Resistance to Supervision

Presented by
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Outline of presentation

Introduction
- Definitions of clinical Supervision
- Functions of clinical Supervision
- Forms of clinical supervision

Our previous studies
- Literature review; Survey, observation, and interview;
  Development and tests of meta-supervision intervention

Resistance to supervision
Introduction: Definitions of clinical supervision

There is no internationally accepted definition of clinical supervision

Our working definition includes three issues:

- Supervision is planned
- During supervision, participants reflect on their clinical work
- During supervision, there is a formal division of tasks between supervisor and supervisee(s)
Introduction: Three functions of clinical supervision

Proctor (inspired by Kadushin) described three functions of supervision:
- Normative (managerial)
- Formative (educational)
- Restorative (supportive)
Introduction: Forms of supervision

- Students - trained staff
- Individual supervision - group supervision
- Methods: Psychodynamic (feelings and relationships), cognitive-behavioural (thoughts and actions), systemic (reflective teams and responses)
- Supervisor: internal or external to the organisation
- Frequency and length: continual or consultation
- Case oriented - staff oriented
Our previous studies:

- A systematic review of empirical studies of clinical supervision (Buus and Gonge, 2009)
- Translation of Manchester Clinical Supervision Scale (MCSS) (Buus and Gonge, 2013)
- A descriptive, sequential mixed methods study of factors affecting participation in supervision and benefits of participating in supervision (Buus, et al., 2011 and 2010, Buus and Gonge 2012, Gonge and Buus, 2011 and 2010)
- Development of a standardised supervision intervention (Buus, et al., 2013 and 2016)
- A randomised controlled trial of the intervention (Gonge and Buus, 2015)
- A controlled trial of the intervention (Gonge and Buus, 2016)
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Some key results from our previous studies:

- There is not clear empirical evidence of positive effects of clinical supervision
- Studies did not analyse take (non-)participation in to account when analysing outcomes of clinical supervision
- Observational data indicated low participation rates in mental health hospital wards, and self-report data that cognitive demands and social support significantly influenced participation
- Qualitative data indicated that supervision could be problematic because of self-disclosure and the exposure of covert inter-personal conflicts
- Makes individual sense, but does not impact on the organisation
Resistance to clinical supervision - psychodynamic

Liddle 1986
- 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)
- v) Anticipated consequences (the expected consequences of the supervisee’s actions lead to resistance)

Bond and Holland (2010)
- 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)
- iii) Anti-emotional climate in the nursing profession (issues related to the organisational suppression of emotions).
Resistance to clinical supervision - social

Kadunshin and Harkness (2002)
- 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
- iv) Controlling the situation

Hollander and Einwohner (2004)
- Perspectivism that examines: i) Recognition (who – actor, target, and observer – recognises an action as resistance?) and ii) Intent (are actors aware of their actions as resistance?)
Aim, design, and study context

Aim:
- To examine resistance to clinical supervision by exploring perspectives on clinical supervision of mental health nursing staff who did not participate in group based clinical supervision

Design:
- Individual, semi-structured interviews

Study context:
- The study took place at five general mental health wards at two organisational sites of a Danish mental health hospital; three open wards and two locked wards
Participants and recruitment

Participants:
- The interview study’s population included the staff members that had not participated in clinical supervision during two observation periods (2 x 3 months in 2014; 14 sessions/16 sessions)
- The sample included 22 women and 2 men. The average age was 46.7 years (range 25-65 years). 11 informants were educated to bachelor level, and 13 had an upper secondary education in health care. 11 informants worked primarily day shifts, 5 worked primarily evening shifts, 7 worked primarily night shifts, and 1 worked mixed shifts

Recruitment:
- Reluctant respondents - The interviewer positioned himself as a non-intimate interviewer and the interview as a one-off, transitory event. The interview took place at a place and time that was convenient for the informant
Interviews

Interview length:
- interviews lasted 63 minutes, ranging from 43 minutes to 84 minutes

Interview guide:
- The interview had seven sections: 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 outcome of clinical supervision.
Analysis:

Potter and Wetherell’s (1987) discourse analysis:

- Focus on thematic content
- Focus on construction (how are accounts organised rhetorically) and function (what are speakers accomplishing when they speak)
Typical constructions of reasons for non-participation

Two positions:

- 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.

- Another position, *deliberate rejection*, was stating that non-participation was the informant’s active decision based on their own perspective on supervision.
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 hour [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.
Two themes in their positioning:

Two positions:
1. Difficulties related to participating in supervision
2. Limited need for and benefits from supervision
Difficulties related to participating in supervision

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 was touched and felt 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.
Limited need for and benefits from supervision

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 I carry it inside myself if something has happened.

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 chocked 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 you should 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 waist my time on it.
Discussion:

No strong alignment with the psychodynamic fear-avoidance perspective

“Who” is resisting according to whom?: Who defines an act as oppositional – and in relation to what?

Social anxiety

Participants’ perspectives are not the only explanation
Thank you for your attention

Time for comments and/or questions?

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