Using solution-focused techniques in clinical supervision

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This article outlines the concept of solution-focused clinical supervision, which offers a simple yet profound philosophy and structure for the supervisory relationship. Solution-focused clinical supervision makes the assumption that the supervisee has the answers within her or himself; focusing on their effective patterns of behaviour uncovers this.

The aim of incorporating solution-focused techniques into clinical supervision is to enhance the supervisor's range of options with which to help the supervisees to move forward positively. As the name suggests, 'solution focus' is about looking for solutions rather than dwelling on problems (Iveson, 2002). At the heart of solution-focused work is what Waskett (2006) calls 'spacious simplicity' - a simplicity that comes from a basic attitude of mutual respect; combined with the intention of moving forward positively (Fowler, 2005). There are a number of ideas and techniques used within solution-based therapies that are applicable in the supervisory relationship. These include (George et al, 1999):

- The use of scales;
- Focused questions;
- Looking for exceptions;
- Constructive feedback;
- Follow-up tasks.

These techniques assist the clinical supervisor to engage collaboratively with supervisees, encouraging reflection on practice and a focus on solutions. The supervision relationship is based
on mutual respect and equality that encourages openness and honesty, and an opportunity to reflect on work-related issues in a safe and non-judgemental environment (Box 1).

**Background**

In 1993, the Department of Health published a strategic document, *A Vision for the Future*. This aimed to give overall direction and focus to the contribution that nurses and midwives could make to the NHS. It was the first time that the term 'clinical supervision' had been used in a way that implied the introduction of a systematic structure. The document described clinical supervision in broad terms that included development, individual responsibility, consumer protection, self-assessment and reflection. From a professional perspective the NMC has recently updated the original (UKCC, 1995) guidance, which identifies the aims of clinical supervision as (NMC, 2006):

- To identify solutions to problems;
- To increase understanding of professional issues;
- To improve standards of patient care;
- To further develop skills and knowledge;
- To enhance the person's understanding of her or his own practice.

A generally accepted umbrella definition of clinical supervision is that given by Butterworth et al (1998) as 'a process that promotes personal and professional development within a supportive relationship'.

However, many trusts have developed clinical supervision to meet their specific circumstances and often refocus clinical supervision with a specific aim. In the case of Leicester City West PCT this aim was identified as follows: to enable staff to meet together in a regular and structured way to reflect upon issues that arise from their own professional work and move forward positively (Fowler, 2005). Note the emphasis that Leicester included about 'moving forward positively'.

**Models of clinical supervision**

In the early 1990s, a number of accounts described how clinical supervision could work, or was working, in a variety of clinical settings. Different models of clinical supervision began to emerge. At the more humanistic end of the spectrum, Faugier (1992) described a growth and support model of the supervisory relationship. This focuses on first the relationship between the individuals. Then, using the interactions within the relationship, it looks at the role of the supervisor to facilitate both educational and personal growth for the supervisee. At the same time, the relationship must be one that provides support for the developing clinical autonomy of the supervisee.

From a more behaviourist perspective, Nicklin (1995) argued that clinical supervision would become rhetoric, promoting the illusion of innovation without producing change. While supporting the developmental elements, he felt that tangible outcomes are required. He proposed that clinical supervision be used to analyse issues and problems, clarify goals and identify
'strategies for goal attainment and establish an appropriate plan of action'. Nicklin (1997) developed these ideas into a six-stage process of supervision. Focusing on practice, it starts with practice analysis, followed by problem identification, objective-setting, planning, implementing action and evaluation.

Solution-focused clinical supervision identifies with both the humanistic and behavioural models, in that it values the enriching humanistic relationship that enhances growth and development, while at the same time using that relationship to help the supervisee to move forward in a positive step-by-step way. In practice, very few supervision relationships would reflect a pure humanistic or pure behaviourist model of working. Human relationships are far too complex (Byrne, 1998) to encapsulate them into narrow boxes.

What can be seen in practice is that some people work more predominantly towards one end of a spectrum than others. Solution-based clinical supervision suggests, however, that these two models are not mutually exclusive. It promotes the idea that a warm, genuine and trusting relationship used to help a person focus on achievable, positive outcomes is an extremely powerful way to help people move forward.

**Solution-focused brief therapy**

Solution-focused brief therapy was developed as a therapeutic technique in the 1980s, by de Shazer (1985) as an option falling within the umbrella of 'talking therapies'. As the name suggests, the approach is about being brief and focusing on solutions with a minimal emphasis on problems. Attention is devoted to developing the person’s idea of:

- A preferred future or goal;
- Discovering the resources needed in order to achieve this.

As a 'talking therapy', a solution-focused approach can be an effective intervention for a range of problem presentations in a variety of contexts (Iveson, 2002). It consists of several techniques that a helper can use to assist people in identifying existing skills, strengths, resources and goals. These techniques include the use of scales, the miracle question, searching for exceptions, constructive feedback and follow-up tasks.

An area that lends itself well to the application of these techniques is that of clinical supervision. The techniques, if used within clinical supervision, help the supervisor to engage collaboratively with supervisees, encouraging reflection on practice and focus on achievable, positive solutions.

**Framework for clinical supervision using these techniques**

The following questions encourage the supervisee to give self-affirmative, constructive feedback:

- So what did it take to do that?
- What helped you to achieve that?
- How did you do that?
- How did you get through that time/experience/deal with that difficulty?
- What did you learn about yourself managing to do that?
- What do you think that that might have taught others about you?

When identifying the supervisee's skills, strengths and resources, the supervisor adopts the stance of a curious inquirer. For example, being interested about how she or he managed a particular situation, despite the difficulties faced, enables the supervisee to acknowledge their ability to identify the skills used in order to have discovered that particular solution.

Although solution-focused clinical supervision uses some core techniques, it is not just a collection of these techniques used in a routine, dehumanised way. They are tools that should be used within a mutually respectful relationship. It is the genuine respect for the person combined with the reinforcement of her or his own ability to move forward positively. The role of the supervisor is to help the supervisee realise her or his strengths and existing ways of coping and then to help the person build upon these strengths (see box 1). There are a number of techniques that can help the supervisee focus on the positive.

One of the techniques is the 0-10 scale, where 10 represents absolute best achievement of the supervisee's goals and zero is the worst-case scenario. The person uses the scale to assess her or his current position. Their satisfaction with this position can be determined and she or he is also able to identify their preferred position. An example of this in supervision can be seen in Box 2.

In addition to scales, use of the 'miracle question' can determine preferred futures or goals. Focusing on a particular aspect of the supervisee's work, the question is asked as follows: 'If you went to sleep tonight and a miracle occurred what would be the first thing you would notice?'

Asking 'What else?' several times elicits the finer detail of the person's preferred future. The supervisee is then encouraged to consider: 'Are there times when some of the preferred future already happens?' This can help them to realise that there are times when a problem does not occur and identify what is different at those times. Those 'differences' can then be the key to developing actions and behaviours for future action.

The supervisee is encouraged to consider if there are times when some of the miracle is already happening (exceptions) and enables the preferred future to be identified. This can help them to realise that there are times when a problem does not occur and identify what is different at those times and what is already working. Asking 'What else?' several times elicits the finer detail of the supervisee's preferred future (see www.northwestsolutions.co.uk/questions-res.html for a full narrative example).

Subsequent sessions again focus on solutions rather than problems. Asking 'What is better?' at the beginning of a session, as opposed to 'How are things?' encourages the person to focus on positives aspects of their practice. At the end of each supervision session, the supervisor provides a summary of the supervisee's strengths, skills and resources. It is the supervisor's role to provide this feedback based on what they have heard. The importance of adopting good communication cannot be overemphasised. The following are important (see box 3 for a further example in practice):
• Listening with a constructive ear for evidence of resources, for example skills, strengths, supportive relationships;

• Acknowledgement of the issue or difficulty being discussed;
• Encouragement - actively showing interest and encouraging the supervisee to continue;
• Noticing and naming - involves feeding back the skills, strengths and abilities that emerge during the session;
• Scaling - using scales from 0-10 as described above.

Appropriate use of questions can aid communication and exploration, enabling the supervisee to be specific:

• Questions which are likely to draw out resourceful answers;

• Questions that lead to exploration;
• Questions of who, where, what, when, how;
• Questions that focus on one point at a time;
• Questions that encourage imagination of new behaviour, new self-image

(George et al, 1999).

Conclusion

Solution-focused clinical supervision provides a structured framework that can be used by a range of practitioners to help colleagues reflect on their practice and enhance their existing skills, moving forward in a positive way.

References


Obtained from http://www.nursingtimes.net/nursing-practice-clinical-research/using-solution-focused-techniques-in-clinical-supervision/199240.article