EVIDENCE-BASED CBT SUPERVISION

PRINCIPLES AND PRACTICE

SECOND EDITION

DEREK L. MILNE

Evidence-Based CBT Supervision

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This book is dedicated to my father, Alec Milne.
Like a good supervisor, he taught me to value
both evidence and experience.

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About the Author

Dr Derek L. Milne (BSc, MSc, DipClinPsych, PhD, C Psychol, FBPS) was a Consultant Clinical Psychologist with Northumberland, Tyne & Wear NHS Trust, and Director of the Doctorate in Clinical Psychology at Newcastle University in England, until his retirement in 2011. His previous experience included 12 years as a Clinical Tutor (Newcastle and Leeds Universities). Prior to this he also gained valuable experience in the roles of clinical supervisor, teacher, tennis coach, sport psychologist, mentor and as an action researcher (on staff development generally, but focusing on clinical supervision latterly). Since 1979 he has published 10 books and over 200 scientific and professional papers, many on staff development and supervision.

Preface

Preface to the First Edition

One of the fascinating aspects of writing this book on evidence-based clinical supervision (EBCS) has been to experience the interplay between theory and practice in clinical supervision at a personal level, as if writing this book was one great big learning exercise. This came about because I adopted the evidence-based practice framework, a broad approach to problem-solving which required me to repeatedly adopt alternating and rather different ways of understanding supervision. As a result, I spent a year revolving around an extensive experiential learning cycle, during the time that was devoted to preparing this book. Much of this period was occupied with discussions with experts in clinical supervision, in order to develop guidelines and to continue my own research programme. But there was also the protracted process of studying relevant theories and research findings in a particularly systematic way, whilst preparing and submitting some of the articles that are embedded within this book for peer review, in relation to publishing in scientific journals. This personal journey of discovery can be seen explicitly in some passages of the book (e.g. in Chapters 3 and 9), where my grasp of similar approaches, such as cognitive-behaviour therapy (CBT) supervision, challenged my assumption that EBCS was a distinct approach. Ultimately, I reasoned that EBCS was sufficiently distinctive to merit its own brand name. For example, by comparison with CBT supervision, EBCS has a wider range of theoretical roots, entails working explicitly with the supervisee's emotional material, draws systematic analogies with related literatures (especially staff development and therapy process–outcome research), and has broader objectives than CBT (e.g. educational goals, especially the development of 'capability').

I appreciated that these apparent distinctions may simply be differences of emphasis, as there would appear to be nothing in EBCS that is fundamentally contrary to CBT supervision. But careful scrutiny of the evidence from observations of CBT supervision and surveys of CBT supervisors indicated that EBCS really was different (Milne, 2008a). By the end of my year's adventure, I came to view EBCS as subsuming CBT supervision, as well as a range of related supervision models. This is largely due to its integrative, 'bigger picture' approach (i.e. seeking out the core psychological and social factors within supervision, based on a fairly general search). Indeed, the original title for this book was *The Psychology of Supervision*. Thus, I believe that EBCS is unique, but affords a suitable way of revitalizing CBT and related approaches to clinical supervision (i.e. modern professional practice; applied science).

The book aims to provide clinical supervisors, and those who support them, with the best-available evidence to guide their work (which is assumed to be primarily CBT in Britain), as practised within the mental health field. This includes empirical knowledge derived from the latest research, and guidance from expert consensus. Such material addresses the 'restorative' and 'normative' functions of supervision, but priority is given to the supervisor's 'formative' or educative role. The resultant material was also sifted and sorted by drawing on my 25 years of relevant experience, moderated by regular interaction with colleagues with a similar investment in developing supervision (at conferences, workshops, etc.). This includes the detailed feedback I received from the referees and editors of scientific and professional journals, as a result of submitting much of the original material in this book as research papers for peer review. Taken together, these aims and methods are intended to address a paradox in the supervision field. This is that, despite its manifest importance, supervision is a sorely neglected topic. As Watkins (1997) has put it, 'something does not compute' (p.604). This paradox has been a spur to my work, as reported in this book.

Based on this evidence-based process of attempting to make things compute, Chapter 1 reviews how supervision has been defined to date, offering a more rigorous definition, derived from a systematic review of 24 recent studies of effective clinical supervision. I describe this particular review approach, the best-evidence synthesis (and continue to draw on it in subsequent chapters). I also question the conventional historical account, which identifies Freud as the first to explicitly utilize and report clinical supervision. Rather, applying the definition of supervision precisely and

delving into pre-Freudian history, it seems to me that the Ancient Greeks got there first (again!). Chapter 2 summarizes the main types of models (conceptual frameworks) that are intended to help us understand supervision. They are mainly ones that are either based explicitly on therapies (where CBT is a strong example), or on developmental models, or are supervision-specific ones. In Chapter 3, I draw on these models to propose my own EBCS approach, which (following a critical review) then colours the remainder of the book. The important role of the learning alliance in supervision is recognized in Chapter 4, alongside some challenges to its creation and maintenance (i.e. the 'rupture and repair' cycle; power dynamics). The first of my four EBCS guidelines is introduced here. These guidelines were designed following the National Institute for Health and Care Excellence (NICE) methodology, but revised as necessary to make the approach as relevant as possible to supervision (what we termed the NICE(R) guideline development procedure). Over a hundred clinical supervisors and tutors helped to refine these guidelines. Chapter 5 sets out the supervision cycle, namely: conducting a learning needs assessment; negotiating the objectives (learning contract); utilizing different methods of supervision; and evaluating progress. Three EBCS guidelines are introduced in this chapter, as it is the heart of routine supervision. All four guidelines are part of the EBCS training manual, which is accessible from www.wiley.com/go/milne2e. The EBCS model has been represented physically as a tandem, according to which reasoning the front wheel of the bike is controlled by the supervisor. This then casts the rear wheel (and the back seat) as the supervisee's province, set out as the Kolb (1984) experiential learning cycle. Chapter 6 details this cyclical process, furnishing supportive evidence and illustrating how supervisees are essential collaborators in the business of supervision. But this tandem duo are insufficient to develop and maintain effective supervision within complex workplace systems, so Chapter 7 reviews the ways in which supervision can be supported, especially through the dominant intervention of supervisor training. Chapter 8 returns to the task of evaluation, offering the 'fidelity framework' as a coherent, step-wise way to view and practise the evaluation of supervision. Implementation issues are also addressed, in order to increase the likelihood that evaluation serves a useful purpose. In the ninth and concluding chapter I tease out the main principles of EBCS, adding reflective commentaries where there is unfinished business, such as the overlap between EBCS and CBT supervision, and I offer a specification for career-long supervision.

The method I've used to tackle these chapters has also been CBT compatible, as in adopting the evidence-based practice model (Roth & Fonagy, 1996), then using it as a framework to guide a process of scholarly review, featuring:

- critically analysing and constructively re-synthesizing the research literature;
- integrating research findings with knowledge from textbooks and from formal consensus statements by experts;
- relating this knowledge-base to the contexts in which supervision occurs (e.g. organizational and professional influences on supervision);
- reviewing the nature and effectiveness of supervisor training and support arrangements;
- comparing closely related approaches to supervision; and
- auditing the fidelity of supervision, and evaluating its results.

This method enabled me to draw out numerous practical implications, and to summarize a comprehensive approach to supervision as an applied psychological science. As a result, I believe that this book is original yet accessible, detailed yet coherent, critical yet constructive. It offers a rounded rationale and a systematic guide for evidence-based supervision, and, more generally, it offers a way of making the vital business of supervision 'compute' (Watkins, 1997). I hope that you will also enjoy the experience of discovery, as you read the book.

Preface to the Second Edition

It gives me great pleasure to present this new edition, which includes a substantial body of additional research findings that have been published since the 2009 edition. This literature has greatly strengthened and enriched the contents of this second edition (e.g. regarding measurement tools), broadening the content to reflect the growing field of clinical supervision. It is stronger because the research literature has continued to grow, sometimes buttressed by expert consensus (e.g. competence-based supervision; evidence-based training; outcome monitoring procedures). It is broader by incorporating far more on the restorative function of supervision (i.e. supporting supervisors emotionally), and by drawing on the expertise literature (including fresh theories of experiential learning).

Also, the passage of time, and not least my continued involvement in supervision since 2009, have also enabled me to review critically the material within the first edition. Like the first edition, this new volume also benefited from my engagement in extensive experiential learning. For the two years leading up to this new edition I was co-authoring (with Robert Reiser) a manual for evidence-based CBT supervision, complete with guidelines, video demonstrations and an extensive review of the best-available evidence (Milne & Reiser, 2017). This work included linked workshops with supervisors throughout the UK, including the guideline development work. The collaborative effort involved working with the British Association for Behavioural and Cognitive Psychotherapies (BABCP) on the design and broad strategy behind the manual. In effect, the two-year stint was like an action-research project, though with the greatest emphasis on reviewing the supervision literature. Some examples of this manual are included here, and this new edition has benefited greatly from that two-year effort. Specifically, that experience further developed and refined my understanding of the status and nature of evidence-based clinical supervision. As a result, this second edition adopts a cognitive-behavioural therapy (CBT) orientation to supervision, while still exemplifying the evidence-based clinical supervision approach. It is because of this more specific focus that the title of this second edition has become *Evidence-Based CBT Supervision*, as well as to try to signal the strong link to the above manual. In effect, this book provides a theoretical companion to the manual, offering a much broader review of the supervision literature. However, it retains the practical emphasis of the first edition, both in its tone and through again linking to supervisor training guidelines and other resources for developing and supporting supervisors.

The net result is a much improved statement of evidence-based clinical supervision, a distinctive and much-needed perspective required to guide the essential business of supervision within modern mental health services. All-in-all, this second edition represents a much more rounded account, portraying supervision as a mature and internationally recognized specialization within professional practice (Watkins & Milne, 2014).

Acknowledgements

As already touched on, the parallel between the experience of writing this book and the experience of supervision appears strong to me: I have grappled with some suitably challenging and perplexing material, learning much along the way, and have been supported and guided by those who have written about supervision (in texts, journal papers and consensus statements). I have also had the benefit of receiving encouragement and feedback from numerous colleagues, locally and nationally. I am grateful to the main local allies for their interest (Peter Armstrong, Helen Aylott, Nasim Choudhri, Tonia Culloty, Chris Dunkerley, Mark Freeston, Ian A. James, Dominique Keegan, Caroline Leck, Chiara Lombardo, John Ormrod, Roger Paxton, Alia Sheikh and Colin Westerman). Nationally, I have felt aided and influenced by Dave Green's DROSS group (i.e. the Development and Recognition of Supervisory Skills initiative, based in northern England, latterly rechristened STAR), by those colleagues who write about supervision (e.g. Joyce Scaife and Graham Sloan), and by my Clinical Tutor colleagues within the Group of Trainers in Clinical Psychology (GTiCP). I am grateful to them all for their collaboration, and for their encouragement to reflect on supervision as a serious academic topic. I am especially grateful to them for their help in developing the guidelines on EBCS (and please note that many additional individuals have had their input acknowledged within the original EBCS training manual, available from www.wiley. com/go/milne).

But the greatest regular impetus I should acknowledge was the stimulating interaction that arose through the EBCS consultancy that I provided to Californian Robert Reiser, during the year when I was writing the first edition of this book. This fortnightly engagement in listening to and discussing tapes of his ongoing supervision provided a vital practical dimension to the book, enlivening the theoretical information that I was

trying to process. As a consequence of this quasi-supervisory experience, I felt energized and supported, and learnt much about this young but essential field of professional practice. Since 2009 I have continued to collaborate with Robert Reiser over EBCS, and would like to thank him for his continued stimulation, general enthusiasm, and for specific help in commenting on revisions to some of the chapters in this second edition. Our intensive collaboration over the co-writing of the manual for evidence-based CBT supervision (Milne & Reiser, 2017) was another major inspiration for this second edition. Helpful comments and material towards this new edition were also received from Craig Gonsalvez, Russell Hawkins, Kieran O'Donoghue, Priya Martin, and Ed Watkins.

Learning is one thing, producing the goods is quite another, and so in relation to the first edition I must also acknowledge the massive assistance received from the secretarial staff at the Newcastle Doctorate in Clinical Psychology programme (Lynne Armstrong, Karen Clark, Kathryn Mark and Barbara Mellors); I am also grateful to Amy Lievesley, for acting as my 'production assistant' (i.e. obtaining articles and checking the manuscript) and Judy Preece (graphic artist, Newcastle University) for drawing many of the figures in the book. Assistance also took the form of grants from the Higher Education Academy (Psychology Network) and the British Psychological Society (Division of Clinical Psychology).

Finally, I must say a heartfelt thanks to my partner Jan Little for her steadfast and warm support, and to my daughter Kirsty for her unstinting encouragement and unfaltering belief. I hope that all these wonderful people will see in this book some worthwhile return for their much-valued help.

Derek L. Milne
Morpeth
Northumberland
31 December 2016

1

Recognizing Supervision

Introduction

Sitting squarely at the crossroads between professional development and professional practice, clinical supervision continues to cry out for study and enhancement. Clinical supervision is defined as 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 (Milne, 2007b). This definition is described later in this chapter.

Supervision merits scholarly attention because it helps to ensure safe and effective practice (Falender & Shafranske, 2004), partly by fostering treatment fidelity (Inman *et al.*, 2014), which in turn helps to maximize the outcomes for clients (Callahan *et al.*, 2009). It also offers support to supervisees (Knudsen *et al.*, 2008) and represents the foremost 'signature' method and most critical part (Watkins & Milne, 2014) 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 for Behavioural and Cognitive Psychotherapies: BABCP, see Latham, 2006) and is an accepted defence against litigation (Knapp & VandeCreek, 1997). Not surprising, then, that Britain's 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, 2004a). For such reasons, supervision has now achieved international recognition as a distinctive and essential professional role (Watkins & Milne, 2014).

Yet, in spite of its critical and 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; Ellis & Ladany, 1997) and narrow in focus (Milne & Reiser, 2016a). Russell and Petrie (1994, p.27) found this neglect 'alarming', and Watkins (1997) noted how this neglect simply 'does not compute' (p.604) with the important role supervision has in professional life. Since 1997 the number of papers on supervision has increased dramatically, but unfortunately the methodological weaknesses remain marked (Inman *et al.*, 2014). For example, there appear to have been five studies of supervision within the otherwise impressive Improving Access to Psychological Therapies (IAPT) programme: McFadyen *et al.* (2011); Newman-Taylor *et al.* (2013); Richards *et al.* (2013); Green *et al.* (2014); and Waller *et al.* (2015). This is disappointing, given that the cognitive-behaviour therapy (CBT) model that underpins IAPT is devoted to an empirical approach. But more worrying is the unsystematic nature of this research. Table 1.1 provides an illustration of the omissions within this small literature. By applying some important questions about these five studies (from the fidelity framework: see Chapter 8), and doing so leniently (see key to Table 1.1), it appears that none of these studies has conducted a thorough evaluation of supervision. In two cases there was reason to believe that supervision had even been implemented in a faulty manner. For example, in the McFadyen *et al.* (2011) study supervision only seemed to include one feature of IAPT supervision (agenda-setting); in the Waller *et al.* (2015) study there was poor attendance at group supervision. Furthermore, only one of these studies utilized a controlled research design (Richards *et al.*, 2013), and none of these studies manipulated supervision or employed direct observation. Indeed, the controlled study (Richards *et al.*, 2013) was focused on patients' clinical outcomes, with only passing mention of supervision (clarification that IAPT style supervision was included was only obtained by personal correspondence between the author and Professor Richards on 16 April 2015).

In relation to Table 1.1, it should be acknowledged that these studies had other important foci, and made an impressively rigorous job of analysing

Table 1.1 An illustration of the methodological weaknesses of supervision research.

Study	Right thing?	Right thing done?	Done right?	Right receipt?	Right outcome?
Green *et al.* (2014)	?	?	?	✓	✓
McFadyen *et al.* (2011)	×	?	✓	✓	?
Newman-Taylor *et al.* (2013)	✓	✓	✓	?	?
Richards *et al.* (2013)	✓	?	?	?	✓
Waller *et al.* (2015)	?	×	?	✓	✓

Key: ✓, clear claim or demonstration (any measure *or* qualitative data); ×, not right (some evidence of low fidelity); ?, not known: no data.

one or more of the fidelity criteria. For example, Richards *et al.* (2013) provided very rare and interesting information on the economics of therapy, including estimating the cost of supervision (£40.50 per patient). However, the overall conclusion I draw is that we still do not know if IAPT supervision works. Whilst there are rigorous clinical outcome evaluations that indicate that IAPT is an effective approach (e.g. Clark *et al.*, 2009; Richards & Suckling, 2013), as far as I know it has not been shown that IAPT supervision contributes to these outcomes. In short, the 'modicum of research' decried by Holloway and Poulin (1995) appears to still hold true more than 20 years later, even for a 'flagship' development like the IAPT programme.

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 inquiry 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, long-standing concerns that the practice of clinical supervision may generally be poor are difficult to dispel (Worthington, 1987; Binder, 1993). To illustrate the validity of such concerns from my own experience, $N = 1$ observational analyses of experienced CBT

supervisors have always indicated surprisingly low levels of competence at baseline assessments.

An Evidence-Based Framework for CBT Supervision

In order to address some of these concerns and to introduce a systematic approach, the present book adopts the evidence-based practice (EBP) approach and applies it to supervision, using an evidence-based clinical supervision (EBCS) framework to guide the development of CBT supervision (i.e. the best-available research, expert consensus and theory). In this sense, EBCS is a research and development rationale or practice development philosophy, similar to 'Best Evidence Medical Education' (Harden *et al.*, 1999), in that both treat professional development in a systematic way, based on the highest quality and most relevant research. It differs most markedly from intensively personal (humanistic) approaches to the development of supervision, which assert, for instance, that 'good supervision, like love . . . cannot be taught' (Hawkins & Shohet, 2000, p.195). As described in the next chapter, the EBCS framework is based on the use of a range of research activities, expert consensus and relevant psychological theories which address the development of 'good supervision' through the applied science of training.

The EBCS framework is therefore a specialized example of EBP (see Parry *et al.*, 1996), a prominent objective 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 (APA) has developed a policy for EBP (APA, 2006), and international scientific journals published in the USA have carried special issues to foster understanding and to promote EBP (e.g. see Thorn, 2007). Internationally, definitions differ minimally, as in the APA (2006) definition of EBP emphasizing individual and situational differences: 'Evidence-based practice is the integration of the best-available research with clinical expertise, in the context of patient characteristics, culture, and preferences' (p.273). The result of applying the EBCS framework leads to a firm theoretical basis in the form of a supervision model, a conceptualization called the tandem model. This model helps researchers to study supervision, and guides CBT supervisors in their practice, as described in the remainder of this book.

In practice, supervisors draw on the tandem model in making considered decisions in relation to supervisory events (e.g. how best to help the supervisee to formulate a client's presentation). Therefore, through the convenient and accessible tandem model, these decisions draw on a range of evidence, especially the best-available research evidence. This definition is explained and elaborated in Chapter 3. For example, Figure 3.4 indicates how research is supplemented by relevant theory and by expert consensus statements, and so on. The EBCS framework is integrative in nature, so the evidence-base is not restricted to material from CBT supervision, and not even to material within clinical supervision, drawing judiciously on evidence from neighbouring literatures (e.g. research findings on feedback from the educational literature). The EBCS framework also integrates practice-based evidence (PBE) alongside EBP (Barkham *et al.*, 2010). Figure 3.4 sets out the EBP framework of Parry *et al.* (1996), adapted only slightly by replacing 'therapy' with 'supervision'. This EBCS framework helps to clarify the different factors that we should consider in relation to supervision, together with the way that they should relate to one another, so as to develop supervision (e.g. the relationship between research findings and professional consensus on what represents best practice). As the guiding rationale, the EBCS framework underpins this book, as summarized shortly under the 'Aims' section, and as detailed in Chapter 3.

On this definition, EBCS could take a number of forms, provided that there was an evidence-base. In this book I adopt a CBT orientation, so I selectively attend to the research and other evidence of most relevance to that approach, and I emphasize how a CBT supervisor might best practise CBT supervision. This is why the book is called 'evidence-based CBT supervision'. Perhaps one day someone will write a book called 'evidence-based systemic supervision', drawing on the evidence that is appropriate for that theoretical orientation. Thus, whereas the first edition of this book avoided adopting a theoretical orientation, this second edition adopts a CBT model, but other models could in principle be developed in this way. The resulting nature of evidence-based CBT supervision is described more fully in Chapter 3.

The extent to which CBT supervision can properly be described as 'evidence-based', given the much-lamented state of the research literature, is discussed in the final chapter. For now let me say simply that my EBCS strategy is to highlight seams of better quality supervision research using the 'best-evidence synthesis' approach to the systematic review, as illustrated below in relation to defining supervision (Milne, 2007b). As already noted,

this selective approach is combined with extensive reference to several neighbouring research literatures, for relevant theories (e.g. leadership), and for evidence-based methods or specific technical details (e.g. how exactly to provide feedback). These findings are interpreted in the light of professional and expert consensus statements, and by means of relevant theory (e.g. lifespan development: see Chapter 3 for a full rationale). My belief is that this can provide a satisfactory evidence-base for the current implementation of policy directives, moving CBT supervision into the era of evidence-based practice.

A result of this EBCS development process has been the clarification of a model of supervision, the 'tandem' model (Milne & James, 2005), also described in Chapter 3. The theoretical foundation is 'experiential learning', broadly as summarized by Kolb many years ago (1984), but still endorsed within the mental health professions (e.g. the BABCP, see BPS, 2003; Lewis, 2005). As detailed in Chapter 3, and in keeping with the evidence-based approach, the emphasis on Kolb (1984; 2014) has been reduced in this second edition, replaced by reference to recent empirical accounts of experiential learning. This is appropriate, as clinical supervision is primarily a form of experiential learning (Carroll, 2007). However, I still draw on Kolb's (1984; 2014) experiential learning model, because it offers some helpful details that can be missing from recent research. In particular, I have retained the fundamental idea that supervisees acquire competence by learning from practical experience, and that this learning results from the necessary combination of five learning modes: reflection; conceptualization (thinking); planning; experimenting; and experiencing (feeling and doing). According to this view, professional competence is achieved most efficiently when the supervisee is given regular opportunities to use all five modes in a balanced or integrated way. Drawing on this theory and on the most recent research literature, it appears that the supervisor needs to use a range of methods to succeed in enabling the learner to utilize these different modes of experiential learning (Milne & Reiser, 2014). 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 skills and its clinical effectiveness. Chapter 8 elaborates this argument, in

discussing the evaluation of supervision. Several studies that I conducted with collaborators have indicated the value of this model for the development of supervision, and they are described later in this book (especially in Chapter 6), together with related research, theory and expert consensus. In summary, according to the tandem model, effective and competent supervision will be characterized by the use of a range of supervision methods (e.g. collaborative goal-setting), ones selected by the supervisor in order to increase the supervisees' use of these five learning modes (i.e. a structural and a functional definition of effective supervision, respectively), and consequently their capacity to work competently, safely and effectively.

Chapter 3 also contains a discussion of what makes the tandem a distinctive CBT supervision model, deriving as it does from a systematic, EBCS framework (as opposed to the therapy-based approach in CBT supervision; Milne, 2008b). The supervision methods should be selected intelligently, partly in a responsive way to best meet the supervisees' learning needs as they unfold (e.g. to address a weak grasp of a relevant therapy technique); and partly to blend these methods to obtain the best results (e.g. following the explanation of a technique with a demonstration). The success of such responsivity and blended training should then be judged by the supervisees' use of the learning modes, which in turn should result in learning episodes and the improvement in the targeted competencies.

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 inquiry dramatically highlighted how the traditional trust placed in doctors needed to be replaced by systems for monitoring competence and for providing relevant training, amongst other things (such as effective quality-control procedures within professionals' organizations; Smith, 1998). Supervision would logically form a central part of that training, and should draw on any monitoring data. There is reason to fear that some supervisors also practice in harmful ways. In a survey of 363 multidisciplinary supervisees in the

USA, Ellis *et al.* (2014) reported that 35% of these supervisees reported currently receiving harmful supervision, such as emotional or physical harm, for instance through negligence or by violating professional standards.

It is unfortunate that supervision is a neglected research topic, despite considerable investment in staff development. In the UK alone, the Department of Health spends about £2 billion per year on the training of clinical staff (Department of Health, 2000). In 2007, this 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 practical investment that healthcare providers like the National Health Service (NHS) make in staff support and development. This investment was justified within a modernization agenda in which the development of the workforce was emphasized (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 (for a thorough review of these policy refinements see Gray, 2006). 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, 2004a, p.35). More generally, 'recognizing the importance of supervision and reflective practice' (p.18) became one of 'the ten essential capabilities' (Department of Health, 2004b), and a core national standard was that 'clinical care and treatment are carried out under supervision' (Department of Health, 2004c, 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 (BPS, 2007). 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', within a system that raises the importance of training to be 'core business' (Department of Health, 2007, pp.26–27). 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. According to the Care Quality Commission (2013, p.6):

> Clinical supervision has been associated with higher levels of job satisfaction, improved retention, reduced turnover and staff effectiveness. Effective clinical supervision may increase employees' perceptions of organizational support and improve their commitment to an organization's vision and goals. It is one way for a provider to fulfil their duty of care to staff. Importantly, clinical supervision has been linked to good clinical governance, by helping to support quality improvement, managing risks, and by increasing accountability.

Because of such considerations, the Care Quality Commission (2013, p.6) added that 'Clinical supervision is considered to be an essential part of good professional practice by a range of different professional bodies.'

Therefore, although there are concerns about the generally poor quality of research on supervision, there is a markedly greater emphasis on the professional importance of supervision, both in developing initial competence (so that trainees become qualified as independent practitioners), and as a major way to ensure CPD. But next I want to try to understand how we arrived at 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 working to the required standard? It appears that

the first faint examples of clinical supervision date from the eighteenth century, when charity workers and philanthropists within European charity organizations provided moral treatments to the poor and sought to ease their poverty (Harkness & Poertner, 1989). Over time, the training of staff and 'friendly workers' (volunteers) in such organizations became increasingly formal, including more systematic approaches to education and supervision ('overseers'), and with it the emergence of the profession of Social Work (White & Winstanley, 2014). Perhaps for this reason, Social Work has remained one of the most impressive disciplines in fostering the practice of supervision, as indicated by Kadushin's (1976) noble efforts to professionalize supervision.

The next development appears to have been the training clinics in psychology, dating back at least to the late nineteenth century, when Witmer (1907) utilized 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 (2007) 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 organize their own programme of professional development. In the USA, it was not until 1945 that training in clinical psychology was formalized 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 were supposed to acquire clinical skills in diagnosis and therapy under 'close individual supervision' (Shakow, 2007, p.7).

It appears that the first clear-cut example of clinical supervision for mental health problems arose in Freud's 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 (1936), 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 workings of the unconscious mind. It soon became established that, for psychoanalysis to be successful, the therapist first needed to undergo psychoanalysis. By 1922, it was further established that 'only those persons should be authorized to practice 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 organizing 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.

In summary, 'almost from the beginning of organized 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 clinical 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).

While research on therapy dates from the 1940s, research on supervision first appeared in the 1950s (Bernard & Goodyear, 2014). I next bring this review up to date, drawing carefully on the research available at the start of the twenty-first century to address another important building block for supervision, its proper definition.

The Definition of Clinical Supervision

It is evident even from these historical accounts that supervision was a complex intervention, defined and practised in a wide variety of ways. To this day there remain significant differences in what is meant by the term 'supervision', resulting in a surprisingly diverse range of practices. 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 (2014). According to them, supervision is:

> an intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning 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 the particular profession the supervisee seeks to enter (p.9).

The evidence that this definition is widely embraced in the USA is indicated by its acceptance within a consensus statement (Falender *et al.*, 2004) and in the *Handbook of Psychotherapy Supervision* (Watkins, 1997).

However, numerous prior reviews have noted that such definitions of supervision are problematic (e.g. Lyth, 2000; Hansebo & Kihlgren, 2004; Milne, 2007b). Additionally, surveys of practitioners indicate that they are unclear over the nature and purposes of supervision (e.g. Lister & Crisp, 2005). There are related challenges for researchers. To illustrate, Ellis *et al.* (1996) 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 readily be manualized or replicated. In turn, this hampers the interpretation of results from research, and the clarification of practice implications.

For these kinds of reasons, I conducted a systematic review in order to develop an empirical definition of clinical supervision, building on the

above definitions in an integrative, constructive fashion (Milne, 2007b). In the first part of that review I examined the logical requirements of a sound definition, then looked hard at a carefully selected sample of successful supervision studies. These steps are now summarized.

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*, 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 (*Concise Oxford English Dictionary*, 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 within an empirical, science-informed approach is to suitably operationalize the key relationships in the model, so that appropriate forms of measurement are planned.

To emphasize this point, consider the summary provided in Table 1.2. This sets out supervision following the specification provided within four illustrative texts. 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 working alliance or 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'? In addition, Table 1.2 presents a disappointing picture in relation to whether the variables that each of these four 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: 'operationalization'. 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 delimit 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 operationalization 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 is discussed and illustrated with supervision research in Chapter 8.

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 1.2 satisfied any of the three evidential criteria. For example, no mention is given to supportive