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Resistance to group clinical supervision: A semi-structured interview study of non-participating mental health nursing staff members

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The authors played different roles in the research process. Niels Buus and Henrik Gonge were in charge of the design and planning of the research project in which the present analysis was embedded. Niels Buus conducted the interviews, made the initial discourse analysis, and wrote first draft of the paper. Niels Buus, Cynthia Delgado, Henrik Gonge, and Michael Traynor all participated in critically interpreting the analyses and writing the final version of the paper.

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Resistance to group clinical supervision: A semi-structured interview study of non-participating mental health nursing staff members

Abstract

This paper is a report of an interview study exploring personal views on participating in group clinical supervision among mental health nursing staff members who do not participate in supervision. There is a paucity of empirical research on resistance to supervision, which has traditionally been theorised as a supervisee's maladaptive coping with anxiety in the supervision process. The aim of the study was to examine resistance to group clinical supervision by interviewing nurses who did not participate in supervision. In 2015, we conducted semi-structured interviews with 24 Danish mental health nursing staff members who had been observed not to participate in supervision in two periods of 3 months. Interviews were audio recorded and subjected to discourse analysis. We constructed two discursive positions taken by the informants: *Forced non-participation* where an informant was in favour of supervision, but presented practical reasons for not participating and *Deliberate rejection*, where an informant intentionally chose to not to participate in supervision. Furthermore, we described two typical themes drawn upon by informants in their positioning: *Difficulties related to participating in supervision* and *Limited need for and benefits from supervision*. The findings indicated that group clinical supervision extended a space for group discussion that generated or accentuated anxiety because of already existing conflicts and a fundamental lack of trust between group members. Many informants perceived group clinical supervision as an unacceptable intrusion, which could indicate a need for developing more acceptable types of post-registration clinical education and reflective practice for this group.

Key words (MeSH):

Education, Nursing
Interviews as Topic
Psychiatric Nursing
Qualitative Research
Stress, Psychological

Resistance to group clinical supervision: A semi-structured interview study of non-participating mental health nursing staff members

Introduction

Proponents of clinical supervision regard it as a supportive practice promoting personal growth in individual professionals and in organisational cultures (Bond and Holland, 2010). Clinical supervision can be defined as a formalised pedagogical process where a trained supervisor assists a clinician or a group of clinicians to reflect on their practice (Cassedy, 2010, Severinsson, 1995). In mental health settings, group clinical supervision is commonly offered to develop professional competency and as a stress-reducing intervention, but the effects of supervision are not well-documented (Buus and Gonge, 2009, Francke and de Graaff, 2011) and nursing staff members can feel anxious or ambivalent about participating in this practice (Buus et al., 2011, MacLaren et al., 2016, Duncan-Grant, 2001). In this paper, we will explore reasons for mental health hospital nursing staff members' non-participation in clinical supervision.

Background

Resistance to clinical supervision is frequently mentioned in the literature, but often without in-depth review or empirical analysis. Resistance to clinical supervision has commonly been theorised within a psychodynamic perspective as motivated by anxiety. It has also been identified in a variety of individual, group, and/or organisational actions, and researchers often proceed from a position of pro-supervision assumptions. Liddle (1986) for example viewed supervisee resistance as maladaptive coping with anxiety, which interferes with supervisees' learning processes. Liddle (1986) listed five sources of anxiety in individual supervision: i) Evaluation anxiety (being evaluated by a supervisor), ii) Performance anxiety (difficulties living up to own standards), iii) Personal issues within the supervisee (supervisee's unresolved conflicts and/or problems), iv) Deficits in the supervisory relationship (insufficient empathy, genuineness, and/or respect), and v) Anticipated consequences (the expected consequences of the supervisee's actions lead to resistance). By describing resistance as maladaptive coping, Liddle (1986) wanted to emphasise that resistance is not necessarily deliberately motivated by uncooperative supervisees, but can be seen as the result of coping gone astray.

Kadushin and Harkness (2002) approached resistance to supervision by depicting interactional ‘games’ between supervisee and supervisor in which they collude to produce hidden payoffs for both supervisee and supervisor. They described four sets of games with different elements and outcomes: i) Manipulating demand levels on the supervisee, ii) Reducing the level of demands on the supervisee by redefining the supervisory relationship), iii) Reducing power disparity, and iv) Controlling the situation. These authors suggest that the supervisee in fact ‘loses’ by winning the games (2002).

Addressing clinical supervision from a nursing perspective, Bond and Holland (2010) argued that resistance to supervision practices should be understood as counter-productive defences against feeling anxiety in difficult situations. They divide the main sources of anxiety into: i) Fears about power and autonomy (issues related to structural and interpersonal power relationships), ii) The fear of developing professional relationships (issues related to interpersonal attachment), and iii) Anti-emotional climate in the nursing profession (issues related to the organisational suppression of emotions, first raised by Menzies (1960)). Following Menzies, a key point for Bond and Holland (2010) was to view many organisational practices as unconscious defence mechanisms, which are as important to address as individual defences.

A key problem of examining resistance to clinical supervision is a strong association between resistance to clinical supervision and ‘resistance’ to research. The vast majority of surveys of clinical supervision participation have low, or non-reported, response rates and have not examined non-respondents as a way of determining whether samples were biased (Buus and Gonge, 2009). A noticeable exception was Buus and Gonge’s (2012) sequential mixed methods study of participation and outcomes of group clinical supervision, which combined organisational register data, survey data, observational data, and interview data. An examination of the survey sample (n = 145) indicated that the sample was not representative of the population (n = 239) and that participation in the survey was significantly linked to participation in supervision (Gonge and Buus, 2010, Gonge and Buus, 2011). The interview study sample (n = 22) was drawn from the survey sample and there were no statistical differences between these samples (Buus et al., 2010). However, the interview study sample was based on maximum variation and recruited both participating and non-participating informants. Unexpectedly, all informants spoke in favour of supervision, which could

indicate a substantial overlap between supervision non-participation and research non-participation. These observations seriously question the validity of the conclusions about outcomes of clinical supervision in many survey studies; they also emphasise the challenges of recruiting respondents for researching resistance to clinical supervision.

It is difficult to determine whether a particular action is a form of resistance. Bauman (1972) argued that there are few reliable cues and the total situation, including the supervisee's personality, must be taken into account. In a review and synthesis of the use of the concept of resistance in sociology, Hollander and Einwohner (2004) were curious about the range of actions that were identified as resistance. Unlike the psychodynamic conceptualisation of actions motivated by fear and/or anxiety avoidance, the sociological conceptualisations focused on resistance as 'oppositional action'. Hollander and Einwohner (2004) proposed seven types of resistance, which were differentiated by examining *intent* (is an actor aware of her/his actions as resistance?) and *recognition* (does the target and/or an external observer recognise actions as resistance?). Analysing the power dynamics of clinical supervision practices becomes a matter of perspective and interpretation of the complex, and sometimes ambiguous relationships between power and resistance. In addition, some authors see supervision and a more widespread focus on the 'inner' or affective performance of employees as evidence of an increasingly penetrating neoliberalism, which seeks to make the individual responsible for structural failings (Neocleous, 2013, Zebrowski, 2009, O'Malley, 2009). In this paper, we will add the social science perspective on resistance to further the existing discussions of resistance to supervision that have traditionally been dominated by the psychodynamic framework.

Aim:

The aim of this study was to examine resistance to clinical supervision by exploring perspectives on clinical supervision of mental health nursing staff members who did not participate in group clinical supervision.

Methods

Design:

Individual, semi-structured interviews.

Study context:

The study took place in five general mental health wards at two organisational sites of a Danish mental health hospital, including three open wards and two intensive psychiatric care wards. The wards' management had volunteered to participate in the study when the researchers approached the hospital. During the observation period, the wards were reorganised; two of the open wards and one intensive psychiatric care ward were merged into a special observation ward and an intensive psychiatric care ward. The other open and intensive psychiatric care wards were merged into a single special observation ward.

For several years, the hospital management had prioritised to routinely offer non-obligatory group clinical supervision to nursing staff members, excluding students, in all the wards. Sessions took place approximately 10 times per year and each session lasted for approximately 90 minutes. Most commonly, sessions took place in the mid-afternoon, at the end of the staff's morning shift. The six supervisors were trained psychotherapists external to the organisation whose fields of practice included registered nurses (n=3), psychologists (n=2), and a psychiatrist. There were no general organisational directions about the precise supervision methods.

Participants & recruitment:

As part of another inquiry into clinical supervision practices on the wards during 2014-2015 (Authors 2016), a cohort of mental health nursing staff members (n=115) was surveyed and their supervision participation was observed in two 3-month periods: February to April 2014 and mid-September to mid-December 2014. In the first period, there were 14 sessions; in the second, there were 16 sessions in total in all participating wards.

The present interview study's population included staff members who had not participated in clinical supervision during the observation periods. A total of 37 staff members were identified as potential participants in the study. At the time of recruitment however 10 of these staff members resigned from their positions, commenced maternity leave or long-term sick leave, or had died. The

remaining 27 staff were all invited to participate. Twenty-five staff initially agreed to participate in the study, but one staff member was subsequently unable to find time for an interview, therefore the final sample comprised 24 informants.

The sample included 22 women and 2 men. The average age was 46.7 years (SD = 10.4, range 25-65 years). Eleven informants were educated to bachelor level (10 registered nurses and 1 occupational therapist), and 13 had an upper secondary education in health care (social and healthcare assistants). In the Danish context, registered nurses, occupational therapists, and social and healthcare assistants were part of a multidisciplinary team providing mental health nursing. Eleven informants worked primarily day shifts, 5 worked primarily evening shifts, 7 worked primarily night shifts, and 1 worked mixed shifts.

We anticipated that the informants would be 'reluctant' (Adler and Adler, 2002) towards being interviewed, because they might be uncomfortable talking openly about their non-participation in clinical supervision and, in general, might have low motivation to voice their personal opinions on this issue. Therefore, the interviewer invited each potential informant in person after a general introduction to the study at staff meetings. The invitation included an attempt at normalisation of non-participation in clinical supervision and an emphasis on confidentiality. The interviewer positioned himself as a non-intimate interviewer and the interview as a one-off, transitory event. Furthermore, the interview took place at a place and time that was convenient for the informant and the informants were compensated with time off in lieu for the time spent on the interview. Finally, all informants participated in a draw where they could win two gift vouchers.

Interviews:

The first author is an experienced interviewer and he conducted all the interviews during October and November 2015. Most interviews (n=23) took place in an undisturbed room in the workplace and one interview took place at an informant's own home. Most interviews (n=16) took place in the daytime; the remaining interviews (n=8) took place in the late evening, which was convenient for many night staff. Most of the interviews (n=23) were audio-recorded and one was recorded by means of written notes because the informant felt uncomfortable being audio-recorded. On average, the interviews lasted 63 minutes, ranging from 43 minutes to 84 minutes. A research assistant

transcribed the recordings into written language and the first author checked the accuracy of the transcriptions against the recordings. The interviews were conducted in Danish and the authors translated the English data extracts presented in this paper.

We developed an interview guide on the basis of a review of the literature on nurses' resistance to supervision. The interview guide was designed to facilitate and support the interpersonal relationship between informant and interviewer and to focus the interview on particular issues (Brinkmann and Kvale, 2014). The interview guide was semi-structured to allow an exploration of the individual informant's perspective by following up on their concrete responses. The interview had seven sections designed to explore and contextualise the informants' views on supervision and participating in supervision: 1. Introduction: The informant's previous experiences with clinical supervision (if any). 2. The informant's understanding of mental health nursing. 3. The informant's views on threats to good mental health nursing. 4. The informant's views on colleagues and collaboration. 5. The informant's views on what facilitated or inhibited their participation in clinical supervision. 6. The informant's understanding of the organisational support for clinical supervision (if any). 7. Close: Any suggestions that might help increase participation and gain benefits from clinical supervision.

Analysis:

We used Potter & Wetherell's discourse analysis (1987) to analyse the interviews. Because the aim of the analysis was to examine the discursive construction of textual accounts of supervision and participation in supervision and the social functions of these accounts, Potter & Wetherell's (1987) discourse analysis was appropriate for this study. Their concept of 'subject positions' was particularly relevant to our analysis because we were interested in: 1. How the 'discourse of supervision' places, or has potential to place, participants and non-participants in particular positions, e.g. as engaged, open, cooperative or as resistant, fearful, non-reflective. 2) How individuals position themselves in relation to such discourses, e.g. potentially participating but powerless, or reluctant resister. Before moving on to the examination of such positions apparent in the text, our analysis started with an exploration of the simple thematic content across all interviews, which was done by means of an open coding process. The open coding identified views on clinical supervision that were grouped thematically, e.g. 'Issues making it hard to prioritise

supervision' and 'Difficult situations during supervision' that included a number of sub-themes, e.g. 'Practical issues' and 'Emotional issues'. Then, in each interview, the conversational contexts of key views on supervision and the subject positions that participants appeared to be drawing on were explored to examine the discursive constructions of accounts and the possible social functions of the accounts. The analysis led to the construction of two overall positions held towards non-participation in clinical supervision, *Forced non-participation* or *Deliberate rejection*. Finally, in the findings section, we provide examples of the analyses of the conversational contexts grouped round two common themes that were drawn upon in establishing both overall positions, *Difficulties related to participating in supervision* and *Limited need for and benefits from supervision*.

Ethics:

In full accordance with Danish legislation, the regional research ethics committee and the Danish Data Protection Agency (J.nr. 2013-41-2658) were notified about the interview study; neither institution had any reservations towards the study. All informants gave their informed consent to participate, based on written and oral information about the study. Interview responses were handled in full confidentiality and all details that could potentially be used to identify individual informants have been altered in the data extracts presented in the findings section below.

Findings:

The first part of the findings describes the most common discursive construction of reasons for non-participation. The second and third parts describe the core themes drawn upon in the arguments for non-participation, by informants taking either position, which emphasise the difficulties of participation and minimising the need for and benefits of supervision.

Typical constructions of reasons for non-participation

There were two fundamentally distinct positions among the informants: One position, *forced non-participation*, was to state that they were in favour of participating in supervision, but that challenges outside their own immediate control made participation appear as something that would presuppose an unreasonable amount of effort, e.g. supervision the day after a night shift, a long

commute to work, or competing family obligations. Another position, *deliberate rejection*, was to state that non-participation was ultimately the informants' active decision based on their own perspective on supervision.

The informants' reasoning was centred on two rhetorical strategies that would be forwarded with different emphases by the two positions. First, informants would accentuate objective difficulties related to participating in supervision. Second, the informants would minimise their experienced benefits from supervision and their personal need for supervision. These strategies added to making the informants' non-participation appear reasonable and legitimate.

In the following Data Extract 1 both the strategies are present. Informant 5 – a registered nurse who positioned herself as *deliberately rejecting* participating in supervision – constructs an array of legitimising reasons for non-participation. The data extract is taken from the beginning of the interview.

[Insert Text Box 1 about here]

Informant 5 has very limited experience of supervision and starts out by briefly pointing out the problem with cancellations of sessions, and later the problem of attending supervision the day after a night shift. She explains how her manager excused her from attending clinical supervision, which lends legitimacy to her standpoint, and shows her perception of supervision as a managerial intervention. She repeatedly states that she does not like or need supervision. She argues that she does not need supervision, because supervision focuses on issues that she was in effect excluded from because of her work at night. Throughout the interview, Informant 5 continued to argue that supervision was not valuable enough for her to prioritise participation. Unlike most other informants, she did not refer to personal feelings of unease during the sessions as a way of arguing for why she did not like it.

In the following two sections we will further explore the thematic content used in these two discursive strategies and contextualise them within the informants' descriptions of their work.

Difficulties related to participating in supervision

All informants described participation in supervision as a question of prioritising. Shift work, timing, small turnouts, not knowing what would be discussed, cancellations, and the commute to work were the most frequently mentioned reasons for not prioritising turning up outside regular working hours. Descriptions of these difficulties made scheduled supervision sessions appear unreliable and somewhat irrational to prioritise. This added to a depiction of supervision as being caught up in a downward spiral of low continuity, poor attendance, and cancellations. Management were described as being only partially committed, as they ensured the provision of monthly supervision, but did not create the resources for people to actually participate.

Some informants described the process of getting ready for supervision as stressful, simply because of the work pressure. It was hard to finish work earlier than usual and focus on supervision. Informant 22 was a nurse working nights who positioned herself as *forced into non-participation* because of a lack of time and competing obligations at home. She relates her experience of participating in her first and only group clinical supervision session in her 3 years with the team; a session, which had been organised after a violent episode on the ward. She commences by describing the session as a bad experience where she had not felt understood either by supervisor or colleagues. She continues by describing the overall management of the violent situation as problematic and somewhat unresolved and that she should have acted differently. Leading up to the following data extract, she reflects on interactions with the supervisor and the other participants.

[Insert Text Box 2 about here]

Informant 22 describes how touched she had felt when the situation was discussed in the supervision group however she had also felt very uncomfortable, crying over a situation that she did not feel that she ought to cry over. She states that the most uncomfortable part of the situation was the unexpected loss of personal control and not being able to focus on what took place in the room. Towards the end of the interview, Informant 22 adds that her bad experience was not the reason for her non-participation, but a lack of time.

The informants often described the atmosphere at the beginning of a supervision session as full of jittery anticipation because no one could think of anything relevant to address. Some informants

described strategies for saying how they felt in a way that ensured that they would not be selected to be the centre supervisee; they tried to appear present and reflective, but not troubled. During the interview, an informant came to realise that nursing staff members unwittingly colluded to cancel supervision sessions. It happened when they all responded to the supervisor's general queries on arrival with an "I don't have anything [to talk about]"; everybody would accept this statement, which legitimised suggestions about cancelling if the turnout was not very big.

The supervision room was described as uncomfortable and unsafe because of a fundamental lack of control. To most informants, it was uncomfortable to organisationally display personal and intimate feelings and professional uncertainty. Further, the group dynamics meant that challenging questions and comments could trigger an unwanted disclosure of personal and professional uncertainty. Many informants described searching questions as a central and important part of supervision, but as something they did not personally appreciate or want to be part of.

Some informants did not like being the centre of attention, and some were concerned that other supervisees would not interpret their contributions correctly. They were also concerned about who was present in the sessions. They stated they did not trust all of their colleagues and they were concerned that powerful and influential colleagues would 'bulldoze' them, particularly if the supervisor was unable to control the session. Informant 21 was a social and health care assistant working nights. She positioned herself as *deliberately not participating* in supervision, mostly because of the group format. Prior to the data extract below, she describes listening to the comments of 'a reflecting team', see for instance Andersen (1987), as horrible and disempowering because the rules of this approach meant she was not allowed to object even when she thought the other supervisees were misunderstanding and misinterpreting her. The key issue for Informant 21 was about talking about personal issues in a group.

[Insert Text Box 3 about here]

Informant 21 starts out by saying that she does not have a problem talking about personal issues in one-on-one conversations, however feels out of control, 'stripped and vulnerable' talking about personal issues in group settings. She feels this is because the supervision inquiry can lead to the

exposure of very normal, but personal issues. She describes it as an uncomfortable objectifying public introspection.

Limited need for and benefits from supervision

All informants described alternative practices to formal group clinical supervision that they found more relevant in their daily work. This included clinical review meetings, informal peer supervision, and exchanging experiences. These practices were considered more relevant because of their flexibility, the focus on the here and now, a strong focus on clinical problem solving and, crucially, a less challenging and safer communicative context. Supervision and supervisors were often criticised for not providing exactly these characteristics and depicted as monotonous, boring, and without wider clinical impact.

Informants regarded drawing on each other's experiences as the most central way of keeping themselves professionally up to date. The idea of continual informal peer supervision was very prominent among evening and night nurses, because they believed that work in the evenings and at night presupposed a strong sense of each other's whereabouts and of the atmosphere on the ward. However, this sense of each other was often tacit and they did not feel the need to speak with the colleagues they knew and trusted. Some informants argued that they had so many years of experience that they were able to critically reflect on their own practices without collegial intervention or formalised supervision.

Informant 6 is a social and health care assistant working day shifts who positioned herself as deliberately non-participating in supervision. She had attended a single group clinical supervision session at the beginning of her 10-year long career in mental health. She described how the session was meant to address a conflict between staff members, but that it in effect was meant to silence her and her group's part of the conflict. She lost faith in supervision and never participated again. She currently works nightshift and in the following data extract, she argues why she does not need supervision.

[Insert Text Box 4 about here]

Informant 6 states that patients mostly sleep at night and do not cause problems that need to be discussed. However, she argues that night nurses are good at discussing problems as they unfold. She initially responds by validating the interviewer's interpretation and asks herself whether it would be beneficial to 'listen in' supervision sessions. She presents herself as open-minded enough to imagine that supervision could be beneficial for her but does not go on to describe participation but a marginal position of "listening in".

Some informants working evenings and nights found supervision to be oriented toward day shifts, where the most formalised decision-making took place. This implied an understanding of staff having different experiences of work depending on their allocated shift, and that organisational continuity was primarily organised during day shifts on weekdays. Several informants described that this excluded them from grasping the continuity of care of patients and from participating in important decision-making processes. The content discussed in supervision was described as being focused more on this formal day shift oriented work and therefore found less relevant.

Informant 19 was a social and health care assistant working nights. She describes herself as deliberately choosing not to participate in supervision. She has participated in what she described as a single clinical supervision session, which had been organised after a violent situation during a night shift. She emphasises that she does not need additional supervision because she and her colleagues make good use of each other.

[Insert Text Box 5 about here]

Informant 19 describes herself as an introvert and that this makes it hard for her to imagine how she would be able to share her experiences and participate in supervision. She describes an extreme episode after the violent event where she felt bad, but chose not to ask for help. At the end of the interview, her explanations shift and she summarises her decision not to participate in supervision because she feels excluded and bullied by colleagues that do not listen, *not* about being an introvert.

Discussion

Informants stated that it was hard to prioritise supervision because of the practical and emotional engagement needed, and that was why they did not participate. The findings indicated that the informants accounted for their non-participation in markedly different ways; positioning themselves as either ‘legitimately’ forced into non-participation or deliberately rejecting participation.

The study’s findings did not resonate strongly with Liddle’s (1986) five sources of anxiety in individual supervision because the group format extended the sources of tension and anxiety. Group clinical supervision created an extended space for group discussion that could generate or accentuate anxiety because of already existing conflicts and a fundamental lack of trust between members of the groups. Thus, it was characteristic that the informants identified relationships between staff members on the ward as a source of anxiety rather than individual conflicts or problems related to the supervisor. Another important characteristic of the informants’ supervision practices was that they were not obliged to spend time with or be evaluated by a supervisor, and they could refuse participation without any formal or informal sanctions. Similarly, Kadushin and Harkness’ (2002) descriptions of collusion in ‘games’ between supervisee and supervisor was recognised by a few informants, but a potential larger group-based game among the nursing staff members, managers, and supervisors undercutting supervision practices was never envisioned and articulated. Collusion (McDermott et al., 1995) in mental health nursing practice has previously been identified as protective interactions necessary for reducing signs of uncertainty and ignorance (Buus, 2008); here it also subsumes signs of overt conflict. Irregular and unproductive clinical supervision was accepted as collateral damage in periods with high workloads, low job satisfaction, and organisational restructuring.

Hollander and Einwohner’s (2004) typology of resistance was based on an examination of an actor’s intention and on whether an action was recognised as oppositional by the target of resistance and/or by an external observer. Considering the position of *forced non-participation*, the informants’ actions were described as legitimately controlling their workload, not as acts of resistance, while supervision practices (target) and observers would probably recognise such non-participation as acts of resistance. Hollander and Einwohner call these types of resistance, where there is no true target and where actions become resistance by virtue of others’ assessments, ‘unwitting resistance’ or ‘externally-defined resistance’. A key issue here is that the informants discursively positioned themselves as legitimately non-participating, and therefore as someone who

should not be punished or blamed, while their actions in effect added to undermine supervision practices. Considering the position of *deliberate rejecters*, the informants' actions were intentionally in opposition to supervision practices, which would most probably be recognised as resistance by target and observer. Hollander and Einwohner call this type of resistance 'overt resistance'. However, deliberate rejecters did not just target supervision practices, they also explicitly targeted strained interpersonal relationships with colleagues, who would most probably not recognise these actions as resistance. Non-participation can therefore be seen as 'overt resistance' to supervision, but simultaneously as 'covert resistance' to challenging interactions with colleagues. Here, a central issue is that the combination of observational data and highly contextualised interview data made it possible to identify several targets of resistance and actions that could be recognised significantly differently by actors, targets, and observers.

Bond and Holland (2010) drew on Menzies seminal study of social anxiety (Menzies, 1960) to argue that nurses often are aware of the institutionalised social defences that create non-caring institutions with increasingly burnt-out nurses blocked from being able to exercise their full range of skills. Bond and Holland argued that nurses suppress their emotions because of fear of retribution and fear of loss of control. Similarly, MacLaren et al. (2016) suggested that benefits of supervision might be negated because it takes a massive effort to address emotions in an institutional environment where emotions are generally suppressed. In line with this, the informants in the present study talk of a preference to develop their skills in small and safe 'unofficial' forums, which could be seen as flexible alternatives to supervision without managerial involvement and where they can understand themselves as taking agency.

Limitations

The interview responses reflected the informants' personal perspective on resistance to clinical supervision and the explanations were co-constructed with the interviewer and tailored to the particular interview situation. Such interview findings must be interpreted within their conversational context (Holstein and Gubrium, 1995). In order to situate the findings, data extracts were presented at length; further, they were contextualised and include basic interactions between informants and interviewer. Moreover, supervision non-participation could be considered to be a sensitive topic to discuss in an interview, but the participation rate was unexpectedly high. Most

interviews were conversational and appeared open; they included personal reflections on interpersonal relationships and organisational issues. Almost half of the informants positioned themselves in the socially less acceptable position of deliberately rejecting participation in supervision. It is possible that the development of a longer relationship between informants and interviewer could have created even deeper insight into the informants' understanding of interpersonal relationships at the workplace and their relationships to supervision practices. Finally, the participants' personal perspectives on supervision resistance should not be viewed as the only explanations of supervision resistance; some reasons may be outside their immediate experience, for instance cultural or organisational factors.

Conclusion

In this article, traditionally reluctant and voiceless nursing staff members articulated their ideas and concerns about participating in clinical supervision. The current 'push towards clinical supervision' (Bond and Holland, 2010) in nursing can be regarded as part of a counter-movement resisting the ways in which professionals are trained and the way in which they practice in current social and health care organisations. However, the analysis indicated that some nurses might perceive clinical supervision as an unacceptable intrusion rather than a positive relationship and that the organisational incorporation of formalised processes of 'professional development' might add to the widespread suppression of emotions, rather than provide solutions. Finally, it became clear that definitions of resistance depended on perspective. Informants' actions could, on one hand, be seen as successful coping with work demands or interpersonal conflict or, conversely, be seen as maladaptive coping with supervision by avoiding participation.

Relevance for clinical practice

Informants stated that supervision was susceptible to being deprioritised during organisational change or when staff members were stressed, the very times when it could be argued that supervision may be most needed. Therefore, organisational providers of clinical supervision can consider: 1) How to organise clinical supervision in ways that would make it possible for all nursing staff to participate. 2) How to systematically and effectively match staff members with acceptable types of supervision so that professional development of all nurses is supported.

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Text box 1:

Data Extract 1:

Interviewer: What are your experiences of attending supervision?

Informant 5: Not much. Actually I've been three times. A couple of times, twice since I've been employed here. I did night shifts and we had to come in during daytime. Sometimes it's cancelled. But I was not interested in participating, because sometimes I'd been on a night shift and needed to sleep and then to come in on a day shift using a whole day on 1, 1½ hours [of supervision]. I thought it was silly to spend my day like that so I spoke to my manager and was excused. I was not to attend supervision anymore; I didn't like it.

Interviewer: What do you mean by that? You didn't like it?

Informant 5: It was not my cup of tea. I do not think it helps very much, you know. In my personal opinion, I don't think I needed it.

Interviewer: You say that you don't need it?

Informant 5: No, I don't. But it is because night duty sometimes. If it was about patients or about some episode at work, you know, that I was not part of then I felt outside the discussion or the things that were said.

Text box 2:

Data Extract 2:

Interviewer: In that situation, did you feel exposed in the group?

Informant 22: No, I didn't feel exposed, just uncomfortable.

Interviewer: It was uncomfortable, but what created that feeling?

Informant 22: I felt touched and sad and I found that a bit uncomfortable, because I thought that it wasn't really a thing to sit and cry over. But I was very touched. It was very uncomfortable, most of all because I couldn't focus. Perhaps, because I was in a place where I could not focus on what was said or the questions asked. So I think I missed the whole point.

Text box 3:

Data Extract 3:

Informant 21: I think it is uncomfortable and I think that if I have any issues then it works better for me to talk one-on-one about it. It is no problem if it is a general issue or something. I find it problematic if I'm somehow at the centre [of supervision] because I think you get stripped and vulnerable, because other things can emerge that you do not want to share with others.

Interviewer: What are you thinking of?

Informant 21: Well, we all have feelings and issues, also toward our consumers, towards patients, etc. Why exactly does it trigger in me when a patient does this or that? What exactly does it do to me? And why does it do so? You dig down into another layer and it is not because something is deliberately concealed or strange. I just don't want to be navel-gazing like that and to be analysed. That's just how it is.

Text box 4:

Data Extract 4:

Interviewer: Why do you think you don't need it [supervision]?

Informant 6: Well, I could discuss things with my colleagues if I had any problems with patients. It could also be [a problem] with a colleague or something. You can have discussions, but I do not think that I've tried it. The patients sleep at night; I only do nights. Really, we are good at starting nights by sitting and discussing what we could do better and so on.

Interviewer: So in many ways, you describe that the night nurses create some of the effects that one might imagine would come out of [formal] supervision?

Informant 6: Yes, where we deal with it here-and-now. But maybe I would profit from listening in [at supervision]?; I don't know.

Interviewer: Listening in?

Informant 6: I would not know what to say because I don't have anything concrete to talk about. But maybe you have when you get into it. I don't know.

Text box 5:

Data Extract 5:

Interviewer: It sounds as if you're saying that you don't need anything extra [than talking with your colleagues]?

Informant 19: No, I guess not. I'm not very talkative and outgoing and those kinds of things I keep to myself, I think. And then I can feel, I'm not sure how to say it, you know, that I should be more part of it [supervision], because if something happens, I carry it inside.

Interviewer: And how does that affect you?

Informant 19: That night [where something violent happened], even though we spoke in the morning, I was quite shocked when I got home and I couldn't sleep. John [the ward manager] told us to come forward if anything felt wrong, but I didn't. So I felt bad afterwards – but I just didn't know – I just said, "Things are fine".

(...)

Interviewer: If I asked you to summarise why you do not attend supervision, how would you do that?

Informant 19: Because I know deep inside that nobody will listen. Yes, so I don't want to waste my time on it.