey together. We would both like to acknowledge Wiley for maintaining interest in our approach to clinical supervision, especially to Jake Opie and Monica Rogers in relation to the present book. Graphic Artist Angela Butler provided some of the figures. Helpful guidance on legal aspects of supervision were welcomed from Ken Hunt and an anonymous second lawyer. Big thanks too, to Duncan Gray, consultant physician, and the anonymous colleagues for the case study illustrations. Our partners, Jan Little and Susan Reiser, and granddaughter Lily Reiser, deserve huge thanks for their unfailing social support and encouragement throughout the writing of this book.

1

Introduction: What are the Critical Issues in Supervision?

In this book we identify the main kinds of critical issues that arise in supervision, suggesting how they can best be resolved. Our guidance is practical, and draws on the evidence-based practice approach that we have used to write prior books and academic papers (e.g., Milne & Reiser, 2017). Much of our earlier work addressed the 'formative' function of supervision, studying how supervisors could facilitate the supervisees' learning and professional development (e.g., Milne & Reiser, 2017). Our last book addressed the 'restorative' function of supervision, again adopting a practical emphasis (Milne & Reiser, 2020). To complete the job, in this new book we will be focusing on the final aspect, the 'normative' function of supervision. This concerns the management or administration of supervision, having to do with areas such as quality control, risk management, gatekeeping, and ethical practice.

Critical issues arise regularly within clinical supervision (hereafter 'supervision'), as an inevitable consequence of complex healthcare environments that include constantly shifting and sometimes competing priorities and pressures. Examples include the often-conflicting priorities of managers and supervisees, which can lead to dilemmas in which supervision is a low management priority, yet essential for the professional development of supervisees (Gonge & Buus, 2010). Even when supervision is securely in place, numerous factors can create tensions between healthcare workers and those who manage their clinical services. A further and fundamental source of tension arises from the sometimes divergent formative, normative, and restorative functions of supervision (Kadushin, 1968). Such intrinsic tensions arise from the increasing organisational pressures on clinical supervisors to monitor and scrutinise the work of their supervisees for varied reasons such as quality assurance, administrative accountability, and risk management. In addition, some professions appear to have a general ambivalence or resistance towards clinical supervision, leading to its devaluation or avoidance (e.g., the nursing profession: White & Winstanley, 2014).

In this chapter we set the scene for resolving such issues, taking a constructive and evidence-based perspective that will characterise this book. Our optimism is based on the accumulating evidence that supervision is uniquely valuable in healthcare (Milne & Reiser, 2020; Watkins & Milne, 2014), and on our extensive experience of working with supervisors and supervisees across many professions and contexts since the 1980s (e.g., Milne, 1983). Our ongoing involvement in supervision research and practice is now approaching the 40-year mark, culminating most recently in an evidence-based

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supervision manual (Milne & Reiser, 2017), and a book specifically concerned with restorative supervision (Milne & Reiser, 2020). Based on this experience and our distinctively evidence-based perspective, we will now outline this latest book, clarifying what we mean by normative supervision, and reviewing the best-available literature in order to classify the main critical issues that arise within normative supervision. We will close this introductory chapter by describing how our evidence-based approach can lead to the resolution of these issues. Later chapters will examine all the identified critical issues. The result is an exceptionally wide-ranging review of critical issues, together with evidence-based suggestions on how best to understand and resolve them.

What Is Clinical Supervision?

Supervision has a long history, dating back to the beginnings of social work in the eighteenth century (White & Winstanley, 2014). Although the different healthcare professions make variable use of supervision (Hession & Habernicht, 2020), it has become increasingly recognised internationally as an essential part of modern healthcare systems (Watkins & Milne, 2014). In addition to supporting staff (Milne & Reiser, 2020), it contributes to evidence-based practice (Beidas & Kendall, 2010), and it enhances clinical effectiveness, partly through minimising harm (Milne, 2020). These benefits of supervision are further examined later in this chapter.

Although these benefits are widely endorsed, the definition of supervision has proved problematic. One problem is that illogical variants such as 'peer supervision' (Martin et al., 2018) and 'self-supervision' (Basa, 2018) have developed. Among other reasons, these are flawed because they are irrational (i.e., they are self-contradictory terms), and because they remove the hierarchical relationship that is required to oversee and control supervision (see Chapter 2). The other problem is that there are many different ways in which supervision has been conceptualised and practised: 'Clinical supervision has become a synonym for coaching, mentorship, peer review, clinical facilitation, preceptorship, clinical teaching, buddying, debriefing and other oversight... encounters. Not uncommonly, the term is also used as a byword for "personal performance review", case review, and even therapy' (White, 2017, p. 1251). A third problem is that the different health and social care professions define supervision in distinctive ways (Vandette & Gosselin, 2019). This makes it vital that we next clarify what we mean by supervision.

An early and influential account of supervision is given by Dawson (1926), which defined supervision in terms of the three functions mentioned earlier: educational ('formative'), administrative ('normative') and supportive ('restorative'). Formative supervision addresses the professional development of staff members, mainly through refining their clinical competencies. Normative supervision focuses on enhancing quality-control, an administrative or management perspective (e.g., managing waiting lists; organisational issues). Lastly, supportive supervision concerns the well-being of staff, improving their morale and job satisfaction. More recent definitions help us to build on Dawson (1926): Clinical supervision is *a formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex clinical situations*

(Department of Health 1993, p. 15). In turn, this National Health Service (NHS) definition provided a foundation for an empirical definition of clinical supervision: *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 designated supervisees. The objectives are primarily: quality control (e.g., "gate-keeping" and ethical practice); maintaining and facilitating the supervisees' competence and capability; and helping supervisees to work effectively (e.g., promoting quality control and preserving client safety); accepting developing own professional identity; enhancing self-awareness and resilience/ effective personal coping with the job; critical reflection lifelong learning skills* (Milne, 2007).

Definition of Normative Supervision

We should also define the normative function of supervision. Following Kadushin and Harkness (2002), we define normative supervision as *an aspect of clinical supervision that addresses supervisees' professional functioning in their organisational context, aiming to ensure that workplace arrangements are effective and satisfactory. It is a formal, constructive, work-focussed, and interpersonal process, addressing the supervisee's critical issues and encouraging positive learning opportunities. It is conducted with due authority by a trained, suitably experienced, and appropriate supervisor. The main supervision methods are workload review (e.g., joint problem-solving discussions); education and training (e.g., competence development through guided experiential learning); awareness-raising (e.g., via facilitated reflection on practice); and evaluation, monitoring and feedback, related to work performance (e.g., to ensure quality control)*. This definition complements and develops the one we provided for the restorative function of supervision in our recent book on that function (D. Milne & Reiser, 2020), and both elaborate as necessary the empirical definition of supervision explained here.

What are the Most Common Critical Issues?

Ladany et al. (2016) reviewed the literature in relation to psychological therapy, concluding that the most common issues presented to supervisors by their supervisees were skill deficits and competency concerns; interpersonal dilemmas (e.g., role conflicts); problematic attitudes and behaviour; and work-related misunderstandings (e.g., diversity or power issues). Some of these will also affect supervisors, and self-doubt about one's supervisory competence appears to be common (probably linked to the scarcity and brevity of training in supervision). Major textbooks of most relevance to this book (e.g., Beddoe & Davys, 2016; Haarman, 2013) also address similar issues, including:

- *Competence concerns:* inadequate cultural competence among supervisors; fostering clinical/professional competence and capability in supervisees (adherence, skill and appropriateness); defining, evaluating and addressing incompetence.
- *Relationship struggles:* collusion; struggles over authority, accountability, and responsibility; interpersonal dynamics and 'alliance ruptures'; tensions between different styles/ approaches/belief systems, including balancing support versus challenge, and the use of

the different methods of supervision (especially ambivalence concerning experiential learning); personality clashes.
- *Communication problems:* confidentiality; criticism, evaluation, and feedback.
- *Work-related stressors:* personal distress (e.g., burnout); diversity issues; ethical concerns (e.g., boundary issues); organisational matters (e.g., staff morale; training and support for supervisors); coping with change (e.g., new technologies and practices).

The Role of Major Workplace Stressors

The aforementioned issues arise in the context of events at work. The main workplace stressors were identified in a systematic review of 49 studies, concerned with work-related psychological problems, such as occupational burnout (Michie & Williams, 2003). Similar findings were reported in a more recent systematic review (Bhatt & Ramani, 2016). Both reviews included international, multi-disciplinary samples of healthcare workers. The review conclusions were highly consistent, regardless of the different nationalities and professional groups, in reporting major workplace stressors:

- long working hours
- work overload and pressure
- lack of control over work
- lack of participation in decision-making
- inadequate social support
- unclear and conflicting job roles.

We would expect there to be significant individual differences in the extent to which supervisees would raise such stressors for discussion in supervision, reflecting their different work histories, personal appraisals, and coping strategies, alongside the other variables in the personal coping model (described shortly). In addition, if the supervisor is also the supervisee's manager, that may significantly influence the nature of the discussion. For example, supervisees are unlikely to freely disclose their work struggles or competence issues to a supervisor who is also their line manager (McMahon & Errity, 2014; Ladany et al., 1996). In turn, line managers may naturally bias the supervision agenda towards organisational matters, and may take an unsympathetic position in relation to their supervisee's struggles to cope at work.

Common Ethical Concerns

Ethical issues are often identified through supervision, which is sometimes described as an ethical 'hornet's nest' on account of the many intrinsic tensio ns (e.g., support versus evaluation: Beddoe & Davys, 2016). Although ethical conduct may be discussed most frequently in supervision, ethics is incorporated in all areas of our work, representing the accepted conventions guiding how we ought to behave in professional life generally. In addition to being so wide-ranging, ethical involvement in healthcare is often unobservable (e.g., private struggles over stressful working relationships). This means that ethical conduct '...although rarely discussed, affects everything we do in our professional life, helping to

regulate, educate and guide us (e.g., with respect to doing no harm, doing what is beneficial, and doing justice'. Watkins & Milne, 2014, p. 684). These moral principles, together with others widely accepted in healthcare, tend to be given varying degrees of importance (e.g., respect for patients' rights, transparency, and honesty). This will depend on the value system of individuals, and of their professional colleagues and organisations, as formalised in their codes of conduct.

Being complex, unobservable, variable, and universal, it is difficult to reduce workplace ethics to a small number of critical issues. One helpful approach is to combine the most common issues, including the codes of conduct and guidelines concerning supervision that have been developed within regulatory bodies and professions internationally. Following this approach, Thomas (2014), defined the most common ethical transgressions as:

- *Blurred relationship boundaries*, including the abuse of power and multiple relationships (e.g., exploitation, oppression, or coercion of the supervisee for personal gain; abuse of power or trust; disrespect and indignities; racial and other forms of discrimination)
- *Lack of informed consent or 'due process'*, failing to protect the rights and welfare of patients and supervisees (e.g., sub-standard supervision, including unclear parameters, vague objectives, and inappropriate methods; misunderstandings over communication, evaluation criteria, confidentiality, and record-keeping)
- *Incompetence in supervisors and supervisees* (e.g., failure to address ethical issues or to develop ethical competence in supervisees; lack of ethical understanding, clinical oversight, or appropriate delegation of responsibilities by the supervisor; lack of supervisor training or consultation; multicultural incompetence, including privilege and oppression).

Similar topics and categories have been described in other supervision texts and journal papers that pay particular attention to resolving critical issues. These include: Barnett and Molzon (2014), Bernard and Goodyear (2014), Ellis et al. (2014), Falender and Shafranske (2008), Haarman (2013), and Ladany et al. (2016).

As far as we know, however, there has not been a clear consensus or classification framework that captures this range of events and associated critical issues in supervision. In some ways, this lack of consensus inevitably follows from the subjectivity implicit in defining critical issues, including the ways that supervisors themselves perceive events. These factors make it problematic to attempt to create an objective and complete list. In addition, critical issues are diverse and wide-ranging (Kadushin & Harkness, 2002). This variability is illustrated by clinicians' misguided efforts at coping with critical issues, leading to disciplinary action in relation to 86 different types of problematic behaviour, as listed by one professional body (ASPPB, 2019). The most common reasons for the actions were 'unprofessional conduct' and 'sexual misconduct', each representing 10% of all disciplinary actions during the 45-year period studied. Despite these difficulties, we attempt to address this diversity of incidents by creating an integrative classification scheme, building on the above summaries. We think that this effort is potentially useful, providing some clarity and order (and a practical basis for identifying which critical issues to prioritise within this book). In addition, there are many common events, such as work overload, which trigger typical reactions, arising from their general features (e.g., their severity, uncontrollability, and unpredictability). This makes it appropriate to try to list the most common events and critical issues with which they are usually linked.

Pulling It All Together: A Classification of Critical Issues

A helpful approach to consider when a literature is unclear is to integrate key ideas from related literatures that have clear relevance, and a stronger evidence-base (extrapolation). We did this successfully when preparing our CBT supervision manual (D.L. Milne & Reiser, 2017), for example, by studying the educational literature in order to better understand how to give effective feedback (e.g., Hattie & Timperley, 2007). We repeat this approach here, to help us to clarify the full range of critical issues in supervision. In particular, the related literature on patient safety is highly relevant, has strong research foundations, and focuses on things that go wrong in healthcare. Things that go wrong are critical issues that have not been addressed or resolved, and have become a greater concern, potentially causing harm. The overlap between patient harm and critical issues in supervision becomes clearer when we consider the definition: Patient harm related to supervision causes lasting damage (psychological and/or physical) due to supervised clinical interventions which have been incorrectly selected or applied, or where unethical events occur. Such harm is understood to arise from clinicians' errors, commonly taking the form of incompetence, unethical behaviour, poor health, and other types of unprofessional conduct (Milne, 2020).

The patient safety literature includes taxonomies covering behavioural interventions in healthcare (e.g., Bellg et al., 2004) and patient safety frameworks (e.g., Chang et al., 2005; Chatburn et al., 2018). In addition, we draw on valuable concepts from the literature on therapy-related harm (e.g., Curran et al., 2019; Hardy et al., 2019; Klatte et al., 2018), and examples of the harm that can be done to supervisors and supervisees within organisations (e.g., due to chronically high stressors: Griffiths et al., 2019). We conducted a theoretical review which integrated these literatures to classify the different sources of harm, in relation to supervision (Milne, 2020). This integrative effort yielded an evidence-based classification system with 10 types of critical issue, as summarised in Table 1.1. These are the critical issues that we address in this book.

The first column in Table 1.1 provides a classification system for 10 kinds of 'adverse triggering events' in supervision, based on the fidelity framework (Bellg et al., 2004). This list starts with individual events with relatively circumscribed implications, such as a supervisor adopting an inappropriate approach to supervision with one supervisee. The list ends with events that affect many people, and which carry huge implications (e.g., a faulty system that leads to a healthcare disaster). Therefore, Table 1.1 incorporates a systemic perspective, one that includes consideration of personal, interpersonal, cultural, organisational, and community issues. The second column in Table 1.1 offers examples of critical events. These examples, such as unstructured supervision or communication problems, are ones that might be expected to occur in conjunction with these adverse triggering events, being a summary of the most frequently mentioned examples in the literature.

By using this extended fidelity framework, we hope to ensure that critical issues are addressed systematically, that supervisors are helped to identify relevant critical issues, and that we provide a properly organised book. For example, in Chapter 2 we next address the power imbalance in supervision, and the tension between autonomy and control. This is consistent with the adverse event in row 1 that is labelled: *1. Faulty 'design' (bad planning*

Table 1.1 A systemic classification of negative critical issues in supervision.

Adverse triggering events	Negative critical issues in supervision (see text for descriptions)
Faulty 'design': The wrong thing is 1. planned or 2. practiced unprofessionally by the supervisor.	Supervisor is unfit for practice: unethical, improper, or illegal acts by the supervisor; professional misconduct; incapacity (physical and mental); personality issues. Lack of due process (e.g., no supervision contract; unclear supervision parameters, such as evaluation).
Faulty 'training': Supervisor training is: 3. done wrong (i.e., lacks adherence to the proper approach).	Supervisor training is unfit for purpose: incompetence due to absent, inadequate or faulty training (or poor training transfer).
Faulty 'delivery': Supervision is: 4. done incompetently by the supervisor (i.e., with a lack of proficiency).	Supervisor is unfit for purpose: supervision techniques, or relationship inappropriate (e.g., boundary violations; power struggles); complications (e.g., non-compliant supervisee).
Faulty 'receipt': Supervision has the: 5. wrong effect on the supervisee (i.e., ineffective supervision plus supervisee factors prevent competence development).	Supervisee is unfit for purpose or award: fails to engage properly (e.g., avoiding experiential learning) or slow to develop competence; may be associated with adverse health conditions (physical and mental, such as burnout, impairment).
Faulty 'enactment': The supervisee provides the: 6. wrong treatment leading to the: 7. wrong clinical outcomes with the patient	Supervisee selects wrong approach, and/or uses flawed implementation (e.g., suspect techniques; under/over-treating; relationship ruptures, accidents, harm, or drop-outs). Client factors may also be influential (e.g., vulnerability; risk-taking). Ineffective treatment, achieving poor outcomes.
'Faulty workplace': 8. Faulty local management (i.e., flawed leadership)	Service managers unfit for practice (e.g., fail to monitor and detect above issues, or to apply supervision standards). May be compounded by work overload, role conflicts, and inadequate social support.
'Faulty organisational system': 9. Flawed feedback systems (i.e., faulty information) 10. Ineffective quality improvement systems (i.e., flawed attempts to improve healthcare).	Organisational systems unfit for purpose; organisation's national leaders unfit for practice (e.g., belated or inaccurate whole system feedback; under-funding of improvement efforts; governance failures; whole system violations or ineffectuality). Loss of staff morale and public trust (e.g., reduced governmental support and private donations).

or unprofessional application of supervision). Subsequent chapters deal with all the other critical issues in Table 1.1, to provide an exceptionally comprehensive coverage of the problems that supervisors face in ensuring that effective supervision is provided.

Understanding Critical Issues

So far, so good, but critical issues such as 'unprofessional supervision' are often not clear-cut or straightforward, being more often obscured by grey areas, and subjected to conflicting opinions. This highlights the significant role played by the way we cognitively appraise events: one person's critical issue is another's routine supervision. Therefore, instead of simply creating a fixed and final list of critical issues (as in Table 1.1), for a more accurate understanding we need to factor in appraisal as a characteristic of individuals, one that explains the origins of a critical issue. Cognitive appraisal is a perceptual process, one which is subjective and initially automatic (i.e., it occurs instantly, without conscious effort or awareness), serving to interpret the personal significance of the events that occur around us. It is this appraisal process that determines whether an event is judged to be a critical issue (i.e., a 'stressor') by an individual. If a supervision event (e.g., a supervisee who avoids a task) is appraised by the supervisor as something that requires a response, then the supervisor making that appraisal is by definition judging it to be a critical issue (i.e., we use 'stressor' and 'critical issue' interchangeably). This logic comes from coping theory, which helps us to understand why some things become critical issues, and which also helps us to formulate and resolve issues.

Because appraisal is such a subjective process, differences between individuals' perceptions of what happened during incidents can readily occur, including whether the incident truly merits a response. For instance, ethical issues are often unclear, and we often avoid dealing with them (e.g., dual relationships, such as a supervisor who is also a manager: see Chapter 3). An important factor during appraisal is whether the incident is perceived as a threat or a challenge. Incidents are often presented in a negative light, as a threatening or problematic event. This is indicated by the terms that are often used, including 'hassles' and 'stressful events' (Thoits, 2010). An event that is perceived as something that could overwhelm or harm us generates an automatic 'flight or fight' reaction from our nervous system (Volmer & Fritsche, 2016). If then our personal coping strategies are ineffective, we will tend to feel distressed (e.g., frustrated or angry). And if this negative coping process occurs frequently or has serious repercussions, we may become sensitised to this stressor, and cope in ways that are increasingly maladaptive (e.g., more frequent use of avoidance-based coping strategies: see Table 1.2 for examples, numbered 5–8). As this vicious cycle recurs, we are likely to experience a loss of confidence (e.g., feeling like a fraud or an imposter), and may have symptoms of personal distress (e.g., occupational burnout). Coping strategies are our ways of dealing with stressors, using all of our resources, and often also drawing on social or other resources in the process. Just like critical incidents, the range of strategies people use to cope is incredibly diverse. But Table 1.2 is an authoritative summary of the most commonly used strategies, and represents a good place to start in trying to understand critical issues.

Table 1.2 The main personal coping strategies, with examples drawn from a survey of American counsellors (Lawson, 2007). Reproduced with the permission of Pavilion books.

Personal coping strategies	Examples from a survey of counsellors
1. Logical analysis	Maintain objectivity; seek case consultation.
2. Positive appraisal	Reflect on positive experiences; gain a sense of control.
3. Seeking support	Access clinical supervision, peer support, personal therapy.
4. Problem-solving	Increasing self-awareness, Continuing Professional Development, reflection, read literature.
5. Cognitive avoidance	Put aside unwanted thoughts, avoid responsibility.
6. Acceptance/resignation	Take a vacation, turn to spiritual beliefs.
7. Seek alternative rewards	Use substances to relax, leisure activities.
8. Emotional discharge	Describe work frustrations to colleagues.

Therefore, coping theory represents a way of defining, understanding, and resolving critical issues (Brough et al., 2018; Sonnentag & Fritz, 2015). Despite a long history, it remains a cornerstone of psychological research and theory on how we function at work (Briggs et al., 2017; Volmer & Fritsche, 2016). As used here, coping theory is also consistent with a cognitive-behavioural therapy approach (CBT), our usual way of working. And like CBT, the theory represents an exceptionally practical, intuitively obvious, and evidence-based way of understanding critical issues. For these reasons, throughout this book we will use coping theory as a way of understanding and considering how to resolve critical issues in supervision. As already noted, the coping process is based on the interaction of several factors, such as an initial event appraisal (threat or opportunity), and then responding to stressors with coping strategies. There are also other factors within the theory. These processes and technical terms are illustrated in Figure 1.1, a summary of the well-established 'coping theory' (Folkman & Nathan, 2010). Critical issues that are part of the coping model (box 4 in Figure 1.1) arise from three broad sources: the general context, the specific workplace, and from the individual. Context is presented as box 1 in Figure 1.1, and refers to the wider environmental system surrounding the workplace (e.g., professional bodies' practice standards; legal considerations and national politics; pandemics). These contextual factors usually act as moderators, affecting the speed, strength, or direction of the variables within the coping cycle. 'Context is key ... critical supervisory events do not occur in a vacuum' (Ladany et al., 2016, p. 35). For this reason, the context encircles the coping cycle, as indicated in Figure 1.1. The other main influencing factors are the workplace system, and personal factors. These are indicated by boxes 2 and 3 in Figure 1.1. Examples of all three factors were included in our earlier definition of normative supervision, including legal challenges, lack of peer support, or a supervisor's resilience. These examples correspond to boxes 1–3 in Figure 1.1, respectively. As a result of the way that these coping factors interact, we will tend to end up feeling good or bad about the coping episode. As per Figure 1.1, these are termed the 'well-being' or 'distress' outcomes of our coping efforts, but many other kinds of positive and negative reactions occur too. For example, in

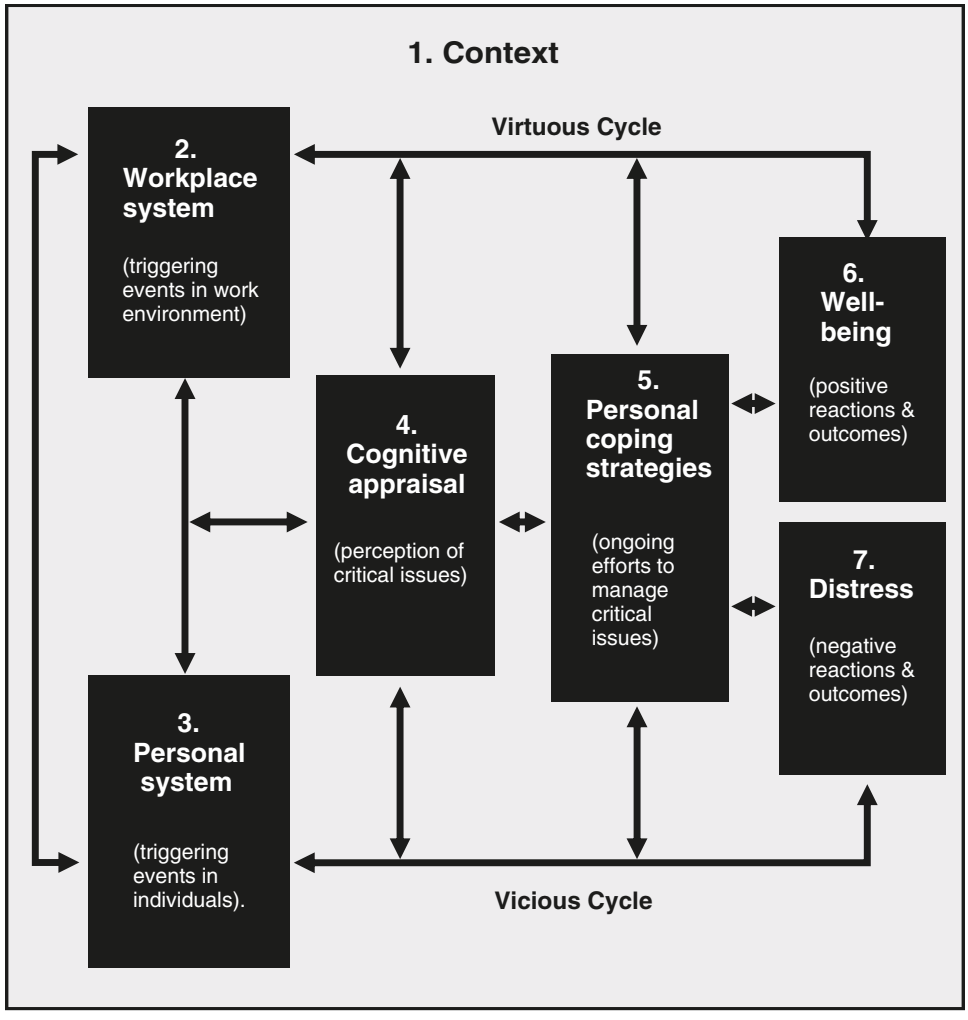

Figure 1.1 The coping cycle, a way of understanding critical issues.

the illustration below, a supervisor was asked to explain her purely didactic approach (a stressor, appraised as a threat), which she coped with by denying that there was a problem, and even arguing that her approach was actually widely accepted. The episode left her feeling angry, misunderstood, and devalued.

To explain the kind of coping process in the illustration below, the supervisor's threat appraisal triggered some emotional discharge, an emotion-focussed and typically maladaptive coping strategy (see Table 1.2). However, she was professional enough to recognise that some problem-solving work might be justified (a more adaptive coping strategy), which was done within a socially supportive if strained atmosphere. This enabled her to exit what was in danger of becoming a downward spiral towards even worse consequences than attending a supervision workshop and reading a guideline (such as being excluded

from serving as a supervisor by the training programme). The downward process is called the 'vicious cycle', to reflect how several things tend to start to go wrong, and the situation worsens (e.g., our appraisals become more negative, and our coping strategies are poorly chosen and incompetently enacted).

The alternative process is when we perceive a stressor as a challenge, and enter a positive or 'virtuous' coping cycle, based on using the adaptive coping strategies (i.e., strategies 1–4 in Table 1.2). The process begins when an incident is perceived as an opportunity, rather than a threat. Our appraisal is that the event can be handled successfully, and once we start to cope with it we may even experience some positive emotions. For example, a supervisor may perceive a supervisee's display of clinical incompetence as the moment to step in and provide some training and encouragement. Consequently, the supervisor may well end up appreciating this chance to flourish, thanks to demonstrating their professional qualities (e.g., clinical expertise). But we also include as stressors those situations where there is no clear incident, but where the supervisor can see an opportunity to implement a different technique, to better help their supervisee (e.g., they sense a 'teachable moment'). This moment may occur when a supervisor notices their supervisee's curiosity over a clinical incident, and an eagerness to learn more about it. Perceiving events in this positive way, a supervisor can draw on their more adaptive (approach-based) personal coping strategies and achieve a satisfying resolution to a critical issue ('well-being' in Figure 1.1). This leads to a virtuous cycle that benefits supervisors personally and professionally (e.g., stimulating their thinking; allowing them to use their skills to the full; aiding their professional development). The sense of well-being generated by successful efforts to manage a critical issue provides a powerful positive feedback loop (the virtuous cycle), thereby further enhancing motivation to tackle critical issues in the future. The effects of the positive feelings further add to the sense of confidence that difficulties can be managed, raising motivation (Folkman & Moscowitz, 2007). Next we provide to our illustration, to bring the coping model to life.

Illustration

The following example of a vicious coping cycle concerned incompetence in the supervisor which was compounded by workload pressure and a strained working relationship with the supervisee: Due to staff shortages in her department, the supervisor had tried working faster. This led to her becoming uncharacteristically short-tempered, inflexible, and confrontational. Faster working impacted the supervision that she provided, which became brief and superficial. A critical issue then arose during a routine visit to the placement by a staff member from the supervisee's training programme (a clinical tutor). Feeling under time pressure, the supervisor had got into the habit of restricting her supervision to fleeting clinical oversight, through a quick discussion of the supervisee's progress with his patients. This aggravated the supervisee's sense of being devalued, and also prevented him from developing the key competencies that had to be demonstrated to progress within the programme. When the clinical tutor pressed the supervisor to explain her purely didactic approach, she became angry, denied that there was a problem, and argued that her approach was actually widely accepted (even though she had not attended a supervision workshop for several years). The meeting became increasingly