John Heron’s six-category intervention analysis: towards understanding interpersonal relations and progressing the delivery of clinical supervision for mental health nursing in the United Kingdom

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Aims. This paper provides a critique of how Heron’s six-category intervention analysis framework has been adopted by nursing in the United Kingdom (UK) as a theoretical framework in nursing research and model for clinical supervision. From this, its merits as an analytic framework and model for clinical supervision in nursing are discussed.

Background. Heron’s six-category intervention analysis has been acknowledged as a means by which nursing could develop its therapeutic integrity. It has also been used as a theoretical framework in nursing research focusing on nurses’ perceptions of their interpersonal style. More recently descriptions of this framework have been proposed as a structure for clinical supervision. However, its use as a theoretical framework to underpin research investigating the interpersonal skills of nurses and as a model of clinical supervision must firstly be scrutinized.

Findings. Returning to Heron’s original description and comparing this with its current adoption in the UK, misconceptions of this framework can be identified. Its value as an analytic tool investigating interpersonal relations in nursing has still to be evaluated. Furthermore, nursing’s emphasis on certain intervention categories has undermined the potential potency of this framework and its contribution as a model for clinical supervision in nursing.

Conclusion. We argue that Heron’s six-category intervention analysis as a framework to investigate the interpersonal competence of nurses, particularly mental health nurses, requires investigation. This, in turn, would provide an opportunity to challenge the framework’s theoretical standpoint. In addition to its value as an analytic tool, all six categories of Heron’s framework have equal relevance to its contribution in nursing as a supervision model.

Keywords: clinical supervision, interpersonal relations, theoretical frameworks, analytic tools, mental health nursing, therapeutic, six-category intervention analysis
**Introduction**

The utility of John Heron’s six-category intervention analysis as a framework for nurses in the United Kingdom (UK) to guide their interpersonal skills has been re-examined recently (Ashmore 1999). Since 1975 the model has been influential in helping psychiatric/mental health nurses to develop a framework for their interactions with patients (Chambers 1990). In addition to its clinical application, the six-category intervention analysis has been incorporated into research as a theoretical framework for investigating nurses’ perceptions of their interpersonal skills (Burnard & Morrison 1988, 1991, Morrison & Burnard 1989, Ashmore & Banks 1997). More recently, it has been put forward as a suitable model to guide the delivery of clinical supervision in nursing (Chambers & Long 1995, Fowler 1996, Cutcliffe & Epling 1997, Driscoll 2000a). As well as being appropriate to a diversity of nursing contexts, a range of other professional groups including medicine, social work, business and management and the police force now integrate this approach to their work (Chambers 1990).

This paper will offer a critical review of how Heron’s model has been used as a theoretical framework for studying nurses’ interpersonal skills and as a model of clinical supervision for nursing in the UK. From this, its value as an analytic tool investigating interpersonal interactions in mental health nursing will be highlighted. First, a description of the six-category intervention analysis is necessary.

**Heron’s six-category intervention analysis**

Heron’s six-category intervention analysis is a conceptual model initially developed to progress the understanding of interpersonal relations, specifically to assist in the delivery of interventions within a helping paradigm. This interpersonal relationship was described as taking place between a practitioner and client. According to Heron’s (1975) first description of the model, a practitioner is anyone who offers a professional service to a client, so the term refers equally to doctor, psychiatrist, psychotherapist, nurse, lawyer, and teacher, for example. The client is the person choosing to involve him- or her-self in the service that the practitioner is offering, in order to meet a need the client has identified. This primary account of practitioner and client roles can, however, be extended.

In the first extension the terms ‘practitioner’ and ‘client’ can be applied in formal, occupational settings, where two people in any organization relate to each other in terms of their work roles, and where one person intervenes with another. Hierarchically, in line-management terms, they can be on either the same or different levels. Interventions in this context may be about work, discipline, career advice, or even about personal matters that have some impact on work (Heron 1989). In the second extension, the terms ‘practitioner’ and ‘client’ can be applied to non-formal and non-professional settings, whenever one person is assuming an enabling role for another, for example, from one friend to another, lover-to-lover, colleague-to-colleague. In each of these interactions one person is the listener or facilitator and the other is the talker, the one dealing with some specific issue. From these descriptions it appears that Heron’s framework might be a useful structure for the delivery of clinical supervision in nursing.

Heron’s six-category intervention analysis progressed from the work of Blake and Mouton (1976). Their diagnosis and development matrix comprised five categories: acceptant, catalytic, confrontational, prescriptive, and theories and principles. The focus of intervention between Blake and Mouton (1976) and Heron (1989) does vary. Heron (1989, p. 7), when describing the work of Blake and Mouton (1976), tells us: ‘Their focus is primarily on interventions in organizational life by organizational development consultants. Mine is primarily on one-to-one interventions from practitioner to client.’ Blake and Mouton’s (1976) matrix was intended therefore for the analysis of interventions made in management consultancy, whereas Heron’s framework is concerned with one-to-one interventions between a practitioner and a client during a variety of helping exchanges. Interestingly, Loganbill et al. (1982) have written a comprehensive description of a conceptual model for clinical supervision which has also been developed from Blake and Mouton’s (1976) diagnosis and development matrix.

In Heron’s framework the six categories are prescriptive, informative, confronting, cathartic, catalytic and supportive, and he subdivides these into authoritative and facilitative interventions (Table 1). Authoritative interventions are those that enable the practitioner to maintain some degree of control in the relationship, whereas facilitative interventions allow the locus of control to remain with the client. Heron (1989, p. 12) states:

Authoritative interventions are neither more nor less useful and valuable than the facilitative ones. It all depends on the nature of the

<table>
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<td>Prescriptive</td>
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practitioner’s role, the particular needs of the client, and what the context or focus of the intervention is... It is the specific concrete context that makes one intervention more or less valuable than another - nothing else.

While Heron (1989) claims that the six categories are exhaustive of the major sorts of intervention any practitioner needs to offer in relation to clients, he points out that the list of interventions for each category is not exhaustive. Instead, he offers a comprehensive catalogue of interventions for each category. The following examples, adapted from Heron (1989), show how each of the categories could be used during clinical supervision.

Prescriptive interventions seek to influence and direct the behaviour of the client and include offering advice and making suggestions. For example,

Supervisee: ‘I don’t know what to do with this client or if what I’m doing is helping?’

Supervisor: ‘Well, I think you should ask them what they have found helpful.’

This is an example of a commanding prescriptive intervention. The clinical supervisor is using their full authority and in a commanding manner is directing the supervisee to do something, with no consultation before or after the command.

To be informative is to offer information or instruction. Heron (1989, p. 38) states that ‘informative interventions seek to impart to the client new knowledge, information and meaning that is relevant to their needs and interests’:

Supervisor: ‘Here are some handouts I’ve prepared following our last discussion. They cover useful questions to ask someone presenting with panic disorder. I also think the Adrian Wells’ book would be useful’.

Confronting interventions directly challenge the rigid and maladaptive ways that limit the client. A confronting intervention tells an uncomfortable truth ‘but does so with love, in order that the client concerned may see it and fully acknowledge it’ (Heron 1989, p. 45). For example,

Supervisee: ‘I should have done more work with him. I didn’t do enough.

Supervisor: ‘I hear you beating yourself up again. You seem to have this unwritten set of rules which dictate what you should be doing, and stop you from seeing some of the other stuff you do. It’s as if you don’t notice your full contribution to their care. Does this ring bells for you?’

Cathartic interventions assist the client to abreact painful emotion, for example, grief, fear and anger. The interventions are pitched at a level of distress which the person is ready to deal with. Interestingly, Heron (1989) claims that cathartic and confronting interventions are those on which participants at his workshops rate themselves weakest. In the following example the clinical supervisor gives the supervisee permission to let go of strong emotion relating to her nursing care:

Supervisee: ‘He just seemed (long pause) so distressed by it all and I didn’t know whether to stop or carry on (eyes filling up’).

Supervisor: ‘Talking about this now seems really tough (brief pause) but I want to help you with this and I don’t want you to worry about being upset (medium pause). Can you tell me some more about what happened?’

Catalytic interventions include encouraging further self-exploration, self-directed living, learning and problem-solving in the client. The use of open questions is a useful starting point for such exploration:

Supervisor: ‘What might you suggest that would help her in dealing with this conflict?’

Lastly, to be supportive is to validate or confirm the worth of the client’s person, qualities, attitudes or actions (Heron 1989):

Supervisor: ‘You have provided excellent care for these clients. Tell me how you might celebrate your achievements?’

Heron’s (1975) model for interpersonal relations did not develop from empirical research. Since its introduction there have been few studies that have attempted to validate its theoretical propositions. Instead, Heron (1990) argues that the overall legitimacy of his framework is a matter of on-going experiential research. To date, few studies have used the six-category analysis to underpin research in the area of interpersonal relations. Yet it appears to hold some value in being incorporated in these types of investigation, particularly in the context of nursing. Heron (1989) emphasizes: ‘The six categories per se and the sorts of interventions that fall under them do not entail any particular theoretical perspective coming from any school of psychology or psychotherapy’ (p. 15). This has relevance for mental health nursing, as the possibility of dissonance between the practitioner’s therapeutic orientation, for example, solution-focused-brief therapy and the categories in Heron’s framework, is minimized (Chambers 1990). Heron suggests: ‘Indeed they could be used as an analytic tool to compare and contrast the therapeutic practice of different schools’ (Heron 1989, p. 15).

Thus, this framework could be used to investigate the delivery of interpersonal transactions used by mental health...
Nurses’ interpersonal skills

Heron’s interpersonal framework has been used in research to study UK nurses’ perceptions of their interpersonal skills. Two studies (Burnard & Morrison 1988, 1991) involved qualified general nurses, while Morrison and Burnard (1989) focused on nursing students. In all of these investigations participants were asked to rank order the six-category items in response to how skilled they perceived themselves to be generally (Burnard & Morrison 1988), or when working with patients (Morrison & Burnard 1989, Burnard & Morrison 1991). The rank order supportive, informative, prescriptive, catalytic, cathartic, and confronting was generated in all three studies. That is, these nurses perceived themselves as more skilled in using supportive (facilitative) and informative (authoritative) and prescriptive (authoritative) interventions and less skilled in using catalytic (facilitative), cathartic (facilitative) and confronting (authoritative) interventions. Burnard and Morrison (1988) acknowledge, as possible limitations of these studies, the difficulty in identifying participants’ therapeutic intentions after the event, subject bias and the use of a forced choice ranking exercise.

A more recent study (Ashmore & Banks 1997) used the same research instrument described by Burnard and Morrison (1988, 1991) and Morrison and Burnard (1989) in an attempt to test the reliability of Burnard and Morrison’s earlier findings with student nurses. They also hoped to make comparisons between their own study of qualified staff and Burnard and Morrison’s (1991) study. A convenience sample of 311 student nurses undertaking a Project 2000 diploma course was introduced to Heron’s six-category framework. Each student was then asked to rate themselves on each of the six categories to correspond with how skilled they perceived themselves to be when interacting with patients. The rating scale procedure devised by Burnard and Morrison (1991) was followed. The student nurses perceived themselves as most skilled in the use of supportive, prescriptive and cathartic interventions and least skilled in informative, catalytic and confronting interventions. Thus, students from a Project 2000 course perceived themselves to be more skilled in more facilitative interventions than authoritative ones, a change from previous findings.

It is notable that in all the previously mentioned studies what has been identified has been nurses’ self perceptions of how skilled they are in the use of interventions from Heron’s framework. The results may have been influenced by participants’ relationship with the researchers (subject bias). That is, were these nurses’ responses to the rating scale being influenced by the researchers and so they rated themselves high on supportive, prescriptive and cathartic interventions because that seemed to be the ‘right’ thing to do? Alternatively, a limited understanding of the interventions in each category may have influenced their responses. Ashmore and Banks (1997, p. 338) inform us that: ‘Respondents were introduced to Heron’s six-category intervention analysis, a brief description being given of each of the categories followed by a period of familiarization and clarification.’ A brief explanation of this detailed and complex framework could result in various misunderstandings. Ashmore and Banks (1997) do question the accuracy of these self-perceptions in relation to actual everyday clinical nursing skills competence. Nonetheless, data obtained from practitioners’ everyday clinical practice would have been a valuable addition in this study and would have enhanced the validity of the results.

The significance of findings from previous studies has been limited as a result of using only participants’ self-perceptions. As highlighted by Heron (1989), this framework has the potential as an analytic tool to explore practitioners’ actual interpersonal behaviours in specific work-related contexts. So far, nursing and particularly the mental health specialty have overlooked the value of Heron’s model in researching nurses’ interpersonal style in their everyday work. This framework may help to uncover what goes on in the day-to-day work of mental health nurses. Using the framework in this manner would also provide an opportunity to challenge its theoretical assertions. For example, can a helping exchange be confined to only one of the six categories and can all helping exchanges be subsumed into six domains?
Clinical supervision in nursing

If consideration is given to some of the current descriptions of clinical supervision found in nursing, the essential components seem transparent. For example, it has been defined as ‘a dynamic, interpersonally focused experience which promotes the development of therapeutic proficiency’ (Community Psychiatric Nursing Association 1985, p. 4), as ‘an interpersonal process where a skilled practitioner helps a less skilled or experienced practitioner to achieve professional abilities appropriate to their role, and at the same time offer counsel and support’ (Barber & Norman 1987, p. 56) and as ‘an exchange between practising professionals to enable the development of professional skills’ (Butterworth & Faugier 1992, p. 12). At its core is a significant relationship demanding command of a high level of interpersonal competence. Unfortunately, many current supervision models cited in the nursing literature would appear deficient in this focus and omit clarification of their essential attributes. Nursing is not alone. Within the psychotherapy literature, Leddick and Bernard (1980), Bernard and Goodyear (1992) and Watkins (1998) allege that clinical supervision research has been handicapped because the supervision models available lack clarity in their structure. Over the last 5 years there has been a gradual increase in the number of supervision models being described for nursing in the UK. Some are original contributions; others are appropriations of existing templates. These include Proctor’s Three-Function Interactive model (Faugier & Butterworth 1994, Jones 1995), a Practice-Centred model (Nicklin 1997), a Problem-Focused model (Rogers & Topping-Morris 1997), Faugier’s Growth and Support model (Faugier & Butterworth 1994), a Double Helix model (van Ooijen 2000), a Solution-Focused Clinical Supervision model (Driscoll 2000b), Heron’s Six-Category Intervention Analysis Framework (Chambers & Long 1995, Fowler 1996, Cutcliffe & Epling 1997) and the Cognitive Therapy Supervision model (Sloan 1999).

Proctor’s interactive model


Proctor’s model (1987), which was developed initially for use in a counselling context, can focus on all or any one of three areas at any time. The formative function is concerned with skills development and increasing the supervisee’s knowledge; the normative aspect concentrates on managerial issues including the maintenance of professional standards (Cutcliffe & Proctor 1998) and the restorative function is focused on providing support in an attempt to alleviate the stress inherent in the occupation of nursing (Jones 1996).

What remain unclear are the components, which can be regarded as requisite for the pursuit of each of this model’s three functions. For example, what supervisor interventions might be considered appropriate when working in the formative, normative and restorative domains? This omission may partly explain the disappointing results (Cutcliffe 1997, Wolsey & Leach 1997, Teasdale 2000) when this model has been evaluated in recent research (Butterworth et al. 1997, Dunn 1998, Bowles & Young 1999). However, relating to this are researchers’ assumptions about clinical supervision and the expectations they hold for current supervision models.

For example, Butterworth and his research team (1997) argued that each of Proctor’s three elements could be evaluated: the normative component using the Minnesota Job Satisfaction Scale, the restorative function using the Harris Nurse Stress Index, Maslach Burnout Inventory, General Health Questionnaire and The Cooper Coping Skills Questionnaire, and the formative component could be evaluated using qualitative methods, for example, observation and in-depth interviews to capture the ‘lived’ experience of clinical supervision (White et al. 1998). The evaluation of clinical supervision over an 18-month period using these measures highlighted, mainly, non-significant findings (Cutcliffe 1997, Wolsey & Leach 1997, Gilmore 1999). It is argued that this may have arisen as a result of the researchers’ initial assumptions concerning clinical supervision. Butterworth et al. (1999, p. 31) state: ‘It was the researchers’ expectation that clinical supervision would help reduce staff stress, and the project was set up to evaluate this experimentally’.

Using measures such as the General Health Questionnaire, stress and burnout scales to evaluate clinical supervision only points us to the confusion and conceptual muddle that exists surrounding its fundamental purpose. Clearly, the evaluation measures used in the Butterworth et al. (1997) research indicate an assumption that diverges from clinical supervision’s traditional intent and instead may be considered as equating it with therapy. It appears that a large proportion of nursing wisdom on clinical supervision concentrates on its ability to resolve the stress and burnout experienced by nurses. Conversely, in a recent Welsh stress study, clinical
supervision was found not to be a favoured coping strategy by participants (Burnard et al. 2000). Furthermore, this is a striking contrast to the fundamental intention of clinical supervision in nursing proposed by Anderson and Dorsay (1998), Yegdich and Cushing (1998) and Platt-Koch (1986): clinical supervision aims to teach therapeutic skills and in doing so, to develop the supervisee's therapeutic integrity. There is no ambiguity with regard to clinical supervision being intentionally therapeutic for the supervisee. To distinguish this focused educational function from a therapeutic one, Yegdich (1999, p. 1272) highlights that: 'It is not merely that supervision is not therapy, it cannot be therapy.' Not surprisingly, and despite some researchers' misconceptions concerning clinical supervision, findings from UK studies so far confirm this stance.

The lack of conclusive findings and the discouraging evaluation of clinical supervision when using Proctor's (1987) model may also be a consequence of this model's failure to guide supervisors to incorporate specific potent supervisory behaviours. As previously asked, how would supervisors know when they were working, for example, in the restorative domain if no specific guidance was available? This supervision framework appears deplete of those aspects that would assist its users to deliver potent, effective interpersonal exchanges. More importantly, how could researchers ensure that the supervision being provided was consistent with Proctor's model or if its intended use was being fully realized? These questions may well raise the possibility of a threat to the Butterworth et al. (1997) study's internal validity.

Clinical supervision guided by Heron's six-category intervention analysis

A major discrepancy with Proctor's supervision model is that it lacks detail as to what should be offered when working from any one of its three functions. For example, a clinical supervisor, when using Proctor's model, may decide that they need to work from the formative aspect. Unless they incorporate teaching strategies from other educational paradigms they may be at a loss as to what to offer.

In contrast to Proctor’s supervision template, Johns and Butcher (1993), Chambers and Long (1995), Fowler (1996), Cutcliffe and Epling (1997) and Driscoll (2000a) have described a supervision model for nursing based on Heron’s (1989) six-category intervention analysis framework. As highlighted earlier in this article, the framework has been used extensively in various professions as a structure for guiding interventions during helping relationships (Chambers 1990). However, Heron implies that this template has equal applicability to the supervisory endeavour: ‘In the first extension, the terms ‘practitioner’ and ‘client’ can be applied in formal, occupational settings, where two people in the same organization are relating in terms of their work roles, and where one person is intervening in relation to the other’ (Heron 1989, p. 8). We argue that, because of its interpersonal focus, Heron’s model is compatible with the interpersonal foundations of clinical supervision.

Cutcliffe and Epling (1997) emphasize the enabling and therapeutic process that develops through the use of confronting interventions and claim that such interventions are not at odds with the supportive nature of clinical supervision. Rather than being regarded as a hostile attack, Cutcliffe and Epling (1997) suggest that confronting interventions should be viewed as offering a gift – a gift with the capability of increasing understanding and insight for the supervisee. These authors go on to state that the therapeutic value of confronting interventions in the context of psychotherapy can be transferred to the supervisory experience: ‘the same therapeutic benefits that arise as a result of therapy can arise in a clinical supervision session’ (Cutcliffe & Epling 1997, p. 175). However, while we concur that such gains may be realized, it is important to note that any therapeutic outcome resulting from supervision must be incidental (Adelson 1995). Furthermore, Cutcliffe and Epling (1997) illustrate, in one of their case studies, how Heron’s framework can be used in a context that differs from clinical supervision. That is, their case study two (Cutcliffe & Epling 1997, p. 178) is an example of managerial supervision not clinical supervision.

Chambers and Long (1995), on the other hand, advocate an emphasis on the facilitative category and, in particular, supportive interventions: ‘Fundamentally, this style of supervision is based on the development of a therapeutic relationship between the supervisor and the supervisee’ (Chambers & Long 1995, p. 312). While Chambers and Long agree with Heron (1989) that none of the intervention categories is better than any other, they do perhaps over-emphasize the facilitative styles. This particular approach to clinical supervision has received scathing criticism on two counts (Yegdich 1999). First, it demonstrates a conceptual error whereby clinical supervision is confused with providing therapy. Second, as a supportive approach, the strategies used are misguided.

Adopting Heron’s framework in this way perhaps undermines the basic premise of the six-category intervention analysis. Heron (1989, p. 14) proposes that ‘there is no real hierarchy among the categories. No one of them is in principle good or bad in relation to any other. In the abstract they are of equal value.’ The nature of the practitioner’s role, the particular needs of the client, and the focus of the helping relationship determine their importance. In the case of
clinical supervision (the helping relationship), where the clinical supervisor (practitioner) attempts to progress the supervisee’s (client) therapeutic proficiency, disregard for either the authoritative or facilitative interventions may, in fact, undermine the dynamism of this framework and its potential use in the clinical supervision context. If we return to the fundamental purpose of clinical supervision, the development of therapeutic competence and therefore patient care, and recall the interpersonal focus detailed in definitions found in the nursing literature, then surely the potential contribution of all six-intervention categories is obvious. In learning new ways of working with clients, supervisees’ therapeutic competence could be progressed using any of the six categories of intervention.

In contrast, Fowler (1996) offers the entire six-category intervention framework as a structure for clinical supervisors to help them know what to deliver after saying ‘hello’. He gives examples for each of the categories (Table 2).

There are other concerns. Heron’s framework not only details helpful interventions; it also describes strategies that can be considered degenerate and perverted (Heron 1989). He elaborates: ‘To say that an intervention is degenerate, in the sense intended here, is not to say that it is deliberately malicious or perverted (I deal with this type later); but rather that it is misguided, rooted in lack of awareness – lack of experience, of insight, of personal growth, or simply of training’ (Heron 1989, p. 149). Four degenerate interventions are described: unsolicited, manipulative, compulsive and unskilled. An unsolicited intervention occurs when, without being asked, the practitioner starts to interact in a particular way with the client without any agreement, negotiation or permission, for example, advising that the supervisee do something when this has not been asked for, or offering therapy when this is not appropriate to the task at hand. Descriptions of how Heron’s framework has been adopted in certain nursing contexts could be criticised as ‘unsolicited’.

Heron’s (1989) six-category intervention analysis as a framework for clinical supervision in a nursing context has been subjected to recent research in the UK. Devitt (1998) explored the nature of the supervisory relationship and the labour of supervision through the eyes of the supervisor, using a grounded theory approach. Four supervisors working in acute paediatrics, intensive care and anaesthetic directorates participated in the study. Analysis of the data from a focus group, self-reported reflective diaries and in-depth interviews generated five sub-themes, which together have been conceptualized as a three-stage trajectory of the clinical supervisory relationship. Despite there being an initial agreement that the use of Heron’s framework would be limited to four of the six categories, confrontative, cathartic, catalytic, and supportive (mainly facilitative interventions), prescriptive and informative interventions (authoritative interventions) were used most frequently by the clinical supervisors. Specific examples of these interventions are not given.

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<tr>
<th>Prescriptive</th>
<th>Directing supervisee to examine their rigid style of management</th>
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<tr>
<td>Informative</td>
<td>A traditional teaching session</td>
</tr>
<tr>
<td>Confronting</td>
<td>Raise supervisee’s attitude to medical staff/patients</td>
</tr>
<tr>
<td>Cathartic</td>
<td>Enable supervisee to express feelings regarding their work related distress</td>
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<tr>
<td>Catalytic</td>
<td>Help supervisee discover strengths they possess</td>
</tr>
<tr>
<td>Supportive</td>
<td>Affirm the value and worth of the supervisee</td>
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**Conclusion**

There are on-going challenges regarding the therapeutic value of mental health nursing – a growing body of evidence suggests that the observed work of mental health nurses generally lacks any particular therapeutic intention (Cormack 1976, Sainsbury Centre for Mental Health 1998, Bray 1999). However, none of this research has illuminated what mental health nurses do, or do not do, when interacting with clients. We argue for the utility of Heron’s six-category intervention analysis as an analytic framework to investigate the interpersonal competence of mental health nurses. An investigation having this as its focus could incorporate an analysis of actual nursing practice in the real world of health care rather than relying solely on self-report data. This would also provide an opportunity to challenge the framework’s theoretical standpoint.

In this paper, by revisiting the original endeavour, we have suggested that nurses in the UK have misinterpreted the basic purpose of the intervention categories and therefore under mined its contribution. In addition to its value as an analytic tool, all six categories of Heron’s interpersonal framework have equal relevance to its contribution in nursing as a supervision model. Its value in this regard has been overlooked.

As a result of the explicit detail regarding specific interventions for each of the six categories, clinical supervisors have a useful resource. Rather than having to resort to using helping strategies from other theoretical paradigms, when using Heron’s framework they have a considerable repertoire of interventions. For example, they have a wealth of strategies, which could enhance the supervisee’s therapeutic competence; arguably, all six categories could contribute to facilitating the supervisee’s discovery in this regard.
Acknowledgements

The authors would like to express their gratitude to the Chief Scientist’s Office, Scotland, and the relevant Primary Care NHS Trust for funding the project referred to in this paper. The views expressed in this publication are those of the authors and not necessarily those of the Chief Scientist, or the relevant Primary Care NHS Trust. We acknowledge the helpful guidance provided by both reviewers of this article.

References


