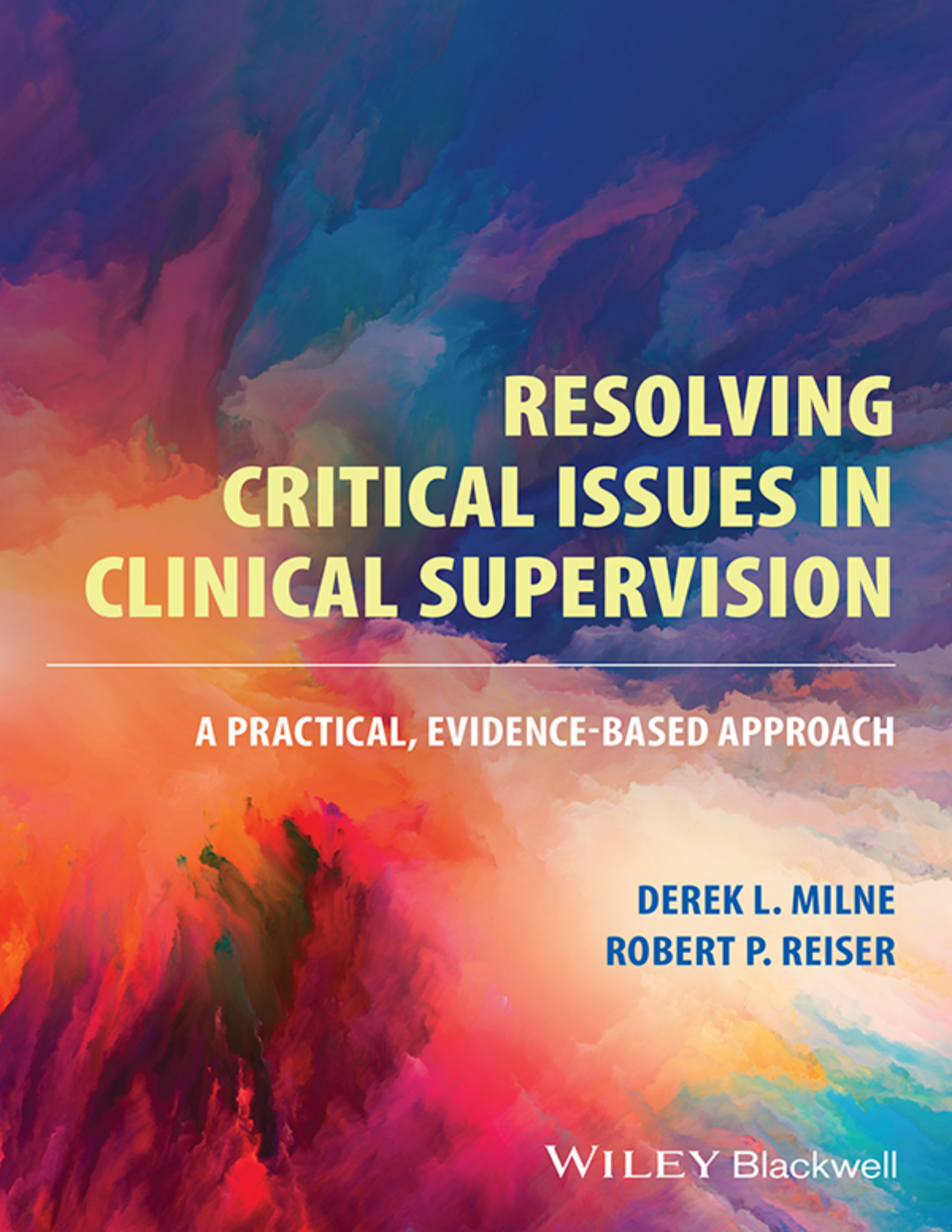




# **RESOLVING CRITICAL ISSUES IN CLINICAL SUPERVISION**

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**A PRACTICAL, EVIDENCE-BASED APPROACH**

**DEREK L. MILNE  
ROBERT P. REISER**

**WILEY** Blackwell

# **Resolving Critical Issues in Clinical Supervision**

## **A Practical, Evidence-based Approach**

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*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.*

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## 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.

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# 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 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 tensions (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.

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

| <b>Adverse triggering events</b>                                                                                                                                                | <b>Negative critical issues in supervision<br/>(see text for descriptions)</b>                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Faulty ‘design’:</b><br/>The wrong thing is</p> <ol style="list-style-type: none"> <li>1. planned or</li> <li>2. practiced unprofessionally by the supervisor.</li> </ol> | <p>Supervisor is unfit for practice: unethical, improper, or illegal acts by the supervisor; professional misconduct; incapacity (physical and mental); personality issues.</p> <p>Lack of due process (e.g., no supervision contract; unclear supervision parameters, such as evaluation).</p> |
| <p><b>Faulty ‘training’:</b><br/>Supervisor training is:</p> <ol style="list-style-type: none"> <li>3. done wrong (i.e., lacks adherence to the proper approach).</li> </ol>    | <p>Supervisor training is unfit for purpose: incompetence due to absent, inadequate or faulty training (or poor training transfer).</p>                                                                                                                                                         |

| <b>Adverse triggering events</b>                                                                                                                                                           | <b>Negative critical issues in supervision (see text for descriptions)</b>                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Faulty ‘delivery’:</b><br/>Supervision is:<br/>4. done incompetently by the supervisor<br/>(i.e., with a lack of proficiency).</p>                                                   | <p>Supervisor is unfit for purpose: supervision techniques, or relationship inappropriate (e.g., boundary violations; power struggles); complications (e.g., non-compliant supervisee).</p>                                                          |
| <p><b>Faulty ‘receipt’:</b><br/>Supervision has the:<br/>5. wrong effect on the supervisee<br/>(i.e., ineffective supervision plus supervisee factors prevent competence development).</p> | <p>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).</p> |

| <b>Adverse triggering events</b>                                                                                                                                   | <b>Negative critical issues in supervision (see text for descriptions)</b>                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Faulty ‘enactment’:</b></p> <p>The supervisee provides the:</p> <p>6. wrong treatment leading to the:</p> <p>7. wrong clinical outcomes with the patient</p> | <p>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.</p> |
| <p><b>‘Faulty workplace’:</b></p> <p>8. Faulty local management (i.e., flawed leadership)</p>                                                                      | <p>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.</p>                                                                                             |

| <b>Adverse triggering events</b>                                                                                                                                                                                     | <b>Negative critical issues in supervision (see text for descriptions)</b>                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>‘Faulty organisational system’:</b></p> <p>9. Flawed feedback systems<br/>(i.e., faulty information)</p> <p>10. Ineffective quality improvement systems<br/>(i.e., flawed attempts to improve healthcare).</p> | <p>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).</p> |

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

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