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**Making Sense of Supervision:
A Narrative Study of the Supervision
Experiences of Mental Health Nurses and
Midwives**

Jessica MacLaren

Declaration

This thesis has been composed by me, is my own work and has not been submitted for any other degree or professional qualification.

Signed:

Dated:

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Abstract

This thesis explores mental health nurses' and midwives' experiences of supervision. The thesis aims to create a partial and situated understanding of the numerous factors which contribute to practitioners' experiences of supervision. In particular the thesis investigates the disciplinary context within which supervision takes place, moving from the experiences of individual practitioners to compare and contrast supervision within two distinct professional disciplines which have common areas of interest. Existing research on the topic of supervision in mental health nursing and midwifery tends to reify the concept of supervision. Supervision is assumed to be beneficial, and there is a focus on investigating the effects of supervision without an accompanying understanding of why, how, where and by whom supervision is done. In this thesis, 'supervision' is critically conceptualised as indicating a cluster of context-specific practices, and the investigation of supervision is located with the practitioner's understandings and experiences.

The theoretical perspective of the thesis is informed by social constructionism, and 'experience' is conceptualised as communicated through meaning-making narratives. The experiences of the study participants were accessed through the collection of data in the form of narratives. Sixteen participants were recruited, comprising eight mental health nurses and eight midwives. Each participant was interviewed once, using a semi-structured interview format. The analysis was influenced by the theories of Gee (1991), Bruner (1986) and Ricoeur (1983/1984), and employed a narrative approach in which the unique meaning-making qualities of narrative were used to interpret the data. The analysis paid close attention to the process of fragmentation and configuration of the data, and produced four composite stories which presented the findings in a holistic and contextualised form.

Two themes were identified from the findings: Supervision and Emotions, and Supervision and The Profession, and these were discussed in the light of the two professional contexts explored, and with reference to supervision as an exercise of

power. The theme of Emotions recognises the integral role played by emotions in both clinical practice and supervision, and conceptualises supervision and the organisational context as emotional ecologies. Supervision can be constructed as a special emotional ecology with its own feeling rules, and this can both benefit and harm the practitioner. The theme of The Profession responds to the importance of the professional context of supervision practices, and the role of discourses about professional identity and status in determining how supervision is done and with what aim.

Comparing supervision practices within two different disciplinary contexts enabled this thesis to challenge tropes about supervision. Supervision cannot be assumed to be either 'good' or 'punitive', and practices are constructed in the light of particular aims and expectations. This thesis also makes the methodological argument that research into supervision must be politicised and theorised and accommodate contextualised complexity. To simplify or decontextualise the exploration of supervision is to lose the details of practice which make supervision what it is. Supervision is a complex process, enmeshed in its context, and may be constructed to serve different purposes.

Glossary of Abbreviations

CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CNO	Chief Nursing Officer
CPN	Community Psychiatric Nurse
CS	Clinical Supervision
ECM	Egalitarian Consultation Meetings
ENB	English National Board
GNC	General Nursing Council
LSA	Local Supervising Authority
LSAMO	Local Supervising Authority Midwifery Officer
MBI	Maslach Burnout Inventory
MCSS	Manchester Clinical Supervision Scale
MPA	Medico-Psychological Association
NHS	National Health Service
NMC	Nursing and Midwifery Council
RCM	Royal College of Midwives
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

1 Introduction

1.1 Researching Supervision

Supervision occurs in many forms, and is practised in a range of disciplines, including mental health nursing and midwifery. In the United Kingdom (UK), all midwives, and many mental health nurses, are currently engaged in practices known as ‘supervision’. *Clinical* supervision is much discussed in nursing, and has been supported by the Nursing and Midwifery Council (NMC) (Nursing and Midwifery Council, 2008a). Various sectors of the National Health Service (NHS) have clinical supervision policies in place (see for examples Ahmet, 2012, Sheffield NHS Primary Care Trust, 2008, Haslam, 2008, The Newcastle upon Tyne Hospitals NHS Foundation Trust, 2012, NHS Lanarkshire, 2010), and all UK midwives are required to undertake *statutory* supervision as a condition of practice (Local Supervising Authorities and Nursing and Midwifery Council, 2008).

Supervision is therefore an important topic of research on pragmatic grounds. Resources are devoted to supervision, and so it is important to understand what is being done when practitioners participate in supervision. Furthermore, certain outcomes – such as maintaining public safety (cf. Nursing and Midwifery Council and Local Supervising Authorities, 2008) – are claimed for supervision, and these must be supported with evidence.

There is also an ethical argument for making supervision the subject of research. Many proponents of supervision argue that it supports the well-being of the practitioner, thus enabling him/her to practise to the best of his/her ability. It is with this perspective that I begin my inquiry into supervision. I argue that the notion of ‘supporting the practitioner’ entails a particular understanding of the practitioner as both providing care for others and also in need of care him/herself. This challenges the dichotomy of care-giver and care-receiver, a view supported by reference to the ethics of care.

The ethics of care originated with the feminist work of Gilligan (1982). 'Care' is conceptualised as a moral and political component of human life, something that we all give and receive, and to which is assigned certain social values (Tronto, 1993). The individual is understood as being in relation to others and to self, and so an ethic of care requires a balance of care for others and self-care (Barnes, 2012). Arguing from this ethical position, 'care for the practitioner' may be posited as an essential component of the process of caring for those who use the health services.

From this perspective, research into supervision responds to an ethical duty to care for those who do caring work. This thesis makes such a response by inquiring into experiences of supervision in mental health nursing and midwifery.

1.2 Personal Experience

My interest in supervision has arisen from my experiences as a practicing mental health nurse. As a newly qualified nurse I was aware of supervision, but had little idea about what it involved. In various hospital and community posts I had encountered different forms of supervision, but in each case it tended to be superficial and inconsistent. My experience of supervision changed when I worked in a primary care mental health team, in which nurses worked closely with counsellors and clinical psychologists. Here I had supervision which supported my use of cognitive behavioural therapy techniques, and this was an opportunity for regular reflection on practice. This gave me some insight into supervision as a supportive and developmental activity.

Reviewing my own experiences of supervision I am struck by how unprepared either I or most of my supervisors were to undertake supervision. We did not really understand how we should do supervision and what problems might be encountered in trying to establish a supervision practice. My good experience of supervision came with a clinical psychologist and psychotherapist who had many years'

experience of supervision and acting as a supervisor. My personal experiences have led me to approach this study with a questioning curiosity about supervision.

1.3 The Construction of Knowledge

This is a nursing thesis informed by sociological literature. The thesis is written from a social constructionist perspective informed by the work of Gergen (1999) and Berger and Luckmann (1966). Social constructionism makes the argument that human beings are actively engaged in interpreting and making the world through the construction of meaning, and that this process of world-making occurs within social interactions and through discourse (Gergen, 1999). Berger and Luckmann (1966) envisage the constructed world as incorporating elements which are experienced as subjective and objective. The individual therefore draws on shared meanings not directly under his/her control, while at the same time the world is continuously legitimised, modified and re-constructed through discourse. From this perspective the supervision encounter can be understood as a discursive, reality-constructing activity which has implications for the ways in which the supervisee experiences and acts in practice.

Understanding knowledge as socially constructed engenders a conscious awareness of what kind of knowledge is produced through research. Informed by the work of Flyvbjerg (2001), this thesis aims to construct ‘phronetic’ knowledge. Flyvbjerg (2001: 57) defines *phronesis* as an ethically framed way of knowing which is “*pragmatic, variable, context-dependent. Oriented toward action*”, it is about the lessons to be learned from specific cases, “*it requires an interaction between the general and the concrete*”. The concept of phronesis responds to the importance of context in understanding social phenomena. Flyvbjerg (2001) argues that without context social phenomena lose their meaning. It is through detail and the analysis of the specific case in context that social research makes a useful contribution to knowledge.

I suggest that the concept of *phronesis* is highly suited to the production of nursing knowledge that is closely allied to context-specific, ethical practice. I have therefore taken *phronesis* as providing a general guiding principle for this thesis, aiming to produce value-based, situated knowledge which illuminates understanding about supervision through detailed consideration of specific cases. The methods which have been used in this study to construct this kind of knowledge are discussed in Chapter 5.

1.4 Use of Language

1.4.1 Supervision

In this thesis the term ‘supervision’ is conceptualised as an umbrella term. As Chapter 3 will show, supervision is used to indicate a cluster of related but contrasting concepts and practices. Supervision is discussed in two professional contexts. Within each professional group in the study the term ‘supervision’ was used in a different way. In midwifery, there is a system of statutory supervision, and it is of this system that the midwife-participants in this study had experience (although as shown in Chapter 3, the concept of clinical supervision is also present in midwifery). The mental health nurses in this study discussed experiences of clinical supervision. Throughout the thesis the term ‘supervision’ is therefore used in a general way, and the terms ‘statutory supervision’ and ‘clinical supervision’ are employed to refer to the different uses of ‘supervision’ within the two professional groups.

1.4.2 Narrative and Story

A key concept in the methodology of this study is ‘narrative’. The term narrative is often used in conjunction with story, and scholars variously use these terms as interchangeable, or as with distinct meanings (Riessman, 2008). In this thesis ‘narrative’ is conceptualised as the broader of these two terms. As discussed in Chapter 5, narrative is used to refer to a kind of discourse which has certain features: temporality, a beginning, middle and end structure, the configuration of events into a whole, and relationality. I envision narrative as evolving or emergent; the division between narrative and not-narrative may be set at different points on a continuum according to the theoretical approach used.

For the purposes of this thesis, ‘story’ is conceptualised as a genre of narrative. My use of ‘story’ assumes a more cohesive and structured narrative. In this thesis I also draw upon the word ‘storied’ (McCormack, 2004), which describes the structuring of discourse using narrative features.

In this thesis ‘narrative’ and ‘story’ are therefore conceptualised as having overlapping meanings. In Chapter 6 individual interview accounts and cross-interview accounts are discussed as ‘narratives’ reflecting their sometimes fragmentary or emergent nature. The composite stories are so-called because they were deliberately constructed to have a form which incorporates narrative features.

1.4.3 Using Gender Neutral Terms

The sample in this study incorporated fifteen women and one man. In recognition of the presence of both genders in the study, this thesis uses gender neutral terminology i.e. s/he, him/her.

1.4.4 Using 'I'

Finally, in keeping with Haraway's (1988) principle of situating knowledge by constructing a "view from somewhere" (Stenhouse, 2013: 7), I incorporate my own perspective as researcher through the use of 'I', and I am identified in interview extracts as 'J'. This reminds the reader that this thesis has been constructed from a specific, subjective perspective.

1.5 The Location of the Study

This study is located in a region of the UK. The precise geographical location of the study has been concealed in order to protect the anonymity of the participants. The location of the study within the UK means that the NHS, as the major health care provider, is a significant part of the study context. Fourteen of the participants were employed within the NHS, and the two self-employed participants undertook occasional supply work within the NHS, and were connected to the NHS through supervisors, contact with stakeholders, and client referrals. The NMC also forms a significant part of the context, as professional governing body for all the participants. A further feature of the study location is the system of statutory supervision of midwives, which is unique to the UK.

1.6 The Contribution of this Thesis

The key contribution which this thesis makes to current knowledge about supervision, is through the use of social theories to construct an understanding of context-specific experiences of supervision. The comparison of practitioners' experiences of supervision within two different disciplinary contexts enables this

thesis to challenge tropes about supervision. These include the reification¹ of the concept of supervision, and assumptions about the beneficial effects of supervision. This thesis makes the argument that supervision practices should be understood as constructed within a specific context, as intended to achieve different aims, and as influenced by professional and organisational discourses. Social theories provide an explanatory framework within which the processes of supervision can be understood and related across contexts.

This thesis also makes a methodological contribution to knowledge. The argument is made that research methods must respond to the complex, context-dependent nature of supervision. Narrative inquiry offers a method of gathering rich data, and of conducting data analysis which preserves details of context and gives insight into meaning making about experiences of supervision. In this thesis, theoretical perspectives on narrative (cf. Ricoeur, 1983/1984, Bruner, 1987, Gee, 2005) are drawn together to create a method of narrative analysis which responds to the tension between the abstraction of data required for analysis, and the context-dependence of meaning in narrative.

1.7 Structure of the Thesis

In Chapter 2 of the thesis the background of this study is discussed, and the two professions involved in this study are located in relation to one another in terms of shared aspects of their historical development. The development of statutory and clinical forms of supervision is reviewed, and the study is also located in the context of current health policies, and in particular the drive for compassion in healthcare.

¹ Reification is defined as “the apprehension of the products of human activity as if they were something other than human products” (Berger and Luckmann, 1966: 106).

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Chapter 3 presents a review of the supervision literatures in mental health nursing and midwifery. The review is thematically structured, creating a critical picture of the field of supervision research. Five themes emerge from the literature describing supervision as a contested concept, supervision as a good thing, supervision as the exercise of power, supervision as a form of reflection, and supervision in relation to professional identity. The review uncovers both differences and similarities in the accounts of supervision in the different disciplinary literatures examined. From the literature review, the current gap in knowledge is identified as including an understanding of supervision practices, practitioners' experience of supervision, the influence of context on supervision, negative and positive outcomes of supervision, supervision as an umbrella term, and supervision as a form of power. These elements are used to formulate the research questions:

1. How do midwives and mental health nurses experience supervision?
2. How can supervision narratives be understood within different professional contexts?

These questions aim to understand the individual experience of supervision in the context of shared discourses in the professional community.

In Chapter 4, theoretical approaches which have informed and influenced the study are discussed. These include sociological literature relating to the construction of occupations as professions, to an understanding of emotions as part of workplace interactions, and to the concept of subjectification.

Chapter 5 explains the research design, and theoretical concepts underpinning the research strategy. The research questions are answered using a study design informed by narrative theory in which narrative accounts of supervision experiences are collected through semi-structured interviews. The chapter discusses the process of narrative analysis created in this study, which uses techniques adapted from the work of Gee (Gee, 1985, Gee, 1986, Gee, 1991), and McCormack (2004), and is informed by the theories of Bruner (1986) and Ricoeur (1983/1984). The process of analysis includes the identification of key narratives which describe shared aspects of

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the supervision experience, and the construction of composite stories to illustrate the study findings. Finally the analysis employs the construct of feeling rules (Hochschild, 1983) to examine emotional discourses in the data.

Chapters 6 and 7 present the study findings. Chapter 6 presents four composite stories which encapsulate the study findings. These are connected to key narratives, which emerged from the data, and the key narratives are discussed with reference to the interview data.

Chapter 7 explores two major themes which emerge from the data: 'The Profession', and 'Emotions'. Feeling rules expressed in the data are discussed, and the themes are discussed in light of the theoretical lens of subjectification (Butler, 1997).

In Chapter 8 I explore three perspectives on supervision which have evolved from the study findings: Power, Emotions and The Professional Context. The key arguments constructed in this thesis are presented, and discussed in the light of the existing research literature, and theoretical perspectives (cf. Witz, 1992, Butler, 1997, Foucault, 1976, Foucault, 1977, Hochschild, 1983, Bolton, 2005)

Finally, in Chapter 9 the thesis is concluded, the contribution to knowledge discussed, and the implications for practice, research and policy are explored.

2 Background

2.1 Introduction

This chapter locates the study in the context of the historical development of mental health nursing, wider debates about supervision, and the policy context within which supervision occurs. The aim of this thesis is to explore the similarities and differences of supervision practices in the different professional contexts of mental health nursing and midwifery. Mental health nursing and midwifery have been selected as offering the opportunity to examine supervision experiences in the context of the distinctive traditions of clinical supervision and statutory supervision. At the same time these disciplines also offer enough commonality of context to allow for an informative and critical comparison of practitioners' experiences.

Mental health nursing and midwifery are distinct and separate disciplines which have some common areas of context, most notably in that they are both regulated by the NMC. Supervision in mental health nursing and midwifery supervision are formed of two separate traditions which in recent years have begun to cross-fertilise, and which draw on supervision traditions in other disciplines. Supervision in midwifery has a particularly unique legislative history, beginning with the 1902 Midwives Act, while supervision in mental health nursing has been largely influenced by supervision in psychological therapies.

The chapter begins with an examination the historical development of mental health nursing and midwifery. This illustrates points of comparison and contrast in the development of these two professions over the course of the 19th and 20th centuries. To locate this study within a broader context, a brief overview is provided of the development of supervision in social work and psychological therapies. These two areas have a long history of supervision, and have influenced the development of supervision in mental health nursing and midwifery. Finally I discuss the

contemporary political context of supervision in mental health nursing and midwifery.

2.2 Mental Health Nursing

It is difficult to define exactly what a mental health nurse is or does (Barker and Buchanan-Barker, 2011, Hurley et al., 2009). Mental health nurses are part of a group of practitioners with various clinical specialisms who call themselves ‘nurses’. The word ‘nurse’ comes from the Latin *nutricius*, meaning ‘to nourish’, and the idea of nursing as distinct from other forms of paid or voluntary healthcare, medicine and midwifery was established only in the 19th century, when the meaning of ‘nursing’ was expounded upon by Florence Nightingale (Borsay and Hunter, 2012). As I shall describe below, mental health care as a branch of nursing was later incorporated into a profession already defined by a focus on physical illness, and there is an on-going tension between the notion of the ‘nurse’ and that of the mental health care specialist (Nolan 1993).

Broadly speaking, mental health nursing may be defined as a branch of nursing which specialises in caring for people who suffer from disorders of the mind, and *Mental Health Nurse* is the current official description as enshrined in the NMC registry code (Nursing and Midwifery Council, 2010). Over the course of their history, mental health nursing and mental health nurses have been known by various different names, and terms such as *psychiatric nurse* continue to be used interchangeably with mental health nurse. The different terms used reflect the changing nature of mental health nursing, and can express allegiance to a particular model of practice (Norman and Ryrie, 2004). For example, *mental health nurse* is seen as demonstrating a positive, recovery-oriented practice and independence from medicine (Nolan, 1993, Norman and Ryrie, 2004).

In this thesis I have chosen to use the term *mental health nurse*, in reflection of the official NMC description, and also because it is the term to which I personally relate.

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This choice reflects a personal philosophy of mental health care as holistic and recovery focused, and situates my view of mental health nursing in a recovery focused paradigm in the context of the early 21st century UK.

2.2.1 The Development of Mental Health Nursing

This section provides a brief overview of the historical development of the mental health nursing discipline. This locates the discipline within an historical context shared by general nursing and midwifery.

The development of the mental health nurse job title reflects the significant changes which have occurred in the field of mental health care over the past two centuries, and also the evolution of an idea of mental health nursing as a distinctive occupation with the status of a profession.

In the UK, contemporary mental health nursing has its antecedents in the male ‘attendants’ and female ‘nurses’ who worked in the asylums of the 19th century and who were responsible for the management of the inmates (Nolan, 1993). The earliest training available for asylum staff was through the Medico-Psychological Association (MPA), which designed a national training programme, and in 1892 began issuing a ‘Certificate of Proficiency in Nursing the Insane’, together with a register of Certificate holders (Nolan, 1993). In this way the special occupation of ‘mental nursing’ was created to serve the needs of the more powerful medical profession (Barker and Buchanan-Barker, 2011).

At this time the asylum workers constituted “*a very frail and vulnerable workforce*” (Nolan, 1993: 72) who were expected to adhere to high standards of Victorian morality while employed in a low wage, low status occupation. Carpenter (1980) observes that on the Victorian salary scale, attendants earned around the same as agricultural labourers, and significantly less than factory workers.

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The predominantly male, working class workforce, and poor working conditions supported a “*trade union consciousness*” (Carpenter, 1980: 142) among attendants, which led to the formation of the National Asylum Workers Union in 1910, and to instances of industrial action during the 1920s (Dingwall et al., 1988). In this regard the development of mental health nursing contrasts markedly with that of general nursing, where middle class values dominated, and trade unionism was regarded as a threat to be averted by registration (Dingwall et al., 1988).

Despite unionisation, mental nursing practice and working conditions stagnated during the 1920s and 1930s (Nolan, 1993). The occupation was caught between the newly established General Nursing Council (GNC), who wanted to incorporate mental nurses into a unified profession dominated by general nursing, and the MPA, who wanted to maintain mental nursing as a speciality, and keep control over the certification of mental nurses (Dingwall et al., 1988). At the same time increasing numbers of (mainly female) mental nurses were registering with the GNC, changing mental nursing from a predominantly male to a predominantly female occupation (Dingwall et al., 1988).

The inclusion of mental nurses on the supplementary nursing register did nothing to improve pay and conditions, which deteriorated in comparison to general nurses. The specialism of mental health nursing was eroded by the ‘unified profession’ agenda of the GNC, and later by the emergence of psychopharmacological treatments which downgraded the importance of nursing care in the treatment of mental illness (Nolan, 1993, Dingwall et al., 1988). Dingwall argues that the economics of healthcare also consistently prevailed over occupational priorities. The mental health services continued as a deteriorating relict of Victorian provision until the 1970s, when the asylums began to be closed in the wake of a new focus on community care (Nolan, 1993).

From the 1960s onwards, mental health nurses began to move into more highly trained and specialist roles in community practice, and a developing body of research by nurses on nursing also helped to create a critical awareness of the issues faced by mental health nursing (Nolan 1993). Mental health nurse education began to be

influenced by the psychotherapeutic model, most prominently through the work of Peplau, Altschul and Barker, who refigured mental health nursing as being primarily about the relationship between nurse and patient (Norman and Ryrie, 2004). However the developing specialism of mental health nursing was soon “*radically undermined*” by the Project 2000 common foundation programme, which established a generic basis for all forms of nursing (Nolan 1993: 144).

Post-Project 2000, the existence of mental health nursing as a distinctive and specialist occupation continues to be in question (Barker and Buchanan-Barker, 2011). 21st century mental health nursing is increasingly influenced by clinical psychology, and in particular by the rise of short-term Cognitive Behavioural Therapy (CBT) (Hurley et al., 2006), and the dominance of the bio-medical model of psychiatry. Many mental health nurses locate their practice within an evolving psychotherapeutic model of care, and practise counselling and psychological therapies (Caie, 2011, Hurley et al., 2006). Caie (2011) argues that this represents a threat to the mental health nurse identity. Supervision practices and policy often occur within this context.

2.2.1.1 Summary

In this section the historical development of mental health nursing has been reviewed. The contemporary professional identity of ‘mental health nurse’ can be located with regard to an historical struggle for professional status, and the development of a clinical speciality. The negotiation of relationships with the disciplines of general nursing and medicine may be compared to similar negotiations between midwifery and these disciplines, and these are described in the next section.

2.3 Midwifery

This section provides a brief overview of the historical development of the modern midwifery discipline in the UK. This highlights points of contrast and comparison with the development of mental health nursing.

The word *midwife* means literally ‘with woman’ – the ‘woman’ in this case being the midwife (Borsay and Hunter, 2012). In the UK, midwifery is a distinctive profession whose work encompasses the care of pregnant women, women in labour, post-partum women, the foetus and baby (cf. Borsay and Hunter, 2012, Curtis, 1992). Midwives may work autonomously or alongside other professionals (Royal College of Midwives, 2013).

Midwifery is possibly the most ancient of all professions, and until the 17th century was almost exclusively female (Donnison, 1988). In medieval Europe, midwifery was a respectable occupation, and some medieval midwives were highly educated and financially prosperous (Donnison, 1988). Their unique role gave midwives a degree of power, but as women working in a misogynist culture, midwives were also vulnerable to exploitation by external authorities like the church, who sought to control women’s sexual behaviour (Donnison, 1988). Even at this time, therefore, there was a sense that midwives had to be monitored or supervised in some way.

In the 17th century, the care of women in childbirth began to change with the emergence of the ‘man-midwife’ – the term used to describe a male physician or surgeon who attended women in childbirth (King, 2012). Unlike female midwives, men had access to contemporary advances in scientific knowledge, and so were able to make some innovations in the management of difficult births, most notably through the invention of the obstetric forceps (Donnison, 1988). As the man-midwives began to invade the sphere of normal birth they came into direct competition with midwives (King, 2012). This involvement of men in birth was initially subject to considerable contemporary criticism, but over the 19th century

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medicine gained in credibility, and it became socially aspirational for a labouring woman to be attended by a physician (King, 2012, Donnison, 1988).

At the same time changes in work and the domestic sphere meant that midwifery was no longer an acceptable career for educated women, and Donnison (1988) observes that by the mid-19th century midwives were poorer and less well educated, and midwifery had become a low status occupation whose clientele were mostly from the poorer sections of society. However Nuttall (2012) points out that at this time midwives were still important partners for the man-midwives, who relied on midwives to call them in for emergencies. This changed over the course of the 19th century as the medical profession tried to gain more control of maternity care, and many doctors looked forward to the time when midwives would have been entirely replaced by physicians (Donnison, 1988, Nuttall, 2012).

By the late 19th century the campaign to improve the position of midwives had gained leadership with the founding of the Midwives Institute (Nuttall, 2012). The main focus of the Institute was registration. This was not a new idea in midwifery; medieval midwives had been regulated in various ways by civil and religious authorities, and debates about the licencing and registration of midwives had been conducted throughout the 17th and 18th centuries (Donnison, 1988). In the 19th century, the issue of midwife registration brought together a number of sometimes conflicting interests, and the outcomes of the campaign have been variously evaluated. For example, the London Obstetric Society wanted to establish control of maternity care, and create a workforce of suitably subordinate midwives who could be relied upon to assist physicians and attend the poor (Donnison, 1988, Nuttall, 2012). At the same time members of the women's movement were seeking to re-establish midwifery as a skilled profession suitable for educated women (Donnison, 1988). Nuttall (2012) argues that this second movement, spearheaded by the Institute, was elitist and lacked a real understanding of how the mostly working class midwives of the time were practicing and the issues they faced. On the other hand Donnison (1988) argues that the Institute was successful in restoring some of the status of midwifery, and in once more attracting educated women to the profession.

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The midwives' registration movement also became entangled with the simultaneous campaign for nurse registration (Donnison 1988). Over the years 1890 to 1902, nursing leaders took various approaches to the issue of midwife registration (Donnison 1988). At times the nursing leadership tried to join together the interests of nurses and midwives, campaigning for simultaneous registration, while at other times they argued that midwives should be replaced by obstetric nurses who would operate under the supervision of a physician (Donnison, 1988). Equally, some nursing leaders tried to promote the empowerment of midwives, arguing that registration should not be under the control of medicine (Donnison, 1988). Nutall (2012) observes that during this period midwifery was becoming increasingly allied to nursing in that many newly trained midwives had previously qualified as nurses. This meant that the new midwives had been educated within the medical model, "*contributing to the growing medicalization of childbirth*" (Nutall, 2012: 143).

From 1890 onwards several Midwives Bills were introduced to parliament (Donnison, 1988). Opposition to these came from parts of the medical profession who believed that registered midwives would encroach on their practice, and conversely from those who argued that the bills would disempower midwives by placing them under the control of the medical profession (Donnison, 1988). Despite the actions of these various conflicting interest groups, the 1902 Midwives Act (England and Wales) and the 1915 Midwives Act (Scotland) were eventually passed (Donnison, 1988, Heagerty, 1996). Donnison (1988) argues that this was a spectacular victory for women, who, despite not having an electoral voice, had managed to get their views taken into account by parliament and had pushed through legislation in the face of organised medical opposition. However, she also observes that the newly established Central Midwives Board was dominated by medical representatives, and there was no statutory requirement for any midwives to be appointed to the Board. This meant that unlike other professions, midwifery was not overseen by its own practitioners, but was controlled by outside interests, leading to a restrictive disciplining of the profession motivated by protectionism in the medical profession (Donnison, 1988).

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The 1902 Act was intended to improve the quality of midwifery practice and exclude undesirables from the profession. In reality the un-certified 'handywomen', who had provided much of the maternity care for poorer women, continued to practise into the 1930s. During the campaign for registration, the social elite of the Midwives Institute had painted the handywomen as ignorant and unsafe, and blamed them for causing infections, and exclusion of the handywomen had been part of the justification for registration (Hunter, 2012). Hunter (2012) argues that a re-evaluation of the evidence suggests that this picture of the feckless handywoman was untrue, and that in most cases handywomen provided a highly valued service. Donnison (1988) observes that after the 1902 Act the expected decrease in maternal mortality rates did not happen, and suggests that this was probably because midwives dealing with complicated births were now regularly calling in medical assistance, as required under the Act. The general practitioners who were called in had little skill and experience in dealing with birth, and probably caused injury and infection by attempting complicated obstetric procedures without the appropriate training or equipment (Donnison, 1988).

This situation gave rise to the 1936 Midwives Act, motivated by concerns over the fitness of the population to cope with on-coming war (Donnison, 1988). The Act required local authorities to provide a midwifery service for the general population, and effectively wiped out the last of the handywomen by also requiring that the local midwife should be engaged as maternity nurse when a general practitioner took charge of the birth. Donnison (1988) argues that the 1936 Act brought great benefits to the midwifery profession, making midwifery a more sustainable occupation, increasing ante-natal provision, and bringing public recognition to the importance of midwifery work.

The 1936 Act improved the status of midwives who practised autonomously in the community, overseeing most of their cases without medical interference (Hunter, 2012). However this situation was not sustained. The post-war period saw a national policy of hospitalisation of health care in general, and this included birth. The movement into hospitals meant that midwives were incorporated into a medically dominated hierarchy, and a policy of medical interventionism brought

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birth increasingly under the control of obstetricians, with the midwife relegated to the role of obstetric assistant (Hunter, 2012, Hunter and Borsay, 2012). The late 20th century saw midwifery training dominated by the medical model of birth, and direct entry to specialist midwifery training under threat, with increasing numbers of midwives having an initial nursing qualification (Donnison, 1988).

The association with nursing, begun in the late 19th century, arguably diminished the status of midwifery as an independent profession and increased allegiance to a medical model of birth (Williams, 1997, Donnison, 1988). In 1983 the Central Midwifery Board role was absorbed into the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), meaning that midwives became a minority group alongside the larger discipline of nursing (Kirkham, 1995). However, although the move into hospitals brought about a drastic deterioration in midwives' independence, the principle of professional autonomy has been consistently asserted by midwives, and the “*unique*”, “*separate*” and “*special position*” of the profession has received official recognition within legislation, notably through the creation of the powerful NMC Midwifery Committee which enshrines the influence of midwives over their professional rules (Winship, 1996: 41, Kirkham, 1998, Department of Health, 2008).

Initially the UKCC tried to include midwifery as a branch of nursing in Project 2000, but this plan was dropped after protests from midwives who saw this as being the end of a distinctive professional identity (Hunter and Borsay, 2012). Nevertheless it is open to debate how successful midwifery has been at maintaining separation from nursing. Hunter and Borsay (2012) point out that many nurses see midwifery as a part of nursing; there is a Chief Nurse (CNO) for each country of the UK, who represents all nurses and midwives, but need not have any knowledge of midwifery; and midwifery courses are generally taught in the same schools and departments as nursing.

2.3.1 Independent Midwifery

In this section the position of independent midwives is discussed. Of the eight midwives recruited for this study, two were independent midwives. This means that their context of practice had some distinctive features.

Independent midwives form a distinctive group within the midwifery profession. The term 'independent midwife' indicates someone who is self-employed, practicing outside the NHS and other institutions (Mander and Fleming, 2002). Prior to the establishment of the NHS, independent midwifery was the usual way in which midwifery care was delivered, but there are now only a tiny number of independent midwives practicing in the UK (Mander and Fleming, 2002).

The position of independent midwives has varied in different parts of the world and at different points in history, in New Zealand for example, there is a well-established system of independent midwifery (The Maternity Services Consumer Council, 2009), while in the USA, midwifery of any kind was illegal until the 1970s (Bourgeault and Fynes, 1997). In the UK, independent midwives are distinguished not only by their circumstances of employment, but also by a philosophy of care: independent midwives often ascribe to a holistic, woman-centred model of care, different to that delivered by the NHS (Mander and Fleming, 2002, Independent Midwives UK, 2009).

Independent midwives are a vulnerable professional group. Wagner (1995) has argued that they are often victimised by those in the standard care services, and Mander and Fleming (2002) comment that there are numerous examples of independent midwives being badly treated by NHS colleagues and by the statutory supervision system. In 1993 the Royal College of Midwives (RCM) withdrew indemnity insurance from independent midwives, meaning that many independent midwives were forced to practise without insurance (Mander and Fleming, 2002). In the UK, the continued existence of independent midwives is now in question, as by October 2013 a European Directive will require all health care professionals to have

insurance, which is unaffordable for most independent midwives (DH External Relations Directorate, 2013, Independent Midwives UK, 2013).

2.3.2 Summary

In this section the historical development of midwifery has been reviewed, and midwifery has been situated as a gendered profession, and in relation to the disciplines of general nursing and medicine. Key aspects of midwifery history were highlighted as informing an understanding of the contemporary professional identity of midwife. These include the significance of registration as conferring professional status. The registration of midwives saw the development of the statutory supervision system, and this is discussed in the next section.

2.4 The Development of Statutory Midwifery Supervision

Statutory midwifery supervision is a system through which standards of practice in the profession are monitored (Nursing and Midwifery Council and Local Supervising Authorities, 2008). The system was established by the 1902 Midwives Act which created Local Supervising Authorities (LSAs) (Heagerty 1996). The LSAs were intended to regulate midwifery practice in each area of the country, and inspectors were employed to oversee the work of registered midwives (Heagerty, 1996). In the early years of registration the inspectors were often chosen for their middle class background rather than their knowledge of midwifery, and Heagerty (1996) argues that they frequently had little understanding of, or respect for, working class midwives and the clients they served. Records from the time suggest that there was often considerable hostility between midwives and inspectors (Heagerty 1996).

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Nuttall (2012) argues, however, that in some areas the LSAs did contribute to the professional development of midwifery.

Following the 1936 Act, the supervision of midwives improved somewhat. Inspectors were now to be known as Supervisors of Midwives, and were required to have knowledge of midwifery practice (Allison and Kirkham, 1996). The problems of supervision were acknowledged, and there was an attempt to make supervision into a less punitive exercise (Allison and Kirkham, 1996). Supervisors were advised that they should conduct themselves towards their supervisees as a “*counsellor and friend rather than... a relentless critic*” (Ministry of Health letter 1937 cited in Allison & Kirkham 1996: 28). However the requirement for local authorities to employ midwives, meant that although supervisors were no longer the punitive inspectors of the early 1900s, they were in positions of power in terms of the management of midwifery services, and so in regard to their supervisees (Allison and Kirkham, 1996).

After the 1936 Act, statutory supervision continued to be confused with management and was experienced by midwives as primarily controlling. This began to change in the 1990s, when an upsurge in criticism of supervision brought about a re-focusing of the system (Kirkham, 1995). In 1994 the Midwives Code of Practice was re-worded to make supervision less about control and more about partnership, and during the 1990s the ratio of supervisors to midwives was gradually reduced, making it possible for supervisors to engage more with their supervisees (Kirkham, 1995). Previously midwives tended to come into contact with a supervisor only when something went wrong, but many midwives now meet with their supervisor once a year for an annual review, as required by the NMC (2008) (Stapleton et al., 1998).

In the 1990s, supervision became a topic for research, and statutory supervision was explored through studies such as the evaluation study commissioned by the UKCC and English National Board (ENB) (for midwifery) (Stapleton et al., 1998). Despite the changes of recent years, statutory supervision continues to be subject to considerable criticism, and to be experienced as controlling or punitive, as well as

supportive and developmental (Stapleton et al., 1998). These criticisms are discussed further in Chapter 3.

This section has explored how the statutory supervision system developed as part of the registration of midwives in the UK. An overview of the historical development of statutory supervision shows that the operation and purpose of the system have varied over the course of the 20th century, with supervision moving from a controlling and punitive system, to a greater focus on supporting and developing the practitioner.

2.5 Clinical Supervision

Supervision is an inquiry into practice. It is a compassionate appreciative inquiry... In supervision we re-write the stories of own practice... supervision interrupts practice. It wakes us up to what we are doing we wake up to what it is, instead of falling asleep in the comfort stories of our clinical routines.

(Ryan 2004, cited in Carroll 2007: 36)

In a landmark text on nursing supervision in the UK, Butterworth (1992b) observed that clinical supervision was well established in the disciplines of psychology, social work, counselling and midwifery. Although this arguably represents a misunderstanding of the nature of supervision in midwifery, (Deery and Corby, 1996), Butterworth's (1992b) remark serves to highlight the cross disciplinary influences of supervision. Clinical supervision in nursing has its roots in supervision in psychotherapy and social work (Carroll 2007) and in this section I shall briefly consider the development of supervision in these disciplines in order to locate this study within a broader context in the caring disciplines.

Carroll (2012) suggests that in the UK, supervision became more widely understood in the late 1980s, when psychotherapy, social work and other disciplines began to

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publish research into the subject. Prior to this, he argues, counselling and psychotherapy supervision in the UK was mainly about practice, and the research literature was largely based in the USA (Carroll, 2012). Supervision has a long history in psychotherapy where it has been in place for a century, and an even longer history in social work, where it began in the USA in the 19th century (Watkins, 2011 Carroll, 2007).

In social work, Bogo and McKnight (2005) observe that there are two distinct traditions of supervision in the literature: the supervision of students and the supervision of qualified social workers. Although these two traditions employ some of the same concepts and models, Bogo and McKnight (2005: 50) argue that “*the difference in context, purpose, and role of supervision*” means that they are essentially separate. Bogo and McKnight (2005) further separate social work supervision from clinical supervision. In some respects social work supervision is comparable to statutory midwifery supervision, in that it is primarily focused on the monitoring of practice, and professional development or support are secondary functions (Bogo and McKnight 2005). Unlike statutory midwifery supervision, however, social work supervision is more overtly managerial, with supervisors holding managerial posts and overseeing the delivery of care (Bogo and McKnight 2005). Supervisors are therefore aligned primarily with the organisation rather than the supervisee. Bogo and McKnight (2005) contrast this with *clinical* supervision, which they argue is primarily concerned with professional development and support through reflection on the practitioner-client relationship.

In counselling and psychotherapy, supervision originated with the work of Freud, and the formal practice of supervision was developed from the 1920s onwards (Watkins, 2011, Bernard, 2005). Watkins (2011) suggests that psychotherapy supervision may be regarded as a defining feature of the discipline which has successfully crossed over into other therapies. During the mid-20th century psychodynamic theories about the client-supervisee-supervisor relationship developed in complexity, while in other therapy modalities supervision took the form of role-modelling by an expert, or a therapy-style interaction (Watkins, 2011, Bernard, 2005, Carroll, 2007). The influence of psychodynamic theories on nursing

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supervision can be seen in the discussions of parallel processes in the literature (cf. Yegdich, 1998).

From the 1970s onwards, supervision became less of a therapeutic practice and more developmental, and in the 1980s, supervision was made compulsory for members of the British Association for Counselling and Psychotherapy (Carroll, 2007). Carroll (2007: 35) observes that in the field of counselling and psychotherapy, supervision is now “*a profession in its own right*”, with specialist training for supervisors.

Bernard (2005) comments that after 1992 there was a huge increase in the amount of research published on supervision in counselling and psychotherapy. The field is particularly rich in research on the supervision relationship (Watkins, 2011, Bernard, 2005). Bernard (2005) attributes this research focus to the important position of relationship theories to counselling and psychotherapy in general. In this regard, the field can be contrasted with research on supervision in nursing, where relatively little attention has been paid to the supervision relationship (Sloan, 2006).

Both Watkins (2011) and Bernard (2005) comment that supervision in counselling and psychotherapy draws upon a well-developed body of research, and this contrasts with the small amount of research done on clinical supervision in social work (Bogo and McKnight, 2005). Bogo and McKnight (2005: 61) observe that there is little empirical research on supervision in social work, although there is a body of “*theoretical, clinical, and anecdotal literature*”. This compares to the midwifery literature, in which there is also a large proportion of anecdotal, clinical and theoretical work.

In psychotherapy, Watkins (2011) observes that despite the rich research field, there is a lack of strong evidence as to the effectiveness of supervision, and in particular the effects of supervision on the client. Watkins (2011) argues that evidence of this effect is needed in order to justify the use of supervision. Looking at the development of supervision in psychotherapy, Carroll (2007) argues that the practice of clinical supervision became justified through the notion of the reflective practitioner. As the ‘reflection’ part of this approach, supervision came to be seen as

a vital part of practice (Carroll, 2007). As Chapter 3 will show, a similar connection has been made between reflection and supervision in nursing.

Watkins (2011: 58) also observes that in the psychotherapy literature there has been widespread debate about the definition of supervision: “*Is supervision teaching? Is supervision therapy? Is supervision consultation? Is it some blend of the three?*”. Again, in the nursing literature there is a similar on-going debate about the conceptualisation of supervision (see Chapter 3). Carroll (2007) argues that the concept of supervision cannot be fixed; it must be understood in the context of its development, and it will carry on developing in the future. Carroll (2007) pictures supervision as a meaning making conversation in which the practitioner learns from his/her experiences. He highlights the focus on work, and the relational nature of supervision as particularly important aspects of the concept.

Supervision has crossed disciplinary boundaries into a variety of occupations (Carroll, 2007). In the UK, Hawkins and Shohet’s *Supervision in the Helping Professions* (2012), first published in 1989, exemplifies the cross-disciplinary nature of its subject, and is regarded as one of the seminal texts on clinical supervision (Carroll, 2012). Hawkins and Shohet (2012) argue that any person whose work involves helping relationships with others can benefit from supervision as a supportive and developmental process. Hawkins and Shohet (2012) also observe that, increasingly, many professions are using counselling techniques in their work, which places new emotional demands upon practitioners. As observed in Section 2.2, this trend is present in mental health nursing. Hawkins and Shohet (2012) argue that this creates a greater need for the supportive and developmental functions of supervision. Similar arguments are put forward in the nursing and midwifery literature on supervision, where scholars highlight the emotional costs of caring work (see Chapter 3).

2.5.1 Summary – Clinical Supervision

This section has given a brief overview of supervision in social work and psychotherapy, two areas in which it has a long history. An awareness of the development of supervision in these two areas helps to locate midwifery and mental health nursing supervision within wider debates. Some of the debates highlighted here are also present in the nursing and midwifery literatures (reviewed in Chapter 3). Supervision in mental health nursing has borrowed considerably from practices in the psychological therapies. These influences have also affected midwifery debates on clinical supervision.

2.6 Current Health Policies

In recent UK health policies ‘compassion’ has been highlighted as a vital ingredient in good quality healthcare. For example, the strategy published by the NHS Commissioning Board Chief Nursing Officer and Department of Health Chief Nursing Adviser (Chief Nursing Officer, 2012) has compassion as a central concept. *Compassion in Practice* (Chief Nursing Officer, 2012), sets out a strategy of nursing and midwifery care organised around six principles – the six ‘Cs’ of: Care, Compassion, Competence, Communication, Courage and Commitment. The wellbeing of nurses and midwives is seen as an important part of compassionate care. The strategy states that in order for nurses and midwives to be able to carry out the six ‘Cs’ “*they need to be in supportive organisational cultures*”, and “*if we feel supported and cared about, we are enabled to support and care about our patients*” (Chief Nursing Officer, 2012: 11). One of the areas identified for action by the strategy is “*supporting positive staff experience*”, and this is clearly connected to improving the patient experience (Chief Nursing Officer, 2012: 24).

Compassion is also a central concept of the *Scottish Government Quality Strategy* for the NHS (The Scottish Government, 2010). The Quality Strategy states that

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compassionate care will be achieved by creating a “*culture of quality*” (2010: 6). The engagement and well-being of staff are regarded as important in establishing such a culture, and as in the CNO (2012) strategy, are connected to the well-being of patients: “*We also know about the correlation between staff experience and staff wellness with the patient experience and patient outcomes*” (2010: 6). Support and development of staff is therefore regarded as a part of creating a high quality service, and actions to be taken include:

Support staff, patients and carers to create partnerships which result in shared decision-making...

Introduce interventions to improve staff experience...

Develop, support and make best use of the skills, knowledge accountability and professional leadership of our staff...

(The Scottish Government 2010: 11)

Throughout the Quality Strategy (2010), healthcare staff are highlighted as an important resource, requiring investment and support in order to achieve the government’s policy aims, and one of the three ‘Quality Ambitions’ focuses on improving relationships between staff and patients. A number of programmes are mentioned which aim to “*develop further the caring and enabling aspects of the Nursing, Midwifery and Allied Health Professions*” (2010: 25).

These two documents (Chief Nursing Officer, 2012, The Scottish Government, 2010) include the support and development of nursing and midwifery staff as a key means through which service improvement can be achieved. However there is a lack of clear explanation of how this might be achieved. For example in light of the Quality Strategy, the Maternity Services Action Group (2011: 3) published an update of the Maternity Services Framework for Scotland in which one of the three areas to be implemented is “*workforce development*”. This is discussed mainly in terms of training and education, and there is little mention of supporting staff, although it is acknowledged that the wellbeing of staff contributes to their ability to promote the health of women (Maternity Services Action Group, 2011). In the *Scottish*

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Government Mental Health Strategy (The Scottish Government, 2012), which also responds to the Quality Strategy, there is almost no mention of staff development, and the strategy does not discuss the support needs of staff.

In contrast, *Midwifery 2020: Delivering Expectations* (Chief Nursing Officer, 2012: 25) describes statutory supervision as playing a “*pivotal role*” in the delivery of high quality services by promoting the midwife’s role, monitoring the delivery of care and supporting midwives. This strategy also recommends that midwives should engage in reflective practice.

The need for compassionate care has been highlighted by serious failings in the health service (BBC, 2012a), such as those at the Mid-Staffordshire Trust and the Winterbourne View Hospital. The report published by the *Mid-Staffordshire NHS Foundation Trust Inquiry* (Francis, 2013) contains the results of a high-profile inquiry into failures of care at the Trust. Many of the complaints considered by the inquiry were about “*basic nursing care*” (2013: 9). However, Francis (2013: 11) reports that the failure of care was systemic, and that while some of the poor care could be attributed to “*uncaring*” staff, most was due to staff shortages, and a problematic organisational culture which included an aggressive management style and low staff morale. Many of the criticisms made in the report concern poor management at the executive and Board levels (Francis 2013). One of the areas of failure identified by the inquiry is a “*lack of support for staff through appraisal, supervision and professional development*” (Francis 2013: 25).

In *Transforming Care* (Department of Health, 2012), the government’s response to the inquiry into abuses at the Winterbourne View Hospital, there is a similar picture of corporate failings and a problematic organisational culture. Members of staff at the care home had engaged in criminal abuse of their clients, but these failings were not identified, and when allegations were made these were not pursued (Department of Health, 2012). One of the report’s recommendations is that the workforce must be better trained and should receive on-going development, however there is no discussion of providing support systems for staff, or using reflective practice techniques (Department of Health, 2012).

In government policy there is a clearly identified need for greater compassion in care, and there is also a clear connection made between the ability of healthcare staff to provide compassionate care and their own support and development. However, recommendations as to how staff can be supported and developed lack direction. Despite a popular tendency to blame nurses for not being caring enough (Clout, 2008, BBC, 2012b), the findings of the Mid Staffordshire (Francis, 2013) and Winterbourne (Department of Health, 2012) reports suggest that corporate management and organisational culture are more clearly implicated in failures of care. This suggests that rather than scapegoating individual practitioners, formal, organisation-wide systems, need to be put in place in order to achieve better care. In the nursing and midwifery literatures, supervision is held to offer a solution to the problem of how to support and develop practitioners and monitor the quality of practice, and this will be reviewed in Chapter 3.

2.7 Summary

In this chapter I have explored the historical development of mental health nursing and midwifery, the roots of supervision practices in these disciplines, and the current policy in context in which supervision occurs. Issues identified include: quality of care, organisational culture, and professional purpose, identity and status.

Exploring the histories of mental health nursing and midwifery side by side highlights some instructive points of comparison and contrast. Both are gendered professions, associated with feminine qualities, and mainly employing women. But where midwifery has always been a female dominated profession, mental health nursing has evolved from a male occupation to become a largely female profession. Where midwifery is ancient, mental health nursing is relatively new. Midwifery has its roots in the community, mental health nursing in the institution. There are also points of similarity. Both occupations have an uneasy relationship with general nursing, and continue to negotiate their separateness from, or alliance with, general

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nursing. Both occupations have also been subject in different ways to the dominance of medicine. Midwifery has been actively attacked by medicine with the aim of taking control of childbearing and limiting the power of midwives. Mental health nursing has been shaped by medicine, to provide subordinates able to carry out the orders of the psychiatrist. Both occupations are engaged in a continuing struggle over professional status. The midwifery focus on normal birth, and the mental health nursing focus on relationships are each rooted in feminine values. They offer a challenge to the masculinist dominance of technology in health care, but are also a source of powerlessness.

Both professions are implicated in the current drive for compassionate care, and both are engaged in responding to the current conditions of the health service. This mix of distinctiveness and commonality provides the basis for a fruitful comparison of the activity known as 'supervision'. This activity is practised differently in the two professions, but is often ascribed similar aims such as client safety, support of practitioners, professional development and improving the quality of care (Nursing and Midwifery Council, 2008a, Nursing and Midwifery Council and Local Supervising Authorities, 2008).

3 Literature Review

3.1 Introduction

The previous chapter situated the topic of supervision within the disciplinary contexts of midwifery and mental health nursing, and the wider policy context. This chapter will explore how particular themes and concepts have developed within the academic literature on supervision, and what methods are being used to produce knowledge within this field. To this end I conducted a review of the scholarly literature relating to supervision in midwifery and mental health nursing.

The literatures reviewed in this chapter are of significantly different size. There is a large literature on supervision in nursing and mental health nursing, and a much smaller literature on supervision in midwifery. This reflects the different sizes of the disciplines – there are around four times as many nurses as midwives on the NMC register (Nursing and Midwifery Council, 2008b) – and also the fact that the statutory supervision of midwives is specific to the UK context, whereas there is an international body of work on supervision in nursing. The midwifery literature is also less scholarly, with fewer empirical studies, and a greater proportion of reports or papers aimed at a professional, not an academic audience.

The difference in the professional literatures poses three challenges: to identify the most relevant publications from the nursing literature, to incorporate enough midwifery literature to provide an informative sample, and finally to connect these two different literatures into a coherent picture of the state of knowledge in the field. In response to these challenges I have chosen to conduct a critical literature review organised around major themes in the field. This kind of literature review, which constructs a narrative about the research topic, is described by Baumeister and Leary (1997: 312) as “*valuable... when one is attempting to link together many studies on different topics, either for the purposes of reinterpretation or interconnection*”. The thematic structure of the review allows the integration of literature from different

clinical disciplines. Publications have been selected for review on the basis of contribution to the field and relevance to my research questions.

Section 3.2 begins with an overview of the search strategy used. In section 3.3 eight published reviews of the supervision literature are discussed. Five of these reviews draw on the nursing supervision literature in general (Hyrkäs et al., 1999, Butterworth et al., 2008, Fowler, 1996, Gilmore, 2001, Sloan, 2006), one has a focus on supervision in mental health nursing (Buus and Gonge, 2009), and two review the supervision literature in midwifery (Stapleton et al., 1998, Henshaw et al., 2013). These published literature reviews introduce some of the themes present in the field.

Sections 3.4 – 3.9 review five major themes which are present in the literature:

1. The concept of supervision: clinical supervision and statutory midwifery supervision.
2. Supervision as a ‘good thing’
3. Supervision as surveillance, and resistance to supervision
4. Reflection
5. Professional identity.

Finally the research methodologies in the field are discussed, and the gap in the current state of knowledge about supervision in the two fields of mental health nursing and midwifery is identified.

3.2 Searching the Literature

3.2.1 Terminology

There is considerable crossover between the literature on supervision in mental health nursing and supervision in other forms of nursing. There are also points of contact between the nursing supervision literature and the midwifery literature, particularly around the discussion of *clinical* supervision in midwifery, or rarely,

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around midwifery supervision as a source of inspiration for nursing (cf. Butterworth, 1992b, Deery and Corby, 1996). Nursing discourses on the meaning, aims and operation of supervision are shared between different clinical specialities. This review therefore incorporates literature on nursing supervision in general, although with a focus on supervision in mental health nursing. In the midwifery literature, supervision is discussed both as *clinical* supervision and as *statutory* supervision, and both these strands of discussion are included in this review.

The term ‘supervision’ is used in conjunction with different descriptors including *midwifery*, *statutory*, *clinical*, *nursing*, *administrative*, *managerial* and *peer*. Hyrkäs et al. (1999: 178) commented that supervision has been associated with a number of other terms such as “*consultation... job management, leadership... therapy... mentorship*”, and these terms can be used as synonymous with supervision, or to describe different practices which nevertheless have similarities to supervision practices. Supervision has also been associated with, but is generally differentiated from, *reflective practice*, *mentorship*, *preceptorship* and *therapy* (cf. Yegdich, 1999a, Kirkham, 1996, Butterworth, 1992b).

The variety of descriptors used with the word ‘supervision’ reflect the association of supervision with many different models, practices and disciplines. In the nursing literature, supervision is usually discussed as *clinical* supervision, while in the midwifery literature there is discussion of *statutory* supervision, and also *clinical* supervision.

As a concept, *statutory* supervision is generally treated as having clear boundaries, defined by its legal and regulatory status. In contrast (as discussed in section 3.3.4), *clinical* supervision is widely regarded as a poorly defined concept. In fact there is much debate about the practices associated with both of these concepts, and I suggest that while the use of supervision in conjunction with different descriptors may sometimes help to distinguish different practices or occupational contexts, it may also give an impression of greater conceptual and practical cohesion than in fact exists. I therefore use the term *supervision* to indicate a cluster of related concepts,

and use descriptors such as *midwifery* and *clinical* to situate the use of the term within particular theoretical and disciplinary fields, and different practices.

3.2.2 Search Strategy and Limitations

In order to maximise the relevance of the search a “*citation pearl growing*” strategy was employed (Harter, 1986: 183). This was particularly useful in managing the large amount of nursing literature, but also helped to expand the search of the midwifery literature. A citation pearl growing strategy begins with a narrowly focused search which is then gradually widened using information gathered from already retrieved publications to identify other key publications and to formulate new search terms (Harter, 1986). Papers were selected for review on the basis that they focused on supervision in nursing or midwifery. In selecting papers from the nursing literature priority was given to research which involved mental health nurses, although research focusing on general nurses was included where it informed the review. Research focusing on the supervision of students or patients was excluded.

The main sources of publications to be included in this review were the databases CINAHL and ASSIA. The search was limited to English language publications. The search included peer reviewed journals, books, monographs and published research reports.

In order to gain some sense of the breadth of the field, an initial search of CINAHL was made using keywords such as ‘supervision’, ‘nursing’, ‘midwifery’ and ‘mental health’. A search for nursing supervision papers retrieved 2,834 publications in peer reviewed journals dating from 1980. There was a dramatic decade by decade increase in the number of papers published, with a simultaneous increase in relevance. For example 119 papers were retrieved for the period 1980-1989, while for 2000-2012 1,944 papers were retrieved, suggesting a huge growth of interest in supervision during this time.

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A similar search of CINAHL for midwifery supervision papers retrieved 106 results. From the midwifery search 44 papers were selected for closer examination. This included a large number of very small-scale projects reported in professional journals. These were largely excluded from this review because a lack of information about research strategy meant it was impossible to assess the quality of the methods used. The citation pearl growing strategy was used to identify some further publications of interest, particularly books and a major research report. Ultimately 13 papers were identified as being of relevance to this review.

Presented with the challenge of filtering a large number of nursing papers I followed the citation pearl growing strategy and began with a very focused search, looking for papers with 'clinical supervision' in the title. This produced a much smaller number of relevant results. I also looked at the earliest and most recent papers published, and at reviews of the literature. The search was then grown using information from the papers already retrieved, and also expanded to retrieve a more comprehensive list of papers published in the last five years. There are a number of books published on supervision, and these were identified using citations from papers, and through the University of Edinburgh and the National Library of Scotland catalogues. Again, the selection of works to be reviewed was made on the basis of relevance to the research topic and contribution to the field.

Papers were excluded from the review where they focused on the supervision of students or patients. Some papers were excluded on the basis that there was not enough information provided to judge the quality of the evidence presented; this was particularly the case in a number of very short papers published in professional midwifery journals. From the nursing literature those papers which discussed the supervision of mental health nurses were prioritised and papers which focused on other branches of nursing were excluded where they did not add any new information to the picture of supervision.

In total 63 empirical research papers are reviewed in this chapter (see Appendix 1, *Table 1: Empirical Research Papers Reviewed*). These include 13 papers focusing on supervision in midwifery, 28 papers focusing on supervision in mental health

nursing, and 22 papers focusing on supervision in interdisciplinary or general nursing populations. The review also draws on some conceptual papers which inform the field. The spread of research methods used is shown below:

	Quantitative	Qualitative	Mixed Methods
Nursing	21	21	8
Midwifery	1	8	4

Figure 1. Table of Research Methods Used in the Literature Reviewed

3.3 Literature Reviews 1996-2013

In this section there is a discussion of eight reviews of the supervision literature. These reviews help to identify major themes in the field. First, two reviews of the midwifery literature are discussed. These were the only published reviews of the midwifery literature I was able to identify. Then six reviews of the nursing literature are discussed in chronological order to show how the field has developed conceptually and theoretically over the past two decades.

3.3.1 Two Midwifery Reviews

3.3.1.1 Stapleton et al. (1998)

A review of the midwifery literature conducted by Stapleton et al. (1998) was used as the background to a large scale evaluation of midwifery supervision. Stapleton et al. (1998: 1) observed that “*There has been little previous research on the supervision of*

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midwives”, and much of their literature review is concerned with discussing the various influences on midwifery supervision. These influences include the location of midwifery in gendered institutions, and the disempowerment caused by its association with the “*female gendered skills of support, caring and being with women*” (Stapleton et al., 1998: 21). Stapleton et al. (1998) argued that midwives were an oppressed group, subject to strict controls from both within and out with the profession. At the same time midwifery continued to be strongly influenced by an aspirational professional project creating an association between supervision and professional status (Stapleton et al., 1998). The authors also described the changes which had taken place in supervision over the course of the 20th century, from the early approach to supervision as control, to a more empowering support-oriented approach. These changes occurred in the context of larger social processes such as the women’s movement which sought to re-empower birthing women and de-medicalise maternity care (Stapleton et al., 1998).

Midwifery supervision has also been influenced by changes to the health services such as the use of corporate and market models in the health service, and a greater focus on risk management (Stapleton et al., 1998). Stapleton et al. (1998) argued that these changes led to greater surveillance of workers. At the same time more emotional demands were made on midwives with the introduction of government policies promoting compassionate care. Stapleton et al. (1998: 24) argued that a paradoxical situation was created in which “*support and care were required but devalued*”.

3.3.1.2 Henshaw et al. (2013)

Henshaw et al.’s (2013: 76) systematic review focused on “*how statutory supervision is perceived and experienced by midwives and supervisors of midwives*”. Henshaw et al. (2013) found that studies employed a mixture of qualitative, quantitative and mixed methods, and that quality was mixed, with only three papers being of ‘high’

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quality, eleven 'good' quality and five 'poor'. The authors identified four themes in the literature: the significance of supervision, supervision as supporting practice, supervision as a means of control and supervision relationships. They observed that midwives seem to be poorly informed about supervision, but that they nevertheless felt that supervision was important. Reports of the supportive nature of supervision were mixed, with a number of studies suggesting that supervision was experienced as unsupportive. Issues of power and control were identified as important. The controlling aspect of supervision was experienced as positive and protective, and yet also punitive. The relationship between supervisor and supervisee could also be experienced as empowering or intimidating (Henshaw et al., 2013).

A major theme present in both these reviews is around supervision and power: the controlling power of surveillance, and the power of professional status. The reviews also highlight the lack of research-based knowledge about supervision. Stapleton et al. (1998) commented that the enormous changes which had taken place in supervision had not been accompanied by research into how midwives actually experience supervision, and while Henshaw et al.'s (2013) review shows that the situation has improved somewhat over the past decade, the field is still narrow and there is a lack of high quality research.

3.3.2 Six Nursing Reviews

3.3.2.1 Fowler (1996)

The association of supervision and the exercise of power is also evident in the earliest of the nursing reviews, by Fowler (1996). Fowler (1996) observed that supervision in nursing had been supported by policies from the Department of Health and the UKCC. Supervision was therefore introduced as a concern of those in authority over nurses. This reflects the numerous references made elsewhere in the

nursing literature to the endorsement of supervision in policy, particularly the UKCC position statement on clinical supervision (UKCC 1996 cited in Gilmore, 2001: 138).

Fowler (1996) also commented on the conceptual confusion which existed around the term 'clinical supervision' and argued that clinical supervision tends to be used as an umbrella term. Fowler (1996) suggested that the term might be clarified by its restriction to an activity involving qualified nurses, thus distinguishing clinical supervision from educational activities.

Reviewing the empirical evidence for supervision, Fowler (1996) concluded that there was little evidence to support the practice of supervision, but that ideas were being drawn from other fields to form what he believed would become a single model of supervision for both nursing and midwifery which could then be tested and developed through research. Despite the lack of evidence, Fowler (1996) observed that there was a general acceptance of supervision as desirable: "*the literature appears largely to consider clinical supervision as a 'good thing'*" (Fowler, 1996: 472).

3.3.2.2 Hyrkäs et al. (1999)

By the end of the 1990s Hyrkäs et al. (1999) were able to identify more empirical research on supervision in nursing, but argued that not only was the body of research methodologically weak, but there was still considerable conceptual confusion, and a lack of theoretical foundation to the field.

The development of the theory of clinical supervision is more or less at a standstill, and practical action lacks cohesion.

(Hyrkäs et al., 1999: 178)

Fowler (1996) had looked forward to the development of a single theory of supervision, and Hyrkäs et al. (1999) commented that there was still a sense that

scholars were looking to develop such a theory, but that many scholars had also challenged this aim as either impossible or unnecessarily restrictive. However the authors also observed that the argument was being articulated that supervision requires a strong theoretical framework, even if not a unified one. Like Fowler, Hyrkäs et al. (1999) identified a widespread concern with the concept of clinical supervision as unclear, and sometimes used interchangeably with concepts such as mentorship.

Methodologically, Hyrkäs et al.'s (1999) collection of studies is dominated by the use of questionnaires to collect data, and the authors argued that this use of quantitative research methods is problematic where the phenomenon under investigation is as complex and variably conceptualised and practised as supervision. They suggested that the number of methodological problems evident in the studies reviewed was symptomatic of the difficulty of researching supervision, and of demonstrating the effects of supervision.

3.3.2.3 Gilmore (2001)

In a review by Gilmore (2001), supervision was situated as the priority of regulatory organisations. Gilmore's (2001: 125) review was commissioned by the UKCC, and she commented that "*clinical supervision has been widely discussed and written about since its endorsement by the Department of Health and UKCC*". Like Fowler (1996), and Hyrkäs et al. (1999) Gilmore argued that there was a lack of empirical evidence about the outcomes of clinical supervision, but observed that clinical supervision projects were nevertheless being implemented in many local health care services.

Despite official support for supervision, Gilmore (2001: 127) identified a number of "*barriers to the uptake of clinical supervision*", and these included resource issues, lack of leadership, and resistance to supervision. Gilmore (2001: 127) suggested that "*resistance appears to arise from lack of knowledge of the purpose and nature of*

clinical supervision". This lack of knowledge was seen in managers, who "*question the time and cost needed*", and also practitioners who didn't see a need for supervision, or didn't trust their supervisor. Gilmore (2001: 134) also commented that although funds of around £800,000 had been allocated by the Department of Health for the implementation of clinical supervision in England, this had failed to create widespread practices of consistent quality. Gilmore (2001) observed that funding had been won for supervision on the basis of a connection to patient outcomes, and argued that making this connection would help to create sustainable funding for supervision projects.

In contrast to Fowler (1996), and Hyrkäs et al. (1999), Gilmore (2001) paid more attention to literature reporting on the implementation and practice of supervision. She identified two major trends in the focus of supervision sessions: on caseload management; and on the needs of the practitioner. She asked if these different approaches should both be regarded as clinical supervision. She also explored some of the literature on the process of supervision, particularly as a relational process. Elements identified included the interaction between supervisee and supervisor, confidentiality, reflective practice and the supervisor's "*helping style*" (Gilmore, 2001: 132).

3.3.2.4 Sloan (2006)

Sloan (2006) also gave attention to the literature on the processes of supervision, arguing that there was little clarity about how supervision was actually being done. He observed that there was some evidence for the characteristics of a good supervisor, but that generally the research literature had failed to produce much convincing evidence on the practices or outcomes of supervision. In the light of this lack of empirical evidence Sloan (2006) challenged attempts to identify a causal connection between supervision and patient outcomes, arguing that in studies where supervision was determined to be 'effective', the practices which produced such

effectiveness were unexplored, and so the cause and effect could not be reproduced elsewhere. ‘Effects’ of supervision also varied between studies, but could include improved sense of wellbeing, professional development, enhanced skills and greater job satisfaction (Sloan, 2006). The Manchester Clinical Supervision Scale (MCSS) was a major tool used to determine ‘effectiveness’ as defined by items such as a trusting relationship, the opportunity for reflection, getting advice, or regarding supervision as important (Winstanley, 1999).

Sloan (2006: 27) also argued the attention given by researchers to the effect on patient outcomes might “*prevent other, less substantial changes being noticed*”. In this way Sloan’s (2006) approach contrasts markedly with Gilmore’s (2001) argument that it is important to show a connection between supervision and patient outcomes.

In a similar vein to Fowler (1996), Sloan (2006) argued that supervision was a problematic concept which is nevertheless “*idealised*” in the nursing literature. He commented that despite the lack of evidence, clinical supervision had become prevalent idea, and received support from politically powerful institutions. Sloan (2006) concluded that more evidence was needed about how supervision was actually being done.

3.3.2.5 Butterworth et al. (2008)

The title of Butterworth et al’s (2008) review of literature published between 2001-2007, *Wicked Spell or Magic Bullet*, acknowledged not only the idealisation of supervision, but also the opposing phenomenon of resistance to supervision. Butterworth et al. (2008) identified four streams in the clinical supervision literature. The most significant of these being around the learning and support functions of supervision. They observed that the supportive function of supervision had received the most research attention, mainly in qualitative research studies, but that the evidence reviewed was inconclusive. A third stream – practitioners’ engagement

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with supervision – raised issues of how supervision was done (location, frequency, duration), and how practitioners were prepared for supervision. Like Sloan (2006), Butterworth et al. (2008) concluded that there was no body of evidence to support one way of doing supervision over another.

The authors also drew attention to the discussion of ethical issues with regard to supervision, and in particular issues of power and resistance. They identified several critiques of supervision as an exercise of power, and some studies which showed practitioners viewing or experiencing supervision as negative. However they argued that there was little evidence showing supervision as a negative experience.

In contrast to Hyrkas et al. (1999), the majority of studies reviewed by Butterworth et al. (2008) used qualitative methods. In contrast to Sloan (2006), Butterworth et al. (2008) argued that research into the connection between supervision and patient outcomes was of value, although they gave equal support to research investigating the effects of supervision on practitioners.

3.3.2.6 Buus and Gonge (2009)

Reviewing a similar period to Butterworth et al. (2008), Buus and Gonge (2009) found that empirical research into clinical supervision in mental health nursing was dominated by quantitative methods. In locating their review in the discipline of mental health nursing Buus and Gonge (2009) challenged the notion of a single model or theory of supervision, arguing that the distinctive work of mental health nurses created a distinctive need for supervision.

Buus and Gonge (2009) identified four types of study in the literature: quasi-experimental, survey, interview and case study. They argued that there were a number of methodological problems with the studies they reviewed. For example, most of the questionnaires used were not widely recognised and validated (the exceptions to this were MCSS and the Maslach Burnout Inventory (MBI)).

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Furthermore, evidence from the surveys was used to make unwarrantable assumptions about causal effects (Buus and Gonge, 2009). The authors also argued that the qualitative interview studies reviewed showed a lack of reflexivity, failing to address issues of co-construction, while the case studies demonstrated a lack of contextual analysis.

Three main points stand out in Buus and Gonge's (2009) conclusion. First, they echoed Hyrkäs et al. (1999) in arguing that supervision was a difficult phenomenon to research because it was a complex activity influenced by numerous factors. Second, they observed the widespread use of 'Proctor's model' in the field. Third, they regarded the lack of consensus over concepts and models of supervision as weakening this body of research. They commented that:

“even after accepting that the term ‘clinical supervision’ may be the only common denominator between papers on the issue, the literature on clinical supervision in psychiatric nursing is not easy to summarize and evaluate”

(Buus and Gonge, 2009: 251)

Finally, (like Butterworth et al. 2008), Buus and Gonge (2009: 262) made a brief reference to the phenomenon of practitioners resisting supervision: “*nurses may be ambivalent about clinical supervision*”.

3.3.3 Summary

The eight published reviews of the supervision literature discussed in this section show certain themes as emerging from the nursing and midwifery literatures on supervision. In the nursing literature the *concept* theme is perhaps the most widespread of these. This is underpinned by debates over the merits of a single definition, theory and model of supervision. Fowler (1996) raises conceptual confusion as a problem in 1996, and this is still seen as a problem in 2009 (Buus and Gonge). Discussion of concept is less evident in the midwifery literature, although there is some debate about the confusion of functions in midwifery supervision.

Despite the frequent references to conceptual confusion, the nursing literature shows an uncritical and widespread acceptance of supervision as a *good thing*. This is expressed in the drive to show good outcomes for supervision, rather than questioning whether supervision is worth doing at all. This contrasts markedly with the theme of supervision as *surveillance* present in the midwifery literature, in which supervision is discussed as a form of control. In the nursing literature the discussion is less politicised, but the phenomenon of *resistance* to supervision is observed. In the midwifery literature supervision is also discussed as underpinning *professional identity*.

The research on midwifery supervision is too limited to have established a methodological tradition, but in nursing, methodology emerges as a major issue. The methodological quality of the field is criticised as poor, but there is also an acknowledgment that supervision is a difficult phenomenon to research. There seems to be disagreement over whether quantitative or qualitative research methods are more dominant in the field. The papers included in this review are evenly balanced between qualitative and quantitative methods, although this is a critical review so does not present a comprehensive picture of the field.

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In general, although the nursing research literature is much larger than the midwifery research literature, neither seem to have produced a convincing accumulation of evidence as to the meaning, practice or outcomes of supervision.

In the following sections a review of the midwifery and nursing literatures is presented as structured around the five themes which have emerged from the supervision literature.

3.3.4 Concept

3.3.4.1 Concepts in Social Science

Concepts are widely regarded as fundamental to social research, although they are developed and employed in different ways within different theoretical traditions (Blaikie, 2000). In Berger and Luckmann's (1966) social constructionist approach, concepts and networks of concepts form the means by which a symbolic universe is maintained. These "*conceptual machineries*" are self-justifying, and so their constructedness is concealed (Berger and Luckmann, 1966: 126). Concepts are thus part of the mechanism by which the norms of social life are established and legitimised.

In social research there is a long-standing "*operationalizing tradition*" which uses concepts to produce researchable variables (Blaikie, 2000: 133). In this tradition a concept is given a stable definition which can then be connected to measurable phenomena (Blaikie, 2000). The concept is assumed to unproblematically represent the phenomena under investigation (Blaikie, 2000). From a constructionist perspective this is clearly an unjustifiable assumption since, as part of the mechanism which constructs and maintains our symbolic universe, concepts both reference a phenomenon and alter how that phenomenon is perceived and/or enacted.

In a challenge to the operationalizing tradition, Blumer (1969/1998:168) argued that concepts should not be treated as though they have “*intrinsic meaning*”, but must remain connected to, and tested against, the phenomenon which they are intended to describe. Blumer (1969/1998) made a distinction between the everyday concept – which is used unreflectively – and concepts in social research – which must be used with critical reflection on their purpose and construction. In social science, he argued, concepts have a “*sensitizing*” function (Blumer, 1969/1998: 147). The sensitising concept reflects a context-dependent way of knowing: since a phenomenon must be understood in its specific context a concept cannot definitively describe the phenomenon, but rather suggests “*directions along which to look*” (Blumer, 1969/1998: 148).

In social science concepts are closely related to theory (Blaikie, 2000). Theories are widely regarded as explaining and organising knowledge about a phenomenon through networks of related concepts (Blaikie, 2000). Traditionally the idea of the social science theory has been based on the stable, explanatory, predictive theory of natural science (Flyvbjerg, 2001), and Blumer (1969/1998) argued that sensitising concepts could be used to create this kind of theory. However, Flyvbjerg (2001) observed that this kind of predictive theory does not seem possible in social science. Furthermore, he argued that because the meaning of social phenomena is inextricable from their context, the creation of an abstract theory is inherently problematic. However Flyvbjerg (2001: 128) did not reject the use of theory, but argued that in phronetic research theory is less important than practice, and that “*theories, and conceptualization in general, must be constantly confronted with praxis*”.

This brief discussion of concepts will inform the following exploration of conceptualisations of supervision in the nursing and midwifery literature. Blumer’s (1969/1998) notion of the sensitising concept challenges the assumption that conceptualisation must be definitive and refer to fixed characteristics, while the arguments of Berger and Luckmann (1966), and Flyvbjerg (2001), have drawn attention to the political role of concepts as a part of the mechanisms of power. Flyvbjerg’s (2001) consideration of theory also casts a new light on the role of the

concept in knowledge creation which brings the role of the concept in research back to Blumer's (1969/1998) argument that the concept must be tested against practice.

3.3.4.2 Clinical Supervision

In this section the concept of supervision is discussed in terms of its use in the literature referring to *clinical supervision*.

3.3.4.2.1 Features of Clinical Supervision

The concept of clinical supervision in nursing has been described as confused or ambiguous (cf. Cleary et al., 2010), and the ambiguity of the concept is associated with difficulties in putting supervision into practice (cf. Rice et al., 2007). Sloan (2006) argued that the essential features of the concept were generally understood, while Hyrkäs (2006) suggested that the nursing literature had accumulated a variety of understandings of supervision which reflected the broad and culturally situated nature of the concept. As Fowler (1996) suggested, it is perhaps most useful to think of clinical supervision as an 'umbrella term' which covers a variety of practices. These include:

- 'peer supervision' (cf. Hyrkäs et al., 2005, Malin, 2000) where two or more individuals supervise each other in an egalitarian relationship.
- 'group supervision' (cf. Arvidsson et al., 2000, Arvidsson et al., 2001, Bradshaw et al., 2007) where one or more supervisor(s) facilitate supervision with a group of supervisees.
- 'one-to-one' supervision between a single supervisee and supervisor. Hyrkäs (2005) and Kelly (2001b) found that this was the most common method of supervision in Finland and Northern Ireland respectively.
- 'team supervision' where an entire team is supervised as a group (Hyrkäs et al., 2002).

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Generally excluded from the category 'clinical supervision' is supervision done for administrative or managerial aims (Cutcliffe and Hyrkäs, 2006).

3.3.4.2.1.1 When, Where and How Often

Some basic features of clinical supervision practices include when sessions happen, where and how often. There is evidence that these factors influence the effectiveness of supervision.

For example, Edwards et al. (2005) used the MCSS (Manchester Clinical Supervision Scale) to survey community mental health nurses in Wales. They found that nurses evaluated supervision most positively when sessions took place away from the work environment, lasted more than an hour, and were held at least once a month. Also using the MCSS, Hyrkäs (2005) found that the majority of respondents had one-to-one supervision, had chosen their supervisor, and had sessions of at least one hour. Frequency and duration of sessions, and choosing the supervisor were associated with effectiveness (Hyrkäs, 2005). Factors such as having more than two years' supervision experience, and being a specialist nurse were also associated with responses which scored the effectiveness of supervision more highly (Hyrkäs, 2005)

It seems that practitioners experience regular supervision sessions as having a more positive effect, but attendance can be difficult. Butterworth et al. (1997) found that participants had to make considerable efforts to keep time and space for supervision sessions. Buus et al. (2010) found that inconsistent attendance of a supervision group created problems and limited any benefits. Similarly, Cleary and Freeman (2005) found that ad hoc supervision perpetuated problematic practices and beliefs, and argued that consistency and continuity are vital qualities of supervision.

Ability to attend supervision sessions may depend on managerial support or on logistical factors such as shiftwork. Gonge and Buus (2010) found that community based nurses were considerably more likely to participate in clinical supervision than

in-patient nurses, and nurses working a day shift were more likely to participate than those working evening shifts. Gonge and Buus (2011) found an association between participation in supervision and effectiveness of supervision, although it was not possible to identify whether increased participation made supervision more effective or effective supervision motivated increased participation (Gonge and Buus, 2011).

3.3.4.2.1.2 Supervisors

Supervisors play a key role in clinical supervision, and some forms of supervision may be particularly challenging to the supervisor (Hyrkäs et al., 2002). Sloan (1999) found that community mental health nurses identified the qualities of a good supervisor as being the ability to engage in a supportive relationship with the supervisee, being a good listener, and having some degree of relevant expertise.

Supervisors may be nurses (cf. Arvidsson et al., 2001, Bradshaw et al., 2007). Supervisors may also be from a different discipline to their supervisees, such as psychiatry or psychology (Gonge and Buus, 2010). In Deery's (2005) study on the clinical supervision of midwives, the different disciplinary background of the supervisor, and the fact that they were unconnected to the maternity service was presented as an advantage. Similarly, Buus et al.'s (2010) participants felt it was important that the supervisor was from outside their workplace.

In some cases supervisors have extensive specialist training. In a three year project on team supervision in a Finnish hospital, Hyrkäs et al. (2002) used supervisors who had, on average, fifteen years' experience working as supervisors. In other cases supervisors have minimal training. In White and Winstanley's (2009) large scale, multi-site, randomised controlled trial of clinical supervision in Queensland, supervisors had four days training. Some scholars advocate that supervisors should have experience and/or expert knowledge (cf. Bradshaw et al., 2007). Scandinavian supervision experts interviewed by Severinsson and Borgenhammar (1997) argued

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that the supervisor must have expertise so that they can guide the supervisee through a process of professional development.

The expertise of the supervisor may be in the form of nursing expertise (Rice et al., 2007), or it may be supervisory expertise (Jones, 1998). Jones (1998) argued that the supervisor must be emotionally skilled, able to safely manage the emotions which discussion of sensitive issues may bring up for both supervisee and supervisor. Jones (1998) also illustrated the interpersonal skill of a supervisor, who is able to challenge the supervisee, uncovering tacit knowledge, without overwhelming him/her. These skills, Jones (1998) argued, depend upon on-going support and education for the supervisor.

Edwards et al. (2005) found that being able to choose one's supervisor was associated with more effective supervision and a better supervisory relationship (see also Ayer et al., 1997, Hyrkäs et al., 2006, White et al., 1998). In Kelly et al.'s (2001b) survey of CPNs in Northern Ireland, over half of the supervisee respondents said that their supervisor had been allocated by management and almost half had a line manager as supervisor. This was despite almost universal agreement that a supervisor should not also be a manager (Kelly et al., 2001b). Similarly, in Sloan's (1999) investigation of the qualities of a good supervisor, mental health nurses who had been allocated their supervisor reported that this reduced the quality of their supervision, and could preclude a supportive supervisory relationship.

The involvement of managers in the supervision of subordinate staff has been problematised. There is evidence that practitioners believe that a supervisor should not be in a managerial relationship to the supervisee as this is likely to cause a confusion of roles (cf. Ayer et al., 1997, Cutcliffe and Hyrkäs, 2006). Mental health nurses in Scanlon and Weir's (1997) study reported that having a manager as supervisor meant that clinical supervision was hijacked by managerial issues. Nurses who had supervision outside of the managerial structure had a more positive experience of supervision (Scanlon and Weir, 1997).

3.3.4.2.1.3 Purpose

One of the main purposes assigned to clinical supervision is support, and the reduction of stress. For the nurses in Teasdale et al.'s study (2001) it was important that their supervisor recognise their need for support. For Marrow et al.'s (2002) community nurse participants, support was the most highly valued function of supervision, while Scanlon and Weir's (1997) participants valued being able to discuss problems in the supportive environment provided by supervision.

Using the MCSS and the Maslach Burnout Inventory (MBI) to survey community mental health nurses, Edwards et al. (2006) found that effective supervision was associated with reduced levels of burnout, particularly emotional exhaustion. Wallbank (2010) described a focused, short term form of clinical supervision used to support midwives and doctors in the aftermath of death on a maternity unit. The supervision was effective in reducing stress, burnout and compassion fatigue amongst practitioners (Wallbank, 2010).

Supervision is also regarded as a way of reflecting on and managing the practitioner-client relationship. The supervision discussion may focus on a particular patient (Arvidsson et al., 2001). Scanlon and Weir (1997) found that supervision supported mental health nurses in managing the emotions of nurse-patient relationships. Holst et al. (1999) observed that nurses used clinical supervision to recount experiences of patients with dementia which they configured into coherent stories, making their patients' behaviour understandable and meaningful. The construct of 'parallel processes' is discussed as forming part of the repertoire of clinical supervision (cf. Playle and Mullarkey, 1998, Yegdich, 1999b). This view of the supervision interaction draws upon a psychodynamic perspective (Playle and Mullarkey, 1998). The supervisee is considered to re-enact practitioner-client relationship dynamics in the supervision session. The supervisee-supervisor relationship thereby becomes a means through which interpersonal aspects of patient care can be addressed. Although the phenomenon is discussed, there does not seem to be any empirical

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research from the nursing or midwifery fields which investigates parallel processes in examples of supervision practice.

Despite general agreement that clinical supervision should be separate from management, in practice it is sometimes used to meet managerial requirements (Sloan, 2006). Health service directors implementing clinical supervision among mental health nurses in Northern Ireland reported that it was difficult to separate clinical supervision from managerial purposes, perhaps because supervision was provided by line managers (Rice et al., 2007). It is argued that supervision should not have a managerial purpose, and that managerial aims, such as professional accountability, should be achieved through specific *managerial* supervision (Sloan, 2006, Cutcliffe and Hyrkäs, 2006, Scanlon and Weir, 1997). Hyrkas et al. (2005) argued that managers themselves may benefit from receiving clinical supervision.

Supervision is also commonly associated with professional development (cf. Butterworth et al., 1997), or with the development of knowledge and skills. Hancox & Lynch (cited in Hancox et al., 2004: 200) describe the purpose of supervision in terms of support and development: “*the focus is to provide support for the supervisees in order to promote professional development*”. Sloan (1999) found that community mental health nurses regarded clinical supervision as being about a combination of professional development, clinical matters, and emotional support. Ayer et al. (1997) conceptualised supervision as a developmental process. Drawing on Farkas-Cameron (1995) they described this process as moving from a situation in which the supervisor leads and the supervisee is un-reflexive, through a process of relationship building and self-discovery, to a stage where the supervisee is able to evaluate him/herself and has acquired new skills.

Binnie (2011), a nurse supervising practitioners using CBT techniques, reflected that where her supervisee did not have a core mental health qualification she found herself taking an actively educational role. Severinsson et al. (2010) conducted a clinical supervision intervention with midwives which is described as focusing on professional identity, although this seems to have included a diverse range of topics including the midwife-client relationship, ethical decision making, and

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documentation. Severinsson et al. (2010) found that the relationships developed in the supervision group helped the midwives to work on issues in the midwife-client relationship and think differently about their professional role.

In contrast Malin (2000) found that members of a supervision group in a learning disabilities service felt that supervision did not encompass professional development, while Stevenson and Jackson's (2000) Egalitarian Consultation Meetings functioned as a way for community psychiatric nurses (CPNs) to deconstruct the concept of professionalism, and challenge organisational structures.

3.3.4.2.1.4 Training

Kelly et al. (2001b) found that the majority of their CPN respondents had not had any training in supervision. Their survey used attitude statements to identify a high degree of uncertainty about supervision, particularly among nurses who had no experience of supervision, suggesting that the CPN population needed to be better informed about supervision. Scanlon and Weir (1997) also identified a lack of training in supervision, particularly of supervisors. Nurses felt that the lack of trained nurse-supervisors meant that supervision was less effective and that they had to look outside of their discipline for supervision. White and Winstanley (2009) reported that a lack of training of supervisees hindered the implementation of a clinical supervision programme.

3.3.4.2.2 Concepts of Clinical Supervision

The features of clinical supervision discussed above show that the concept of clinical supervision is associated with a wide diversity of contexts, aims, philosophies and practices. There are also a variety of conceptualisations of clinical supervision as these recently published definitions demonstrate:

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“an activity that brings skilled supervisors and nurses together in order to reflect upon their practice”

(Francke and Graff, 2012: 1166)

“Clinical supervision is a formalized pedagogical process where nurses, individually or in groups, discuss work-related issues with a qualified supervisor. The purpose of clinical supervision is to improve the quality of nursing care by directing, developing, and supporting nurses.”

(Buus et al., 2011: 95)

“Clinical supervision... is the provision of time-out and an opportunity within the context of an ongoing professional relationship with an experienced practitioner to engage in guided reflection on current practice, in ways designed to develop and enhance the practice in future”

(White and Winstanley, 2010 adapted from the Open University 1998)

In the first of these definitions Francke and Graff (2012) included the notion of the supervisor and reflection as the mechanism of supervision. This definition says nothing about the reasons why supervision might be done, and could be misread as meaning that it is supervisors not nurses who are reflecting on practice. Buus et al.’s (2011) definition constructs supervision as educational, and covers the questions of who does supervision, how and why. The fact that the authors felt it necessary to begin their discussion with this definition may indicate that the concept of clinical supervision is as confused as ever, or it may be the sign of a maturing field in which clinical supervision is understood as a broad term, whose scope must be defined in the context of a specific research project.

The third definition (White and Winstanley, 2010) emphasises the role of time in supervision: supervision is *time out*, it occurs in a relationship which lasts over a

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period of time, it is concerned with *current* practice, and is intended to improve *future* practice.

There are common elements in these three definitions. They each describe supervision in terms of a relationship between supervisor and practitioner, they identify supervision with work, and they describe the activity of supervision as being communicative. This lends support to Sloan's (2006) argument that there is a general understanding of the core features of clinical supervision.

Another definition, offered by Cleary et al. (2010) shares these relational, communicative and work-focused elements.

Definitions of clinical supervision vary but primarily refer to a semi-structured process where a mental health nurse (the supervisee) meets regularly and confidentially with a more experienced practitioner (the supervisor) to discuss issues of relevance to the supervisee's practice.

(Cleary et al., 2010: 525)

Cleary et al. (2010) have included the requirement for confidentiality in their definition. This is supported by evidence which suggests that practitioners regard the confidentiality of supervision as vital (Cutcliffe and Hyrkäs, 2006). Cleary et al.'s (2010) definition also included the notion of conceptual diversity, suggesting that there is not a single definition of supervision. They argued that supervision practice should be developed with regard to the requirements of a given context and suggested that "*clinical supervision should be defined by the mental health nurses who will partake of it*" (Cleary et al., 2010: 530). Cleary et al. (2010) went on to suggest that such a definition should encompass a clear sense of what can realistically be achieved through supervision, thus framing the understanding of supervision in terms of what it is intended to accomplish. The different concepts of supervision discussed here can therefore be understood as representing different answers to the question 'what is supervision for?'

Finally, Hyrkas et al. (2003) suggested that concepts of clinical supervision may be culture-specific. Validating the MCSS for use in Finland, Hyrkäs et al. (2003) identified some items on the scale as irrelevant to the Finnish context. These included “*my supervisor is never available when needed*” and “*my supervisor offers me guidance with patient care*” (Hyrkäs et al., 2003: 623). Hyrkäs et al. (2003) argued that these items suggest that the supervisor is available outside of supervision sessions, and that supervision involves giving concrete advice. In contrast, in the Finnish context the supervisor is usually from outside the supervisee’s workplace (so not available between supervision sessions), and learning in supervision is facilitative rather than directive (Hyrkäs et al., 2003).

Stevenson and Jackson’s (2000) grounded theory study of clinical supervision as ‘egalitarian consultation meetings’ (discussed in section 3.3.4.2.4) challenged the conceptualisation of supervision. Discussing this study, Stevenson (2005: 520) argued that while some scholars have challenged the idea of a single concept of clinical supervision, the conceptualisation of clinical supervision continues to be “*grounded in modernist assumptions*”. These assumptions include the concept of the supervisor as having an overview of the supervisee’s problems/practice; the supervisor as an expert, in a hierarchical relationship to the supervisee; the idea that supervision perfects the practitioner (Stevenson, 2005). In this paper Stevenson (2005) moved the discussion of supervision as a concept from attempts to define features of supervision, to the consideration of what discourses underpin the practice of supervision.

3.3.4.2.3 Proctor’s Model

‘Proctor’s model’ has had a major influence on the concept of clinical supervision in nursing, appears in numerous supervision studies (cf. Ayer et al., 1997, Bowles and Young, 1999, Walsh et al., 2003), and forms the framework for the MCSS (Winstanley, 2000-2012).

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The model is widely referenced in the nursing literature on supervision (Cutcliffe et al., 2001), and also appears in the midwifery literature (cf. Halkswork et al., 2000, Wallbank, 2010). The model has been used as a framework for such influential studies as *It is Good to Talk* (Butterworth et al., 1997). Scholars usually describe the model as composed of three domains: the restorative, the normative and the formative. These domains describe three different functions or tasks of supervision. However the three domains were not intended to form a stand-alone model, but were originally at the core of the *Supervision Alliance Model* developed by Proctor and others (Proctor, 2001).

Proctor's model, as it is used in the nursing literature, appears to have emerged without the knowledge of its creator, who reported being "*surprised, gratified (naturally) and then concerned*" when she became aware of the model's use in nursing (Proctor, 2001: 25). The supervision alliance model was developed for practitioners using counselling skills in their work, and is therefore based on theoretical assumptions drawn from counselling and psychotherapy (Proctor, 2001). Proctor (2001) argued that this kind of thinking might be unfamiliar, confusing or inappropriate for nurses.

The supervision alliance model, as described by Proctor (2001), offers a carefully formulated approach to supervision, but it is worth emphasising that this is not 'Proctor's model' as it has been adopted in the literature. Generally speaking, the field has simply taken the core framework of the supervision alliance model, the three domains, and used these as a way of articulating what supervision is supposed to do. It is easy to see the appeal of using Proctor's model in this way. From the 1980s onwards the field of nursing supervision has grown in complexity. In light of the often reiterated problem of conceptual ambiguity, Proctor's model is simple and yet informative, and is easy for non-academics involved in the implementation of supervision to understand. The inclusion of the formative and normative domains may also be appealing to managers who want to see evidence of how supervision will improve services (Butterworth et al., 1996).

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To summarise, the three tasks of supervision as described by Proctor (2001) are:

Restorative – Supervision is refreshing and supportive for the supervisee. Proctor (2001: 31) suggested that “*if supervision is not experienced as restorative, the other tasks will not be well done*”.

Formative – Reflection on practice enables the supervisee to learn from his/her experience and from the experience of his/her supervisor, and fellow supervisees (if in group supervision).

Normative – To varying degrees, practitioners are likely to have some responsibility for monitoring their own performance. Supervision can be a space in which supervisees can discuss problems or difficulties, and where the supervisor can challenge practice s/he sees as problematic

3.3.4.2.4 Other Models of Clinical Supervision

Proctor’s model has been criticised by Sloan (2001), who argued that the model failed to give guidance on how supervision should actually achieve the three tasks, which in turn made it difficult to evaluate supervision practice using the model. As an alternative Sloan and Watson (2001) and others (cf. Chambers and Long, 1995b), have proposed ‘Heron’s six-category intervention analysis’, a model which has been formulated for use in therapeutic and other helping-style relationships. Sloan and Watson (2001) argued that Heron’s six categories of intervention (Prescriptive, Informative, Confronting, Cathartic, Catalytic and Supportive) offered supervisors more detailed guidance on how to conduct supervision, and that Heron’s inclusion of ‘degenerating’ interventions acknowledges the potential for problematic or unsafe interactions in supervision.

Other models of clinical supervision used by nursing scholars include a model of supervision which combined Egan’s problem management and phenomenological interviewing which was formulated by Jones (1998), and CBT based supervision

(Sloan et al., 2000). Stevenson and Jackson (2000) proposed the model of egalitarian consultation meetings, drawn from social psychology and social constructionist therapy. However, overall the evidence suggests that clinical supervision in practice is atheoretical and improvisational (Scanlon and Weir, 1997, White et al., 1998, Sloan, 2006). Butterworth et al. (1997) observed that nurses had little knowledge about models or theories of supervision, and supervision seemed to have been an emergent process, with some participants deliberately avoiding a more structured or theory-driven format.

3.3.4.3 Statutory Midwifery Supervision

In this section the concept of supervision is discussed in terms of its operationalisation in the literature referring to *statutory midwifery supervision*.

The concept of statutory supervision in midwifery dates back to the 1902 Midwives Act in England (Nutall, 2012). The parameters of this kind of supervision are officially set by the NMC and LSA (Nursing and Midwifery Council and Local Supervising Authorities, 2008). The legal status of statutory midwifery supervision, and its history, contribute to the sense of supervision as a clearly defined concept. However supervision practices in midwifery have undergone significant change over the course of their history, and supervision is seen as incorporating a variety of sometimes conflicting activities such as empowerment and control (Kirkham, 1996). Winship (1996: 56) argued that supervision is “*not a static scenario, but is dynamic, questioning and moving forwards at all times*”. The concept of supervision in midwifery can therefore be understood as having a clear location within the boundaries of the midwifery profession, but as changing over time, and subject to criticism and debate as the priorities of the midwifery profession change.

In the midwifery supervision literature the concept of statutory supervision is mainly discussed from four perspectives: protection of the public, the role of the supervisor,

the role of managers, and clinical supervision. These perspectives are discussed below.

3.3.4.3.1.1 Statutory Supervision – Protecting the Public

Protection of the public through the promotion of high quality care, is regarded as the primary purpose of supervision (Nursing and Midwifery Council and Local Supervising Authorities, 2008). This purpose was established in the 1902 Midwives Act with the aim of excluding poor quality practitioners from the profession (Heagerty, 1996). Over the course of the 20th century, the aim of protection of the public has remained at the heart of midwifery supervision, but the mechanisms by which this is achieved have changed, with more emphasis being given to the empowerment and support of midwives (Winship, 1996). Duerden (1996) found that midwives regarded the most important outcome of supervision as the protection of the public, with professional support as the second most important outcome.

In statute, supervisors of midwives have a relationship with clients as well as midwives, but this relationship has been problematised. Beech (1995) observed that supervisors normally came into contact with women having home births, and argued that such contact could be authoritarian, rather than empowering. Lewison (1996) asked:

“If supervision is truly to protect the public, why are women having babies not better informed about the role of the supervisor in helping maintain professional standards of midwifery?”

(Lewison, 1996: 75)

Lewison (1996) argued that in many cases supervisors engaged in defensive practice, protecting themselves, other midwives, GPs and obstetricians, rather than clients. Lewison (1996) concluded that the role of the supervisor should not be to engage with the client directly, but to support the midwife-client relationship. Direct

engagement with service users should only be undertaken where there was a clear need for the supervisor to intervene (Lewison, 1996).

3.3.4.3.1.2 Statutory Supervision – The Role of the Supervisor

The second major dimension of the concept of statutory supervision in midwifery is the role of Supervisor of Midwives. In the NMC/LSA's (2008) supervision guide most attention is given to explaining the role of the supervisor. Supervisors of midwives have defined legal responsibilities to oversee the practice of their supervisees, primarily by meeting with a midwife, but supervisors may also observe a midwife's practice, or inspect her equipment, place of work, or records (Winship, 1996). Supervisors can also refer midwives to the LSA, but are not empowered to suspend midwives from practice on their own authority (Winship, 1996). However, as well as this clear legal responsibility for monitoring practice, it is also argued that supervisors are expected to fulfil a variety of other roles such as providing support for midwives, professional leadership, advocacy for women, and clinical expertise (Johnson, 1996, Kirkham, 1995). Deery and Corby (1996) argued that the supervisor of midwives role contains inherent contradictions, and several authors have discussed the issue of supervisors' divided loyalties (cf. Lewison, 1996, Allison and Kirkham, 1996).

In the 1980s and 1990s there was growing concern that midwifery supervision was ineffective, and in particular that supervisors were not well prepared for their role (Thomas and Mayes, 1996). In response to this the English National Board (ENB) tried to enhance and standardise the training of supervisors through the creation of an Open Learning Programme for supervisors of midwives. The programme was linked into higher education and consisted of a combination of study days and mentored practice, and was positively evaluated by the supervisors (Thomas and Mayes, 1996). Through training and practical measures such as reducing the ratio of midwives to supervisor, the role of supervisor has developed in recent years. The relationship between the supervisor and her supervisees has become more important, and

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midwives are increasingly likely to attend a regular annual meeting with their supervisor (Duerden, 1996). Duerden (1996) found that the majority of midwives believed they should be able to choose their supervisor, but had not been able to.

In an evaluation of the supervisory activities of all Supervisors of Midwives in England, Mead and Kirby (2006) found that the majority of supervisors were employed within the NHS, were on a mid-senior grade, had many years' experience, and worked full-time. Some supervisors were allowed time within which to undertake supervisory duties, and some were paid more, or given more annual leave (Mead and Kirby, 2006). However not all supervisors had their role recognised in these ways (Mead and Kirby, 2006).

Mead and Kirby (2006) found that supervisors tended to interpret their role either as separate from their other midwifery work, or as an integral part of everything they did as a midwife. This meant that calculations of time spent on supervisory activities varied enormously (Mead and Kirby, 2006). Mead and Kirby (2006) observed that the supervisors' role was complex, and some activities were easier to measure than others. For example, activities such as annual reviews, meetings, and drug administration were relatively easy to measure, while professional support, decision making and educational activities were more difficult to quantify. Mead and Kirby (2006) argued that the time spent on supervisory activities should be more thoroughly investigated to ensure that supervisors were properly supported and remunerated for their work.

The role of the supervisor is often discussed in terms of leadership, and there are a number of publications documenting the leadership role of supervisors. Thomas and Mayes (1996), and Demilew (1996), argued that the supervisor has a key role in the implementation of policy, advocating for clients and midwives, auditing care, and the facilitation of change in the maternity services. However Walton (1995) argued that if supervisors do not have the right clinical skills they may be unable to support innovative changes in care.

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Johnson (1996) described a project in which local supervisors of midwives took a very active role in creating service change, developing new policies in response to *Changing Childbirth* (Department of Health, 1993), and a supervision strategy for the local services which aimed to reflect the concerns of local midwives. Warwick (1996) described supervisors taking a lead role in facilitating the implementation of a new model of care. The lead supervisor had regular meetings with the midwives, and key stakeholders (Warwick, 1996). In this instance the lead supervisor was also the Director of Midwifery, and it is unclear to what extent the lead supervisor's activities were managerial or supervisory. Duerden (1996) found that supervisors were involved with a number of leadership activities, including contract negotiations, development of policies, and giving expert advice to various stakeholders.

3.3.4.3.1.3 Statutory Supervision – Management

Many midwifery scholars have commented on the widespread conflation of the roles of supervisor and manager (cf. Shennan, 1996, Williams, 1996, Burden and Jones, 1999, Seaman, 1995). Historically supervisors have been closely associated with managerial activities, and have often simultaneously held a managerial post (Allison and Kirkham, 1996). In a study on midwives' perceptions of the role of supervisor and manager, Burden and Jones (1999) reported that at their research site the role of midwifery supervisor was written into the manager's job description. They found that their participants were confused about the distinction between the two roles. Two large scale studies of supervision also found that supervisors often also held managerial posts (Stapleton et al., 2000, Duerden, 1996). In Duerden's (1996) study 65% of supervisors were also managers. Shennan (1996) and Demilew (1996) both argued that the conflation of supervision with management meant that supervisors may be loyal to their employer rather than their profession. Shennan (1996) found that when a problem arose supervisors tended to prioritise their managerial role over their supervisory role.

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The association of supervision and management is problematised in the literature, and it is generally argued that these roles should be kept separate. It may be that the association of supervisors with managerial roles is beginning to lessen, as in recent years there have been attempts to separate supervision and management, with more midwives in clinical roles becoming supervisors (Mead and Kirby, 2006). However, Mead and Kirby (2006) observed that there did still seem to be an association between managerial work and supervisory work, with midwives in managerial positions regarding supervision as an integral part of their role.

3.3.4.3.1.4 Statutory Supervision – Clinical Supervision

Statutory supervision in midwifery is also discussed in terms of its relationship to *clinical* supervision. For example, Kirkham (1996) cited the UKCC's 1996 position statement which contended that clinical supervision was a part of the function of statutory supervision. Some authors have discussed incorporating into statutory midwifery supervision, qualities associated with clinical supervision, such as a non-hierarchical relationship and a focus on support (Burden and Jones, 1999).

Clinical supervision has also been discussed as something which could complement statutory midwifery supervision (Caldwell, 1996, Oakey, 2002), or inform a completely new system of supervision (Association of Radical Midwives, 1995). Duerden (1996) found that clinical supervision was a widely discussed topic among midwives, but argued that there was a certain amount of confusion about the difference between statutory and clinical supervision. Duerden (1996) argued that while there are some shared features between these kinds of supervision, and statutory supervision is often described as having some of the functions of clinical supervision, they are also significantly different.

In a similar vein, Deery and Corby (1996) have argued that supervisors of midwives can't provide clinical supervision because the nature of the midwifery supervisor role mitigates against the establishment of an egalitarian, safe relationship in which

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midwives can reflect openly about their practice. Deery and Corby (1996: 204) argued that statutory supervision does not empower midwives, but “*instead only offers guidance and protection to ensure practice is correct*”, and that because the statutory supervision relationship is innately hierarchical, statutory supervisors cannot provide *clinical* supervision. Deery and Corby (1996) argued that clinical supervision is different because it is a relationship of equals, creating a supportive rather than a disciplinary interaction.

In the midwifery literature, clinical supervision is associated with support, and there are numerous reports of midwives expressing the need for greater support. Shennan (1996) found that midwives wanted to talk about their work-related feelings, but that they felt under pressure to appear in control. In response to this, Shennan (1996) argued that statutory supervisors should be trained in counselling skills.

3.3.4.4 Concept – Summary

The conceptualisation of supervision is not only of relevance to the academic literature, but also to practice. How practitioners conceptualise supervision influences expectations, enactment, and resistance to supervision (Sloan, 1999). Concepts, models and theories drawn from other disciplines may be difficult for practitioners to understand. Deery (2005) pointed out that different forms of supervision may draw on concepts which are unfamiliar to practitioners, and Sloan (2006) argued that mental health nurses lacked the necessary knowledge about interpersonal dynamics to engage in effective supervision.

The literature reviewed in this section has focused on two ways in which the concept of supervision is used: *clinical* supervision and *statutory midwifery* supervision. It can be seen that each of these uses incorporates debate and disagreement about meaning. Clinical supervision is widely regarded as an ambiguous concept, and statutory supervision is associated with a range of sometimes conflicting aims and functions. Any conceptualisation of supervision must therefore be understood in

terms of its disciplinary context, the aims it expresses, and the practice to which it refers.

3.3.5 Supervision as a Good Thing

Todd and Freshwater (1999) argued that clinical supervision has been invested with an emotional significance, and connected this to the confusion or ambiguity of the concept:

“The expanding definitions and literature regarding clinical supervision places it in a dangerous position, that of becoming idealized and viewed as the panacea for the ills of nursing practice”

(Todd and Freshwater, 1999: 1383)

Some years later this idealising of clinical supervision was expressed in the *Nursing Management* article, *A Magical Factor*, in which it was claimed that clinical supervision can “*transform patient care*” (Corrigan, 2005: 14). In Kelly et al.’s (2001b) survey of CPNs, around 80% of respondents believed that clinical supervision improved standards of care. However evidence connecting supervision practices to care outcomes is limited. In this review only two studies show a connection between supervision practice and improved care (Hyrkäs and Lehti, 2003, Bradshaw et al., 2007). Hyrkäs and Lehti (2003) observed that a project combining team supervision with systematic self-evaluation by nurses plus patient feedback, was associated with an improved quality of care, while in a quasi-experimental study by Bradshaw et al. (2007) the clients of nurses receiving supervision showed a greater clinical improvement than those whose nurses did not have supervision (Bradshaw et al., 2007).

Despite minimal supporting evidence, the idea of clinical supervision as offering a ‘magical’ solution is widespread. Nurses and midwives can have high expectations of supervision, seeing it as “*a solution to all their working problems*” (Berg and

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Hallberg, 2000: 114, Deery, 2005). Practitioners' expectations of supervision may not be based on an informed understanding. There is evidence of widespread support for supervision even where practitioners may have little knowledge about supervision. CPNs in Northern Ireland evinced strong support for supervision, despite there being very little training in supervision in the area (Kelly et al., 2001b). Malin (2000) found that nurses expressed a general view of supervision as 'a good thing'. Buus et al. (2011) observed that nurses could be in favour of clinical supervision even where they did not see it as having any effect on practice. Buus et al. (2011: 100) suggested that nurses might support supervision because it is "*pleasant*".

A variety of good effects are associated with clinical supervision. For example, from a case study on the implementation of clinical supervision in a hospital, Ayer et al. (1997) derived more than sixty separate benefits of clinical supervision. Cleary et al. (2010) have asked if any single activity can reasonably achieve all the outcomes associated with supervision, and argued that ascribing such general benefits to supervision makes it difficult to evaluate. Furthermore, when high expectations of supervision are not met, practitioners can become disillusioned and unwilling to participate (Berg and Hallberg, 2000, Hyrkäs et al., 2002, Deery, 2005).

Although evidence connecting supervision to patient outcomes is lacking, the field has begun to accumulate evidence supporting the argument that clinical supervision has a positive effect on practitioners' wellbeing. Research using the MCSS in conjunction with the MBI has suggested that effective supervision is associated with reduced levels of burnout (Edwards et al., 2006, Hyrkäs, 2005, Hyrkäs et al., 2006), although researchers have yet to produce an explanation as to *how* clinical supervision reduces burnout. In a recent study on the association between burnout and clinical supervision, Koivu et al. (2012) emphasised that reduced burnout was associated with *effective* clinical supervision as measured by the Finnish version of the MCSS. From a synthesis of three clinical supervision studies, Bégat and Severinsson (2006) argued that supervision improved nurses' wellbeing, helping them to manage stress and other work-related emotions, making them feel more

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empowered and able to act autonomously, and giving them a more meaningful understanding of the nursing role.

There is a lack of critical perspective taken in some studies exploring the effects of clinical supervision. This supports the general idea of supervision as a good thing. Studies focus on benefits, and negative experiences of supervision are not investigated (cf. Bowles and Young, 1999, Arvidsson et al., 2001, Bradshaw et al., 2007, Magnusson et al., 2002, Severinsson and Hallberg, 1996). The arguments put forward by researchers can betray a degree of conviction about the effects of supervision which does not seem to be necessarily supported by the evidence. For example, Kelly et al. (2001b) stated that:

“Almost one fifth of practitioners are not engaged in clinical supervision, and this must diminish their potential for personal development and growth and their capacity to advance nursing practice”

(Kelly et al., 2001b: 42)

Arvidsson et al. (2001: 162), while describing numerous benefits of supervision (pedagogical, supportive, reflexive, promotes holistic care), note that “*a critical approach to clinical supervision is still lacking*”. They argue that a critical approach requires investigation of the effects of supervision, especially long term effects. However they do not discuss what values or expectations are attached to supervision, or the outcomes and processes which might occur.

Supervision is given a more sceptical treatment in the midwifery literature, and Mayes (1995) has argued that examples of good supervision practice tend to be ignored. However, there is also evidence of a widespread belief in the potential of midwifery supervision to achieve beneficial outcomes despite a lack of empirical evidence to support this. For example, the Association of Radical Midwives (ARM) (1995) conference recommended that the supervision system be changed, but supported the principle of supervision. One of the ARM contributors, Seaman (1995: 29) reported experiencing supervision as a punitive activity, but nevertheless argued that “*It is not the principle of supervision that is under attack, but its*

operation". In a discussion paper, Thomas and Mayes (1996) saw supervision as an essential means by which the care of childbirth could be radically changed, and argued that good supervision aids the implementation of evidence-based practice.

Supervision as a good thing also leads to the assumption that it is equally beneficial for all kinds of practitioners. Yegdich (1999a: 1200) observed that despite conceptual ambiguity and resistance in practice, nursing scholars tend to assume that clinical supervision is "*suitable for all*". However, Teasdale et al. (2001) found that junior rather than senior nurses benefited from supervision, and a survey by Hyrkäs et al. (2006) showed that the benefits of supervision varied according to the experience, speciality and working conditions of the practitioner.

3.3.5.1.1 A Good Thing in Context

Supervision takes place in an organisational context, and is influenced by both practical factors such as time, resources or training, and cultural factors such as attitudes towards supervision. For example, Hyrkäs et al. (2002) found that an organisational culture in which problems are denied, and the presentation of efficiency is important, may hinder participation in supervision, where problems are openly discussed. In a similar vein, Kirkham (1999) has shown how the culture of midwifery influences statutory supervision interactions. Midwives internalised a culture of coping, meaning they did not feel able to ask their supervisors for support (Kirkham, 1999). They also internalised a culture of blame, and when they did receive support through supervision they were unable to step out of a cycle of self-blame (Kirkham, 1999). The organisational culture affected the operation of supervision even though the statutory supervisory system is structurally separate from the health service.

Buus et al. (2010) found that the high-pressure, anxious and insecure organisational context within which supervision took place limited its possible impact. Organisational constraints resulted in limited attendance of supervision, and plans

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formulated in supervision were not put into action; consequently any beneficial effects of supervision were short lived (Buus et al., 2010). Cleary and Freeman (2005) found that shift work, unpredictable workload, and a task-oriented philosophy impeded implementation of supervision.

Implementing clinical supervision with a group of midwives, Deery (2005) found that a heavy workload, massive organisational changes, a disempowered position, and unsupportive managers effectively prevented the midwives from continuing with their supervision group, even though they regarded supervision as beneficial. Deery (2008) argued that the midwives worked in an organisation with a production-line ethos of care which resulted in an allegiance to a hurried, task oriented 'clock time'. In contrast, clinical supervision imposed a different, relational timeframe, which required the midwives to take control of their time in order to invest in their own development (Deery, 2008). In the end the midwives found this impossible to do, and the demands of the organisational timeframe prevented them from investing time in themselves through clinical supervision.

In the large scale introduction of clinical supervision in the mental health services in Queensland, sceptical or hostile managers obstructed the implementation of supervision, particularly through control of the staffing rosters, and workloads also impeded participation in supervision (White and Winstanley, 2009). Exploring mental health nurses' experiences of clinical supervision, Scanlon and Weir (1997) also identified that a lack of managerial support prevented nurses from making full use of supervision. In contrast, Severinsson and Hallberg (1996) found that aspects of the workplace context such as informal support and ability to act autonomously, did not appear to have any influence of clinical supervision. This is the only study identified which produced such evidence.

There is a tendency in the literature to discuss supervision as unilaterally improving the wellbeing and development of practitioners. A project carried out with midwives in Exeter challenges this view (Caldwell, 1996). The project introduced a range of supportive interventions intended to complement statutory supervision (Caldwell, 1996). The aim was to improve the well-being of midwives, and this was achieved

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through a variety of means, including training, team building and one-to-one support from a counsellor and psychotherapist, free massage, discussion groups, and social events during working hours (Caldwell, 1996). Midwives participating in the programme reported that team dynamics and communication with their clients and with colleagues had improved (Caldwell, 1996). Sick rates were lower than for other parts of the service, and in a government survey, local mothers assessed their maternity care as 'excellent' (Caldwell, 1996). This suggests that both practice and practitioner well-being can be improved in a variety of ways, and that supervision is only one method which may achieve these aims.

3.3.5.1.2 Supervision and Negative Consequences

A small number of studies consider possible negative consequences of supervision (cf. Butterworth et al., 1997, Scanlon and Weir, 1997, White et al., 1998, Farkas-Cameron, 1995). Supervision experts interviewed by Severinsson and Borgenhammar (1997) identified a possible negative effect of supervision as being increased stress due to the time taken away from direct care. In a case study of a supervision session Sloan and Watson (2001) observed that the supervisor's interventions were both positive and negative. Sloan and Watson (2001), who considered supervision in terms of a reflexive, professional activity, identified potentially negative interventions as including directive questioning and organisationally oriented information giving. These interventions did not fit the aims of supervision discussed by Sloan and Watson (2001).

Exploring the supervision relationship in the supervision of community mental health nurses, Sloan (2006) found that supervision discussions could be unboundaried with the supervisee encouraged to discuss anything, including aspects of their personal life. Supervisors were line managers, and supervision was dominated by the managerial agenda, with a focus on problem solving and risk management. Sloan (2006) argued that this meant that supervision did not give enough attention to the

therapeutic relationship, and found that at one case site supervisees experienced supervision as actively “*detrimental*” and felt “*trapped*” and unable to address the problem with their supervisor/line manager (Sloan, 2006: 132).

3.3.5.1.3 Summary

There is a widespread belief in both clinical and statutory forms of supervision as being ‘good’. However the literature shows that the picture is more complex. Statutory supervision is strongly criticised as controlling, and there is little evidence supporting its status as improving midwifery practice. Evidence for the effects of clinical supervision is mixed, and while there is a body of work supporting the hypothesis that clinical supervision improves practitioners’ wellbeing, there is a lack of research which explains the nature and cause of this effect in-depth, and there is also little evidence showing the effect of supervision on practice and clinical outcomes.

3.3.6 Surveillance and Resistance

In the course of this review two critical themes have been identified in the supervision literature. In the first supervision is conceptualised as a form of surveillance, and in the second the existence of resistance to supervision on the part of practitioners is observed. The concept of surveillance is present in the literature as a theoretical construct. It is taken from Foucault’s (1977) theory of governmentality, and describes a means of normalising behaviour by making the individual visible to power (see Chapter 4).

In contrast, ‘resistance’ is present in the literature as an observed phenomenon. Practitioners are reported as resisting participation in supervision, but the phenomenon is not analysed theoretically. In this section of the review, the

phenomenon of resistance to supervision is examined in the light of a theoretical approach in which resistance is understood as a complex activity which takes place in opposition to a controlling power (Collinson 2004), and as a form of power exercised by those who do not have access to the strongest forms of power (Heller, 1996). This theoretical approach to resistance is further discussed in Chapter 4.

3.3.6.1.1 Surveillance

The concept of surveillance is of clear relevance to statutory supervision in midwifery with its emphasis on the monitoring of practice. Perhaps because of this function, the discussion of statutory supervision in midwifery is highly politicised, with articles in professional journals which refer to supervisory processes in terms of a ‘witch-hunt’ (Jowitt, 2004, Beech, 2009, Baker, 2005). There are also more scholarly critiques of midwifery supervision which draw attention to problematic uses of power.

Demilew (1996: 192-193) found that independent midwives experienced supervision as “*useless or obstructive*”, and it seemed that sometimes “*the supervisor needed to show a degree of control over the midwife*”. Shennan (1996) also found that supervisors were regarded as being in a powerful position, particularly with regard to suspensions from duty, which supervisors instigated through their managerial roles. At the same time, Shennan (1996) observed that supervisors of midwives were also subject to power through their organisation.

Although statutory supervision is popularly regarded as promoting the professional autonomy of midwives, researchers have argued that it actually creates dependency (Stapleton et al., 2000). Williams (1996) has suggested that the perceived power of the supervisor has led midwives to shift the responsibility for ensuring good practice onto the supervisor, creating a dependent rather than an independent relationship. Similarly, Taylor (1996) has argued that supervision does not promote autonomy, suggesting that supervision may symbolise a fundamental distrust of practitioners.

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The discussion of clinical supervision in nursing is less politicised, but some scholars have given critical attention to clinical supervision as an exercise of power. For example, Gilbert (2001) argued that supervision is a form of surveillance which subjectifies practitioners. Adapting Cotton's (2001) argument on reflection, the supervisee-as-subject objectifies herself through reflection on her practice, and in doing so becomes subjectified by the discourses of the institution or profession (as represented by the supervisor). Responding to Gilbert's (2001) paper, Clouder and Sellars (2004) argued that being subject to surveillance is inevitable for healthcare practitioners, and should be regarded as part of the responsibilities of being a professional. The authors examined the use of clinical supervision as surveillance through a synthesis of two studies on clinical supervision with occupational therapy students and with physiotherapists. These studies suggested that practitioners could welcome surveillance through clinical supervision and regarded it as necessary.

In the clinical supervision literature, researchers have recorded examples of supervision being used, or experienced as a way of making supervisees visible to power. Group supervision may be particularly experienced as surveillance, with self-disclosure in a group making participants feel exposed (Berg and Hallberg, 2000, Cleary and Freeman, 2005). If practitioners are inadequately prepared, the dynamics of group supervision may be distressing (Deery, 2005). Buus et al. (2010) found that group supervision could be highly exposing for nurses, and that in the group, normal mechanisms which nurses used to avoid anxiety were overturned, and sublimated problems were brought to the surface. In this way the nurses were both subjected to the power of being made visible, and also deprived of means of resistance.

Buus et al. (2010) found that their supervision group was very open, with attendance varying according to workplace demands. Trust between supervisees therefore depended on relationships formed outside of the supervision group (Buus et al., 2010). When unfamiliar colleagues joined the group, supervisees could feel reluctant to "*self-disclose and expose themselves to people whose response they could not anticipate*" (Buus et al., 2010: 657). The supervision group was an emotionally difficult space, acting to "*expose and nourish disagreements and conflicts among the*

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nurses that otherwise were not explicit in everyday work-situations” (Buus et al., 2010: 658). The process used in the supervision group, in which one supervisee was ‘interviewed’ by the supervisor could leave the supervisee feeling “*professionally stripped in front of the group and maybe overwhelmed by an unanticipated emotional response*” (Buus et al., 2010: 658), and could also make the other supervisees feel uncomfortable.

Buus et al (2010) also found that supervision could expose divisions within the nursing community and also increase conformity to group norms. The group enforced communal norms, through ‘gentle’ correction of deviant group members, and the labelling of non-attending nurses as less caring. Supervision was therefore a locus of control, but Buus et al. (2010) argued that this was not managerial control, but professional and moral control.

Supervision involves the disclosure of information which might otherwise remain private. In light of this a number of studies identify confidentiality as an issue. Some of Malin’s (2000: 555) participants viewed supervision records as an “*ambiguous threat*”, with concerns about how the information would be used. Scanlon and Weir (1997) found that there was a lack of trust in the supervisory relationship when the supervisor was a manager, with supervisees worrying about issues such as confidentiality. Some of the mental health nurses in this study avoided having supervision with a manager by covertly arranging for supervision outside of the workplace (Scanlon and Weir, 1997). Scanlon and Weir (1997) argued that if covert supervision was a widespread phenomenon it would have implications for the maintenance of safety and standards.

Sloan (2006: 134) found that supervision was seen as a way to ensure that community mental health nurses were “*doing the right thing*”, and this kept the focus of discussion on managerial priorities and problem solving, rather than exploration of interpersonal issues. Supervision did not promote autonomy, with supervisors having a controlling role (Sloan, 2006).

3.3.6.1.2 Resistance

The tendency to think of supervision uncritically as a good thing influences resistance to supervision in two ways. On the one hand, practitioners may have unrealistic expectations of supervision which are not met, and so they become reluctant to engage in supervision. On the other hand, it means that unwillingness to participate is regarded as the practitioner's problem, rather than a valid criticism of supervision practice.

Farkas-Cameron (1995) identified resistance to supervision among psychiatric nurses. The nurses were unconvinced about the usefulness of supervision, and regarded it as a form of therapy. In response Farkas-Cameron (1995: 36) argued that nurses need to be educated about supervision "*to reduce any misconceptions or fears*". In Hyrkas et al.'s (2002) study on team supervision, the supervisees had little knowledge or experience of supervision when starting the project. The supervisors reported that supervisees initially expressed suspicion and dislike of supervision and of the supervisors themselves. White and Winstanley (2009) observed a combination of managerial and staff resistance to the implementation of clinical supervision.

Berg and Hallberg (2000) identified a lack of trust between their study participants (who were team-members). The authors reported that at the start of the study participants were uncertain about sharing thoughts and feelings in a group format (the authors did not discuss how this might have related to mistrust within the team). The intensity of feeling about this is expressed in the comment of one participant who described talking about feelings in the group as potentially 'dangerous' (Berg and Hallberg 2000). Tensions and conflicts did arise within the group, but over the course of the study the nurses developed a less wary attitude, and in the end the study participants evaluated their supervision positively (Berg and Hallberg, 2000).

Health service directors in Northern Ireland identified that the implementation of supervision for mental health nurses was impeded by a fear of supervision among staff (Rice et al., 2007). When clinical supervision was introduced to mental health

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nurses in Queensland there was a certain amount of suspicion about the practice (Hancox et al., 2004). The authors reported that this meant that the programme had to change nurses' attitudes towards supervision, and an educational programme was developed as a way of achieving this. In contrast, Cleary and Freeman (2005) found that, although nurses seemed to have a positive attitude towards supervision, there was an underlying culture of passive resistance to supervision. Cleary and Freeman (2005) argued that nurses resisted the implementation of supervision partly because they thought that informal practices already in place constituted supervision. This compares to Butterworth et al.'s (1997) finding that nurses regarded a variety of activities as being the same as clinical supervision.

The research literature shows that participation in supervision is not straightforward, but is associated with numerous risks and fears on the part of practitioners. In a discussion paper, Cottrell (2002) argued that the nexus of sometimes conflicting relationships in supervision could create suspicion and resistance. Practitioners might believe that their supervisor was in collusion with authority figures such as the line manager, or managers might believe that supervisors and supervisees were in collusion against the organisation (Cottrell, 2002). These suspicions might result in passive resistance to supervision, where those involved maintain an appearance of compliance, but do not participate in a meaningful way, or active undermining of supervision programmes (Cottrell, 2002). Cottrell (2002) notes that resistance to supervision not only comes from practitioners, but may also come from managers or the organisation. This reflects White and Winstanley's (2009) finding that the implementation of clinical supervision was resisted by managers, who used their control over shift patterns to interfere with the scheduling of supervision sessions.

Gonge and Buus (2010) assessed factors influencing participation in supervision by mental health nurses who were offered group supervision. They found that nurses whose work included high cognitive demands (numerous on-going tasks such as in a ward environment) were less likely to participate in supervision. Conversely they found that nurses who were well supported by their colleagues were more likely to engage in supervision. Gonge and Buus (2010) argued that good support amongst

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colleagues might help to reduce anxiety associated with self-disclosure in supervision.

Participation in supervision is also dependent upon feelings of safety. Sloan (2006: 132) reported that mental health nurses wanted supervision to be a “*safe place*”, while Walsh et al. (2003) observed a possible disadvantage to creating supervision as a safe space; participants felt that in the effort to be mutually supportive they did not challenge one another sufficiently.

Stevenson and Jackson (2000) responded to the problems of hierarchy and power in clinical supervision by turning to an alternative model: egalitarian consultation meetings (ECM). Stevenson and Jackson (2000) found that the meetings created a special, liberating, space in which pre-existing norms and rules of clinical supervision could be challenged. The ECMs included a number of renegotiated rules. For example, locating expertise with the person who brought the case rather than with a supervisor. The CPN’s storytelling about cases was valued, and the narratives constructed in the ECM were not necessarily regarded as ‘truth’, and did not have to focus on what changes the CPN could make to his/her practice. Finally, the supervisee role of “*reporter and responder*” and the supervisor role of “*expert and omniscient truth-sayer*” (Stevenson and Jackson, 2000: 497) were abandoned. Participants in the study connected these roles to feelings of suspicion surrounding clinical supervision. The CPNs reflected that the ECM group felt cohesive, that case discussions were useful, and discussions felt comfortable.

The egalitarian and cohesive space of the ECM group provided a safe space within which the CPNs could criticise and challenge aspects of their work context, and in this way the group fostered radical thinking (Stevenson and Jackson, 2000). However radical talk could also be experienced as uncomfortable, and Stevenson and Jackson (2000) argued that the culture of the organisation encroached on the group’s ability to truly reconstruct clinical supervision.

3.3.7 Reflection

Hawkins and Shohet (2012: 16) state that “*supervision develops out of the rich soil of reflective practice*”. The activity of reflection may be understood as a process of thinking about work with the aim of uncovering and developing the tacit knowledge employed in practice (Schön, 1983). Schön (1983) described two forms of reflection: reflection-in-action and reflection-on-action (Schön, 1983). Reflection-in-action alludes to the process of thinking and witnessing which happens alongside doing (Schön, 1983). Reflection-on-action is thinking in retrospect about what was done (Schön, 1983). This is the kind of activity which might occur in supervision.

In the nursing supervision literature ‘reflection’ is widely regarded as the key activity in clinical supervision (cf. Arvidsson et al., 2001, Ayer et al., 1997, Gonge and Buus, 2010, Clouder and Sellars, 2004). Reflection on practice is also identified as one of the components of statutory supervision (Nursing and Midwifery Council and Local Supervising Authorities, 2008). Scanlon and Weir (1997) argued that supervision provides a safe space in which reflective exploration of the therapeutic relationship can take place. A reflective account of supervision in Marrow et al. (2002: 278) gave a nuanced assessment of reflective practice: the nurse regarded reflection as facilitating her professional development, and noted that while reflection could be “*a positive or negative experience*” it continued to offer useful learning.

Exploring supervisors’ perceptions and practices, Begat et al. (2003: 11) found that “*reflection theory*” was used by the majority of supervisors to structure supervision, with ‘pedagogy’ being the least commonly used theoretical approach. Todd and Freshwater (1999) argued that the use of reflection in supervision requires considerable skill on the part of the supervisor. Where the supervisor is unskilled, reflection can result in unfounded use of psychodynamic interpretations, and the open questioning style of guided reflection can become emotionally unsafe (Todd and Freshwater, 1999).

3.3.8 Professional Identity

Statutory supervision is a system unique to midwifery which is strongly connected to the professional identity of midwives, and is seen as confirming professional status (Winship, 1996). Duerden (1996) found that midwives believed that statutory supervision was a good model of supervision for other professional groups. Williams (1996) found that supervisors were regarded as defending the profession and the role of midwives. Stapleton et al. (1998) reported that when asked to explain the value of supervision, many midwives talked in terms of supervision as underpinning midwifery identity and distinguishing the profession from medicine and nursing. This was despite the fact that midwives were “*remarkably ignorant about the nature and purpose of supervision*” (Stapleton et al. 1998: 28). Williams (1996) also identified that midwives regarded statutory supervision as valuable, but were fairly ignorant about what it was.

Demilew (1996) challenged the belief that statutory supervision ensures safe care. She found that the supervision system acted to undermine independent midwives’ practice (arguably a ‘best evidence’ form of practice), instead promoting organisational priorities.

Clinical supervision does not have the same association with the professional status of nursing, but Arvidsson et al. (2001: 184) found that during the course of their supervision intervention participants developed an increased focus on “*nurse-orientated thinking*”. Supervision increased the nurses’ sense of disciplinary identity and gave value to a unique nursing perspective on care (Arvidsson et al., 2001).

3.3.9 Conclusion

This chapter has reviewed five themes which emerge from the literature on supervision in mental health nursing and midwifery. These include: debates over the

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concept of supervision; the assumption that supervision is beneficial; the observation of resistance to supervision among practitioners and the theoretical discussion of supervision as a form of surveillance; reflection as the primary mechanism of supervision; and supervision in relation to professional identity.

The literature reviewed incorporates a variety of methodologies, ranging from large scale randomised controlled trials, to small case studies, to ethnographies, to questionnaire surveys; but Gonge and Buus (2010) have argued that not enough attention has been paid to the influence of context (both the organisational and the personal context) on supervision practices. Sloan (2006) has also argued that not enough attention has been paid to who the supervisee is, and to their location in the working environment.

In the midwifery literature, small scale qualitative studies predominate, while in the nursing literature there seems to be a fairly equal number of qualitative and quantitative studies. Qualitative research into supervision has employed a variety of methods, but data collection through interviews is most common. Analysis of data is often thematic, and lacks contextualisation. I suggest that this leads to a rather simplistic analysis of the complex processes occurring in supervision. Much of the qualitative research conducted on supervision does not seem to be guided by the use of social theory, reducing the possibility of connecting context-specific findings to a more general, theoretical understanding.

There is a drive to prove that supervision improves care (cf. Berg and Hallberg, 2000, White et al., 1998). Butterworth et al. (1997) concluded that evaluation of the outcomes of supervision was essential in order to convince organisations to dedicate resources to supporting supervision practice. In a subsequent discussion of the Butterworth et al. (1997) findings, White et al. (1998: 191) argued that employers were unlikely to support supervision on the grounds that “*a happy nurse is a happy patient*”. This argument challenged the initial concept of outcomes of supervision presented in the Butterworth et al. (1997) report where outcomes were described in terms of practitioner wellbeing and development. In the later White et al. (1998: 191) paper, the argument was made that researchers must “*track a causal*

relationship between clinical supervision, better nursing care and improvement in patient outcomes". Subsequently (Winstanley, 2001) went on to address this issue of evaluating effects of supervision, developing the MCSS.

There are a growing number of studies using the MCSS (cf. Edwards et al., 2006, Hyrkäs, 2005, Hyrkäs et al., 2006, Koivu et al., 2012, White and Winstanley, 2010), and this is evidently an important and useful tool. However, as White and Winstanley's (2010) experience shows, supervision is a highly complex intervention which is context dependent. As such, it resists a simplified, generalised way of knowing, and it is difficult to prove causal processes, particularly where these are directed to clinical outcomes at one remove from supervision. Stapleton et al. (1998: 3) have argued that "*any effect of supervision on practice must be indirect as it is mediated through the midwife*". Research methods which respond to the praxis of supervision will produce meaningful knowledge about supervision which can be used to inform supervision practices more generally precisely because the influence of context is addressed.

3.3.9.1 The Gap in Knowledge

The degree of uncritical support for the cluster of concepts and practices which are described as 'supervision', suggests that research needs to take account of the variations in practice, and to examine the assumptions and expectations which underpin supervision. Stevenson and Jackson (2000: 492) argue that the concept of supervision tends to be reified, and "*A certain form and content of CS² is prominent despite recognition that CS has various presentations*". By focusing on how supervision is experienced in practice, researchers can move away from the unceasing debate over concepts, and test against practice, reified assumptions present in the field.

² Clinical Supervision

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The field of midwifery supervision research is small, and dominated by the influential ENB study (cf. Halkswork et al., 2000, Stapleton et al., 1998). There is room for a better understanding of statutory supervision as a practice rather than an ideal. Stapleton et al. (1998) have argued that supervision in midwifery has evolved with little input from the people who are supervised. There is an opportunity for research which explores supervision in midwifery from the perspective of practicing midwives. Support for practitioners is one of the numerous qualities attributed to statutory supervision, and in the midwifery literature there is also interest in clinical supervision as a source of support for midwives. The field would therefore benefit from inquiry into the value of statutory supervision as supporting practice. Multi-disciplinary studies investigating different supervision practices in relation to midwifery could also contribute to an understanding of possible uses of supervision in midwifery.

The practitioner needs to be brought back to the centre stage in supervision research. The attempt to identify a causal connection between supervision and patient outcomes is problematic because such an attempt reifies supervision as a phenomenon with fixed characteristics. The reification of the supervision concept rests on the assumption that supervision is 'a good thing'. This expresses a reforming vision which, I suggest, is motivated by admirable ideals. The concept of supervision comes to represent a belief in holistic, humane, compassionate care. But as the presence of resistance, and the reporting of punitive uses of supervision show, the 'good thing' discourse does not take account of the complexities of supervision practice.

Research into the causal connection between supervision and patient outcomes is politically problematic in that it diminishes the practitioner. It is the practitioner who is supervised, it is the practitioner who is active in the clinical area, and it is the practitioner who incurs the costs of caring work. Scholars such as White et al. (1998) have argued that if supervision is to be seen as a justifiable use of resources then it must show that it contributes to quality of care. The problem with this argument is that it assumes that quality of care can only be understood as an endpoint

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(the patient outcome) and not a process (happening through the person of the practitioner).

In contrast, supervision itself is not about evaluating the goals of healthcare, but working with the messiness of how healthcare is done. Research should reflect the fact that supervision is a process which is intimately bound up in its context. The current field of research is lacking in research which produces an in-depth understanding of aspects of supervision situated in their context. At the same time there is a lack of explanatory evidence in the field exploring how and why and under what circumstances the effects of supervision occur. The complexity of supervision means that it is difficult to tease out discrete cause and effect mechanisms, but different methodological approaches may contribute to this. For example, narrative research offers the possibility of constructing an explanatory account in a different way to experimental research.

To summarise, I have identified the following areas as containing unanswered questions about supervision in midwifery and mental health nursing:

1. What happens in practice.
2. How practitioners experience supervision.
3. How personal, professional and organisational contexts influence practitioners' experiences of supervision.
4. Supervision as having both negative and positive outcomes.
5. Supervision as an umbrella term which covers a variety of practices.
6. Supervision as a form of power.

This is the gap in knowledge which I aim to address in this thesis. In Chapter 5 I develop the research questions from these areas, and discuss the research design and methodology. However first, in Chapter 4, I discuss the theoretical perspectives which have influenced how I have addressed the gap in knowledge in the field.

4 Theory

4.1 Introduction

To adopt a social constructionist perspective means to abandon the notion of an all-seeing, objective researcher. Research is inevitably situated in time and place, and the meanings constructed through research are informed by theoretical perspectives adopted by the researcher. Haraway (1988) argues that the credibility of knowledge depends upon a specific, subjective location. Knowledge which is presented as independent of prior theoretical or personal influences is therefore disingenuous and less trustworthy than knowledge which shows the means of its production. As researcher I brought numerous influences into this study, and continued to do so as the study developed. These influences included theoretical approaches which influenced the study at various stages: choosing a topic, constructing a research design, and interpreting the findings. In this chapter I discuss those theories which have most significantly influenced the course of this study.

An early influence on this study was Hochschild's (1983) theory of emotional labour. Reading *The Managed Heart* (Hochschild, 1983) as an undergraduate, I found that it resonated with my nursing experiences. This promoted a long-term interest in the role of emotions in healthcare, and subsequently sensitised me to the emotional component of my research topic. Creating a research design which privileged the subjective experience of the practitioner also created the opportunity to explore practitioners' emotional experiences of supervision. When interviewing participants the accounts collected showed that emotions were an integral part of practitioners' supervision experiences. During analysis and the discussion of findings, this relationship between emotions and supervision within the work context was explored with reference to the sociological literature on emotional labour. This thesis does not represent a study of emotional labour, but draws on aspects of the theory as an aid to analysing the findings.

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The structuring of this study around two comparable yet contrasting professions was intended to give the exploration of supervision a critical framing by elucidating the differences and similarities between the participants' experiences and understandings of supervision. Furthermore, the literature review showed that in midwifery, supervision is connected to issues around professional status and identity. The concept of 'profession' therefore entered the study both as context, and as part of the midwifery supervision discourse. Analysis of the data identified connections between professional identity/status and supervision within *both* disciplinary groups, and this prompted an exploration of the sociological literature around professions to inform the discussion of the findings.

When reviewing the nursing supervision literature, the critical approach of papers by scholars such as Gilbert (2001), Clouder and Sellars (2004), and Rolfe and Gardner (2006), stood out in a field in which the power mechanisms of supervision tend to be unexamined. Drawing on Foucault's work, these papers consider supervision as the exercise of power. Similar themes of control, monitoring and punishment are also prominent in the midwifery supervision literature (although I was unable to identify any papers which specifically drew on Foucault in order to understand supervision). These critical strands in the literature led me to explore the Foucauldian concept of subjectification as politicising the discussion of the findings from this study.

To summarise, this thesis draws on theoretical literature to inform the understanding of three broad areas: professions, emotions, and subjectification. In this chapter each theoretical perspective is discussed in turn.

4.2 Professions

A key concept in this study is that of the profession. Both disciplinary groups included in the study identify themselves as professions; although the professional status of these disciplines has sometimes been contested (Macdonald, 1995). The histories of mental health nursing and midwifery reviewed in Chapter 2 show that

being a profession has had considerable significance for both disciplines, and professionalisation has been pursued as a means of enhancing the status of these disciplines. Identification with a profession is a part of the work-life experience of participants in this study.

The concept of the profession is also present in the supervision literature. Statutory supervision is held to support the professional status of midwives, and clinical supervision is commonly associated with 'professional development'. As Chapter 6 will show, participants' accounts of supervision collected in this study described an interaction between the experience of supervision and the experience of belonging to a profession.

In this section I shall give a brief overview of sociological approaches to professions, and I shall consider how an exploration of supervision in mental health nursing and midwifery may be informed by the literature on professions.

4.2.1 Professional Identity

An identity can be understood as a set of meaning-making processes which operate both within the individual and through interaction with the environment (Burke and Stets, 2009). Individuals associate themselves with shared norms of identity which provide a framework for the interpretation of experience, and for action (Burke and Stets, 2009). In this way identity forms a feedback loop between the individual and their environment which alters how the individual perceives their environment, and how they present themselves (Burke and Stets, 2009).

Identity arises partly from the enactment of roles in conjunction with membership of social groups, and partly from a sense of oneself as unique (Burke and Stets, 2009). The concept of role identity derives from a micro-sociological perspective, as the way in which a sense of self is constructed through the enactment of roles, while social group derives from a macro-psychological perspective, and explains the ways

in which individuals associate themselves with the ideal type represented by a group (Burke and Stets, 2009). Identity can therefore vary according to context as role and group membership changes, but also has a cross-context component which is the unique person identity (Burke and Stets, 2009). In this study the participants are grouped according to their professional identity. This identity incorporates both membership of the social group (mental health nurse or midwife), and the enactment of roles associated with these groups.

Burke and Stets (2009) argue that the individual's ability to select meanings which support their identity is closely associated with self-esteem and emotional wellbeing. Where a situation does not allow the verification of identity, the individual experiences distress and is likely to seek an alternative situation in which their identity can be verified (Burke and Stets, 2009). The process of maintaining a professional identity can therefore be understood as having significance for the wellbeing of the practitioner.

The maintenance of a particular identity involves the active use of various social and material resources (Burke and Stets, 2009). In midwifery, supervision is one of the resources employed to verify professional identity. Burke and Stets (2009) argue that status is a major resource for identity verification: research suggests that individuals of higher status are better able to maintain their identity (and thus maintain self-esteem and emotional wellbeing). The status of mental health nursing and midwifery in relation to other professions may therefore affect the strength of these professional identities.

4.2.2 Occupations as Professions

Professions are a type of occupational group whose precise characteristics have long been contended, but who tend to be associated with a privileged social position. Larson (1977) comments that in certain professions this association may in fact be aspirational rather than real; however she observes that the identification with middle

class values and “*relative superiority over and distance from the working class*” (Larson, 1977: xvi) form core values shared by the professions. Although nursing and midwifery commonly identify themselves as professions, they do not enjoy the degree of privilege associated with the archetypal profession of medicine (Abbott and Meerabeau, 1998). They do however lay claim to some of the classical professional traits, and the history of both these occupations reveals an identification with middle class values as a source of autonomy, power and status, and a deliberate distancing from working class associations (Dingwall et al., 1988).

Sociological approaches to conceptualising professions have ranged from describing the traits of the ideal profession, to re-classifying the term as a folk concept unsuited to scientific definition (Macdonald, 1995). An alternative to the conceptualisation of profession has been to focus on ‘professionalization’ as an activity undertaken by certain occupations (Macdonald 1995). However Freidson (1994) (while acknowledging that a reified definition is undesirable) argues that this focus on process does not eliminate the need to provide some conceptualisation of how the term profession is used. He argues that the process of professionalization implies that an occupation has professional status as its goal, and there must therefore be some sense of what the goal looks like. He therefore offers the following conceptualisation of a profession:

“an occupation that controls its own work, organized by a special set of institutions sustained in part by a particular ideology of expertise and service”

(Freidson, 1994: 10).

Dingwall (2008) argues that Freidson’s conceptualisation essentially reifies ‘autonomy’. He observes that the autonomy of medicine, for example, varies in different societies without any compromise of professional status. Dingwall (2008) argues that it is better to understand the concept of a profession in terms of how it is enacted by a given group. Dingwall (2008) is particularly concerned with how professions can be researched, and so makes ‘profession’ specific through focus on the specific case to be researched.

Dingwall's (2008) argument suggests how a researcher may avoid imposing meaning upon the understanding of profession in a particular context. However, for the purposes of this study I suggest that it is also useful to begin with an understanding of the characteristics commonly associated with 'profession', as this sensitises the analysis to the shared understandings of 'profession' which the participants in this study may draw upon. These characteristics include autonomous working, an expert knowledge base, the group control entry to their discipline, and professions are often regarded as having beneficent aims (Freidson, 1994, Macdonald, 1995, Freidson, 2001).

4.2.2.1 Demand and Supply

Dingwall (2008) identifies two categories of theory about professionalization: 'demand' and 'supply'. Demand theories are exemplified by the work of Larson (1977), who introduces the concept of the 'professional project' to explain how occupations go about achieving the status of a profession. Larson (1977) frames the activity of professionalisation in terms of the achievement of desirable social outcomes for an occupation:

“I see professionalization as the process by which producers of special services sought to constitute and control a market for their expertise... professionalization appears also as a collective assertion of special social status and as a collective process of upward social mobility... Professionalization is thus an attempt to translate one order of scarce resource – special knowledge and skills – into another – social and economic rewards”

(Larson 1977: xvii)

Larson (1977) argues that in order to achieve this translation, an occupational group must create demand for its services, it must acquire exclusive access to a body of special knowledge, and it must convince the public that it is trustworthy. State sponsorship may assist with professionalisation, but it is a combination of all of these

factors which results in an occupation acquiring a market monopoly and autonomous self-control (Larson, 1977). Larson (1977) goes on to argue that while professionalisation begins with a pragmatic organisation of 'education and the marketplace' in order to acquire 'social and economic rewards', the process then moves on to the justification of those rewards on the grounds of the 'ideology of expertise and service' described by Freidson (1994).

An alternative analysis of professions is offered by Friedson (2001), who turns to 'supply' theories of professionalisation (Dingwall, 2008). The role of the state is given more prominence, and professions are seen as being created by the state for its own purposes (Freidson, 2001). Professional status and privileges are awarded and protected by the government in exchange for an occupation fulfilling a necessary purpose (Freidson, 2001). Freidson's approach provides a particularly useful way of looking at professions in the context of contemporary corporatisation of health care systems. Freidson (2001) argues that this process has transferred some power from professionals to bureaucrats, but that professions can still support their special economic status on the basis of their beneficent motivations.

4.2.2.2 Professionalisation Through Social Closure

An important way in which professions support their special status is through the negotiation of relations with other occupational groups (Dingwall, 2008). Witz (1992) theorizes these relationships in terms of the exclusion of others. She argues that 'social closure' is the primary mechanism by which professions are formed (Witz, 1992). Social closure describes the way in which groups create collective social mobility by appropriating particular values and symbols as designating the group, and by excluding others from membership of the group (Macdonald, 1995). In terms of professions, social closure secures the position of an occupational group by preventing other occupations from colonising that area of work (Witz, 1992). Witz (1992) argues that professions employ four kinds of 'discursive strategies' to

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achieve social closure. An *exclusionary* strategy focuses on preventing the entry of a subordinate group (Witz, 1992). If the excluded subordinate group respond by trying to acquire eligibility, this forms an *inclusionary* strategy (Witz, 1992). A *demarcationary* strategy achieves a more complete dominance of the field by exercising control over other occupations (Witz, 1992). This strategy has been used most notably by medicine in defining areas of healthcare which may be undertaken by other, subordinate occupational groups. Finally, Witz (1992) identifies the strategy of *dual closure*. This describes the approach taken by those groups who are excluded from a dominant occupation and respond by creating their own, subordinate, professional field, from which they then exclude others (Witz, 1992). It is the concept of dual closure which has the most relevance to nursing and midwifery.

Both nursing and midwifery, have engaged in professionalization through dual closure. Both professions have been excluded by the dominant occupation of medicine, and have proceeded to create an area of exclusive practice for themselves, but in a subordinate position to the dominant occupation. Both midwifery and nursing supported their professional status by excluding a subordinate group: the working class practitioners who prior to professionalization had carried out most of the work in these areas. The distancing from the working class which Larson (1977) observes can be clearly seen in the histories of nursing and midwifery. The professional projects of both of these occupations were driven by a 19th century elite who wanted to create respectable employment for middle class women, and who were motivated by a genuine belief that the working classes needed the leadership of their social superiors (Heagerty, 1996). This process can be seen at work in the scapegoating of the handywomen midwives who were unfairly blamed for causing infection; a process which ultimately justified the complete exclusion of these midwives from the register (Kirkham, 1998).

In contrast to midwives, who have actively engaged in their professional project, the history of mental health nurses suggest that they have been co-opted into the general nursing professional project. This might be regarded as a form of demarcationary closure on the part of general nursing: as the dominant group, general nursing has

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exercised control over the occupational boundaries of mental health nursing. However Witz's (1992) notion of demarcationary closure is primarily concerned with the exclusion of others, and so the case of mental health nursing does not seem to fit any of Witz's (1992) categories.

Social closure may be only one stage in the process of maintaining professional status. Freidson (2001) argues that while the early stages of professionalisation are characterised by a status-seeking professional project from which others are excluded, once the profession is established there is less concern with creating conformity within the profession, and more interest in extending the influence of the profession through new specialisms. The profession therefore begins to differentiate internally, and become a loose collection of interests, rather than a rigidly unified group (Friedson 2001).

4.2.2.3 Supervision and Professionalisation

During professionalisation, midwifery and mental health nursing (in collaboration with general nursing) have adopted both supply and demand positions. As Larson (1977) describes they have associated themselves with an aspirational, middle class position and have worked to create special forms of education and areas of expertise. However both professions have also been procured by the state to fulfil the need for health care workers, and in particular for occupations which could assist medicine (Dingwall et al., 1988). The professional projects of both nursing and midwifery have been supported and shaped by their importance to the state.

Supervision in midwifery has served the professional aspirations of midwives in that it forms a means of excluding undesirable practitioners, and also the needs of the state, in that it monitors midwives' practice in the public interest. In mental health nursing, supervision is becoming increasingly visible in government policy, and with the drive for compassionate care may come to be seen as serving the interests of the state. However the antecedents of supervision in mental health nursing are closer to

the aspirational professional project of creating autonomous practitioners with an expert knowledge base.

4.2.2.4 Summary

The disciplines of mental health nursing and midwifery have created themselves as professions, and this has been a source of economic monopoly and social status. The identity of 'professional' may therefore be understood to have personal significance for individual practitioners. However professional identity is in some ways an ideal which is not enacted (Freidson 2001). The autonomy, power and unity which are associated with the concept of the profession, are in practice compromised by factors such as the power of the state and association with the more powerful profession of medicine. For practitioners, therefore, it may be difficult to verify their 'professional' identity according to this idealised standard.

This study is therefore located in relation to the profession as an aspirational ideal which may not be enacted in practice, as a source of group identity and role identity, as a source of status, and as a means of state control.

4.3 Emotions

4.3.1 Emotions in Contemporary Healthcare

Smith (2011) observes that from the 1970s onwards, nursing leaders have promoted 'holistic care' as central to nursing work, but have largely failed to address the emotional skill and effort required in whole-person care. This emphasis on caring has expanded beyond the nursing leadership: 'compassionate care' is now at the heart of current health policy, and in the wake of the Mid-Staffordshire Inquiry

(Francis, 2013) the ability of nurses to ‘care’ has become a subject of public debate (cf. Channel 4 News, 2013, Campbell, 2013). The public drive for ‘compassion’³ in healthcare, requires nurses and midwives to achieve a specific emotional state when interacting with clients. Practitioners’ emotional capabilities become a defining feature of their work.

There is some evidence of recent political recognition of the impact which emotion work has on practitioners. The Chief Nursing Officer (2012: 24) states that high quality healthcare can only be achieved where staff are given “*supervision and support within a culture of care, compassion and a recognition of the emotional labour of nursing, midwifery and care giving*”. Despite this statement, there is little in the Chief Nursing Officer’s recommendations which explains *how* the emotion work of nurses and midwives might be acknowledged and supported, and what the implications of this might be for training, and for the terms and conditions of healthcare work. As observed in Chapter 2, other government publications are similarly vague on this subject.

Current healthcare policy therefore highlights the use of emotions as an essential part of healthcare work, but has given inadequate attention to the impact of emotion work on practitioners, and to the training and support needs which emotion work entails.

4.3.2 Sociological Approaches to Emotion

Emotions are arguably fundamental to understanding human life. Turner and Stets (2005: 1) describe emotions as “*the ‘glue’ binding people together*”; present in all human beings, emotions are a driving motivation, a cause of unity, of division and

³ ‘Compassion’ is defined in the Oxford English Dictionary (2013) as “The feeling or emotion, when a person is moved by the suffering or distress of another, and by the desire to relieve it”. Compassionate care therefore alludes to both the emotional state of the practitioner, and the emotional state which is to be created in the client.

revolution. Despite their significance, emotions were largely excluded from much of social science until the 1970s (Turner and Stets 2005). Ehrenreich (2011) argues that one of the reformers of this ‘arid’, emotionless, sociology was Hochschild (1983), who brought attention to the personal emotions involved in social processes. The sociological study of emotions now forms a large and diverse field.

In this thesis emotions are explored with regard to the participants’ experiences of work, and it is from this perspective that the thesis approaches the theoretical understanding of emotions and work – a sub-discipline of sociology which is largely characterised by a social constructionist approach (Fineman, 2000). In this thesis Hochschild’s (1983) influential middle range theory of emotional labour is taken as the starting point for thinking about emotions in the work domain. The thesis then draws upon more recent theoretical literature which builds on the use of Hochschild’s (1983) work.

4.3.3 Emotional Labour

Hochschild’s (1983) theory of emotional labour identifies the use of emotions as an integral part of certain occupations, and explains the mechanisms by which this happens, and the consequences which this has for workers. The theory builds on the dramaturgical work of Goffman to explore how and why emotional displays are produced in social interactions, and on Marxist concepts to describe the consequences of emotion work in a capitalist system. Hochschild (1983) also employs the Stanislavkian concepts of ‘deep’ and ‘surface’ acting⁴ in order to explain how individuals manage their emotions on different levels.

⁴ In surface acting an emotional display is created which does not reflect the actor’s personal feelings, while in deep acting the display is created through the elicitation of embodied emotion using memory and imagination (Hochschild 1983).

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Hochschild (1983) formulated her theory based on research done with university students, flight attendants and debt collectors. She observed firstly that all social interactions require the management of emotions to produce acceptable displays of feeling, and secondly that certain occupations required employees to suppress or induce emotions in order to create a particular emotional display. The employee's emotional display was intended to produce a desired emotional state in the customer/client, and was prescribed by the employer (Hochschild, 1983). Hochschild called this kind of work 'emotional labour':

“the management of feeling to create a publicly observable facial and bodily display; emotional labour is sold for a wage and therefore has an exchange value”

(Hochschild, 1983: 7)

Distinguishing characteristics of emotional labour as compared to other kinds of emotion management are that it is salaried work and it is carried out in the public domain, and a key tenet of Hochschild's (1983) theory is this distinction between the management of emotions which occurs in private life, and the management of emotions which occurs in public (specifically the work domain). In private life, *emotion management* forms part of a gift exchange in which social actors negotiate emotional obligations and payments (Hochschild, 1983). In contrast, *emotional labour* occurs in public, working life, and the actors are involved in a commercial transaction.

With the 'labour' component of emotional labour Hochschild (1983) situates her theory in terms of a Marxist understanding of the relationship between worker and employer in a capitalist system. Hochschild (1983) makes a comparison between the physical labour carried out, for example, by a factory worker, and the emotional labour carried out by a service worker. She argues that the emotion-managing service worker is involved in the same kind of commercial transaction with their employer, engendering the same conflicts and bearing the same risks of alienation and exploitation as the physical labourer (Hochschild, 1983). Hochschild is therefore concerned with the mechanisms of power present in emotion work:

“We do not think twice about the use of feeling in the theater [sic], or in psychotherapy, or in forms of group life that we admire. It is when we come to speak of the exploitation of the bottom by the top in any society that we become morally concerned”

(Hochschild 1983: 12)

Hochschild (1983) also considers the gendering of emotional labour. Emotions are associated with the feminine, and the management of emotions is seen as women’s ‘natural’ work (James, 1989). Hochschild (1983) argues that this assumption of naturalness, and the association of emotions with the subordinate position of women has led to a general devaluing or ignoring of emotion work. This makes emotional labour a particularly useful theory for the traditionally female-gendered professions of nursing and midwifery, in which the ability to offer care is regarded as essential and yet the effort required to produce care has been invisible (Smith, 2011).

Although Hochschild (1983) draws attention to the exploitation of emotional labourers, she does not regard emotional labour as necessarily problematic. In fact she argues that it is a part of “*any functioning society*” (Hochschild, 1983: 12). Her concern is that emotional labour is not adequately recognised or rewarded, and that where emotional labourers are disempowered, their work has harmful personal consequences (Hochschild, 1983).

4.3.4 Feeling Rules

The main concept which Hochschild (1983) formulates to articulate the operation of emotions in social interactions is that of ‘feeling rules’. The concept of feeling rules connects the display of emotion and the inner experience of emotion. Feeling rules are the cultural scripts which tell us about the appropriate emotional response in a situation (Hochschild, 1983). They set the boundaries of a space in which we can experience a feeling without “*worry, guilt or shame*” (Hochschild, 2003: 98). We

manage our emotions in accordance with feeling rules, and the rules also help us to identify how we feel in a given situation (Hochschild, 1983).

Following a feeling rule may require us to work on our emotions in order to form what we believe to be the correct emotional response. Hochschild (1983) describes this as an internalised process, of which we are generally unconscious. We tend to be aware of it only at the “*pinch between ‘what I do feel’ and ‘what I should feel’*” (Hochschild, 1983: 57). We may be alerted to the breaking of feeling rules by an internal sense of “wrongness” or by the responses of others (Hochschild, 1983: 61). When we become aware of feelings which seem wrong or inappropriate, we may then engage in emotion work in an attempt to mould our inner emotions or external emotion display into a more appropriate form, or we may attempt to change or subvert the feeling rule (Hochschild, 1983).

4.3.5 Responses to Hochschild

A number of aspects of Hochschild’s (1983) theory have been both extended and critiqued, including her conceptualisation of emotion; the division of public and private; her argument about alienation and authenticity of emotional expression; and the limitations of emotional labour when applied to non-service sector occupations. In this section some of these critiques are addressed.

4.3.5.1 Conceptualising Emotion

The sociological study of emotions has been mainly carried out from a social constructionist perspective (Turner and Stets, 2005). It is argued that since emotions are formed, expressed and interpreted in a socio-cultural context, they may be understood as socially constructed (Turner and Stets 2005). However the purist constructionist approach has been criticised as neglecting the role of the body and

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unconscious in the experience of emotion, and Turner and Stets (2005) argue that a sociological conceptualisation of emotion must combine the social with the biological and the cognitive.

In *The Managed Heart* Hochschild's (1983) conceptualisation of emotion gives emphasis to the social, but also draws on Darwin and Freud to incorporate the biological and the cognitive. She defines emotion as "*a biologically given sense... it is a means by which we know about our relation to the world*" (Hochschild 1983: 219). But, she continues, while emotion is like our other senses in that it is an instinctual precursor of action, it is also unique in that it can be modified or created by cognition.

A detailed critique of Hochschild's conceptualisation of emotion has been made by Theodosius (2008). Theodosius (2008) argues that the primacy of the social in Hochschild's conceptualisation means that emotion is ultimately treated as subordinate to cognition. Although Hochschild (1983) seems to state that emotion can be pre-cognitive, the embodiment of emotions is inadequately explained, and her concept does not allow for emotions which are experienced as unpredictable, and as overwhelming the agency of the individual (Theodosius, 2008). Hochschild (1983) regards 'overwhelming' emotions as purely metaphorical, an artefact of language.

In response Theodosius (2008) creates an alternative conceptualisation of emotion. She challenges Hochschild's reading of Freud, arguing that Hochschild imperfectly translates Freud's theory of repression into the suppression of already socially managed emotions, thereby excluding the possibility of spontaneous emotion. In contrast, Theodosius (2008) argues that Freud explains the repression of emotion as a process which circumvents cognition. *Thoughts* emerge from the unconscious into the pre-conscious, where they become subject to cognition; but Freud argues that *emotions* do not enter the pre-conscious, they are only either conscious or unconscious (Theodosius, 2008). Therefore if a repressed emotion enters the conscious mind it does so without the mediation of the pre-conscious, and so may be "*unpredictable and volatile*" (Theodosius, 2008: 84). In this way emotions can overcome agency. This argument is supported by neurological evidence which

shows that the emotion parts of the brain can act independently of the thinking parts. Emotion can be expressed both through language and, pre-linguistically, through the body (Theodosius, 2008).

An advantage of Theodosius' (2008) conceptualisation of emotions is that it constructs emotions as forming a multi-dimensional experience in which emotions may conflict with one another. Theodosius (2008) supports this multi-dimensional vision of emotions with reference to Archer (2000), who divides emotions along a spectrum from first order (biological) to second order (social). Archer (2000: 195) argues that emotions are "*relational to something*". They are both physiological and embodied, and are also modified and influenced through interaction with the world. Conceptualising emotions as relational captures the inner dialogue between first and second order emotions – in other words reflexive emotion management (Archer, 2000).

Archer goes on to say:

“Because of their situational and relational character as imports, our emotionality is regarded as a continuous running commentary (that is something we are never without) and therefore it is only in sudden or urgent contexts that we are aware of a specific emotion”

(Archer 2000: 197).

This argument recalls Hochschild's (1983) observation that unless there is some disruption we are generally unaware of our processes of emotion management, and these are a continuous part of social life.

Archer's (2000) conceptualisation of emotion as situated in both cognition and culture makes codification of emotions irrelevant; they are too complex, and a single language is unlikely to have names for all possible emotional experiences (Archer, 2000). Hochschild (1983: 202) makes a similar argument when she says that emotion "*is best understood in relation to its social context*". She believes that

attempts to codify emotions tend to obscure meaning, losing the complexity of emotions as they are lived.

Archer's (2000) view of emotions as a situated and relational 'continuous commentary', means that to understand the complexity of emotion there must be some understanding of the context in which the emotion emerges. Hochschild's (2003) view of feeling rules as 'latent' supports this requirement for a contextualised understanding of emotion. Accounts of experience in the form of narratives therefore offer an ideal means by which to understand emotions as contained in the details of life.

4.3.5.2 The Public:Private Dichotomy

A key part of Hochschild's (1983) theory of emotional labour is the distinction between emotion management which is done in private life, and emotion management done in public, working life.

Hochschild (1983) argues that in the social interactions of *private* life we give and receive the emotional effort required to display appropriate feelings: demonstrating care, respect or conformity to others. Emotion management is guided and constrained by feeling rules, but participants in the emotional gift exchange may also improvise upon or subvert feeling rules (Hochschild 1983).

Hochschild (1983) contrasts this with what happens when emotion management is commodified as part of *public*, working life. She argues that when the elements of social interactions (feeling rules, deep acting, surface acting) become part of a labour-wage exchange, conflict inherent in the employer-worker relationship engenders the exploitation of the worker's emotion management. In private life, feeling rules can be improvised upon, in working life, feeling rules are scripted by the employer and the worker must engage in emotional effort in order to create the feeling display prescribed by their employer (Hochschild 1983).

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Hochschild's (1983) distinction between emotion management in public and private has been criticised in different ways. For James (1989: 39), the distinction is an "*artificial dichotomy*", and emotion work in both of these spheres is emotional labour. James (1989) argues that the emotional skills learned by women in the domestic sphere are used in jobs requiring emotion management, and so emotion work in private and public is subject to the same social forces. For Bolton (2005), the dichotomy is oversimplified, and conflates 'public' with 'commercial'. She argues that Hochschild's approach fails to address the variety of emotion management which may take place in a waged context.

For Theodosius (2008: 15), Hochschild's distinction "*represents the exploitation to which she feels emotional labourers are subjected*". This highlights the picture of power relationships contained in Hochschild's theory. Hochschild (1983) differentiates emotion management in private and work contexts because she regards the capitalist relationship as endangering the worker's emotional integrity. Bolton (2005) argues that Hochschild's comparison of emotional labour to physical labour does not take account of the way that the emotion worker can choose whether to engage in a superficial or deep emotional performance. Bolton (2005: 112) concludes that Hochschild does not allow the worker enough agency. She argues that each actor interprets and reacts to situations in a unique way, that feeling rules do not produce a "*standardised product*" but actors "*mix and match feeling rules*".

This challenges Hochschild's picture of agency in private life as opposed to lack of agency in working life, but it can equally be argued that Hochschild (1983) does not necessarily deny agency to the worker, rather she highlights the problems of reduced agency in the workplace. Bolton (2005) complicates the picture of emotion work and agency, and pays more attention to the possibility of resistance to workplace feeling rules. However, in focusing on the agency of the worker she gives less consideration to emotion work as a source of exploitation, and this portion of her analysis is largely reserved for her discussion of emotion management in the service sector.

The public:private distinction may perhaps most usefully be understood as a way of thinking about differences in emotion management between different contexts, rather than a ‘real’ division, and the boundary between these domains must be understood as blurred and permeable. Bolton’s (2005) argument suggests that emotion management in the workplace may, in fact, involve private-domain style interactions, while Hochschild’s (2003) later work suggests that emotion management in the private-domain may occur in a commercialised context.

4.3.5.3 Self and Authenticity

The public:private dichotomy highlights the different contexts of emotion management, and the different styles of emotion management in these contexts. However, Theodosius (2008) argues that it most importantly highlights the distinction made between the sense of an authentic self, and a self modified according to workplace norms. Hochschild (1983) sees a consequence of emotional labour as being changes in the worker’s sense of identity and self-coherence.

A key concept in Hochschild’s (1983) argument is that of ‘authenticity’. Hochschild (1983) and later scholars argue that the quality of authenticity is highly valued in modern culture (cf. Sloan, 2007). Organisations try to create a sense of authenticity (Ashforth and Tomiuk, 2000). On an individual level, feelings of *inauthenticity* cause distress, alienation, and meaninglessness (Sloan, 2007). The ‘authentic self’ is commonly associated with an idea of naturalness, of free expression “without regard for norms of emotional feeling and display” (Sloan, 2007: 307). However authenticity of self is arguably socially constructed and contextually located. For example, Turner (1976) observed that during the 20th century the location of the ‘real’ self has moved from association with the institutional to association with the impulsive, and Ashforth and Tomiuk (2000) argue that a sense of self-authenticity may vary from context to context.

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Hochschild (1983) argues that an emotion worker's experience of authenticity is influenced by the ways in which s/he constructs his/her self in relation to the work role. Some workers may create the required emotional display by personally identifying themselves with the priorities of the employer (Hochschild 1983). Hochschild (1983) argues that this is the approach favoured by many employers, but she regards this as problematic because it does not allow the worker to separate him/herself from the emotional exchanges of the workplace, causing emotional burnout.

Alternatively workers may experience both private and work selves as “*meaningful and real*” (Hochschild 1983: 133). At work they use deep acting skills to produce what they experience as an authentic emotional display (Hochschild 1983). Hochschild (1983) argues that this separation of selves makes workers less vulnerable to emotional injury, but requires the right conditions in order to be sustained. Where workers are disempowered, or lack the resources to perform deep acting, they may employ surface acting in order to produce the required emotional display (Hochschild 1983). The separation from self involved in surface acting protects them from burnout, but threatens their sense of authenticity, alienating them from their emotions (Hochschild 1983).

Three ideas underpin Hochschild's (1983) argument about the relationship between self, authenticity and workplace emotion management. First, she argues that a 'false', workplace-self may act as an emotional buffer for the worker, protecting a 'true', private-self. Second, she envisages a situation in which the emotional exchanges of the workplace are problematic: the worker is disempowered in the emotional gift exchange, and the level of emotion management required is personally unsustainable. Third, as Theodosius (2008) observes, Hochschild (1983) associates surface acting with inauthenticity. These three ideas have been problematised and are discussed below.

4.3.5.3.1 The false self protects the true self.

Anthropologists have exposed the cultural foundations of the construct of ‘self’, leading some social constructionists to challenge the usefulness of talking about self at all (Lock and Strong, 2010). However, in Western culture there is an undoubted folk understanding of the self, and people talk about ‘*myself*’ (Lock and Strong, 2010). Theodosius (2008: 193) argues that Hochschild seems to reify the self as “*a fixed, knowable entity*”. This study aims to understand supervision from the participants’ perspectives, rather than to deconstruct the concept of self, and can therefore accept ‘self’ as part of subjective experience. However this does not imply the reification of a single self. The experience of self can be thought of as a “*shifting montage of many selves*” (Ashforth and Tomiuk, 2000: 184), something which is both socially constructed and depends on context, but which is experienced as ‘true’ or ‘real’, and as having degrees of authenticity (Sloan, 2007).

Hochschild (1983) distinguishes a true and a false self. The false self is associated with a socialised, ego-like aspect of the person which manages the impulses of an id-like “*noble savage*” (Hochschild, 1983: 192), who is free of societal constraints. As such the false self can be protective (Hochschild, 1983). Conversely Hochschild’s (1983) argument seems to associate the ‘true’ self with the id-like noble savage, who does not follow feeling rules (although she is less clear on this point). At the same time she also associates the true self with ownership of feelings, suggesting that the self-constrained by imposed feeling rules is not the true self.

In contrast to Hochschild’s approach, Gordon’s (1989) theory of self-orientation suggests that conforming to emotional norms does not necessarily inhibit a sense of emotional ownership. Gordon (1989) argues that emotional experiences are made meaningful through ‘emotional culture’. Emotions are therefore connected to personal values and motivations, and function as a way of “*defining one’s place in a situation*” (Gordon, 1989: 116). In a similar vein to Archer (2000), Gordon (1989) argues that emotional experience occurs on both individual and social levels, and is subject to continuous reflection. The spontaneous emotions elicited by a given

situation are therefore interpreted in the light of pre-existing cultural orientations. To paraphrase Gordon's (1980) argument in terms of Archer's (2000) inner dialogue between first and second order emotions, Gordon (1989) is suggesting that in the individual's inner dialogue, the socio-cultural emotional orientation may carry more weight than the immediate biological emotional state.

Gordon (1980) – drawing on Turner (1976) – calls these different orientations of self in emotion culture 'institutional' and 'impulsive'. The institutional orientation is associated with long term, low intensity feelings and the desire to produce an emotional display which conforms to social norms, while the impulsive is associated with short-term, high intensity feelings which are displayed in a way which feels unrestricted and spontaneous (Gordon 1989). The individual may experience their true self as located with either the institutional or the impulsive (Gordon, 1989). A sense of self-authenticity therefore depends on how feelings accord with the orientation of the individual (Gordon, 1989). An individual who is oriented towards the institutional experiences an emotional process which conforms to institutional norms as *authentic*, and an impulsive emotional outburst as *inauthentic* because it contradicts his/her most deeply held values.

Gordon's theory is supported by Sloan's (2007) study which shows that workplace emotion management is not universally associated with a sense of emotional inauthenticity. Sloan (2007) found that the location of self influenced feelings of authenticity at work, with those workers who had an institutional orientation feeling most authentic and happiest at work. However Sloan (2007) also found that institutionally oriented workers were the most negatively affected by having to perform emotion management.

Sloan (2007) suggests that this counter-intuitive finding may highlight the different meanings which workplace experiences have. For institutionally oriented individuals, workplace experiences are highly meaningful, and so the management of emotions, and the experience of emotions not conforming to workplace feeling rules, has a greater emotional impact. In contrast, impulsively oriented individuals distance themselves from the emotional experiences of the workplace, and so although they

may generally experience the workplace more negatively, emotion management at work has less profound personal consequences.

In light of Sloan (2007) and Gordon's (1989) arguments, Hochschild's (1983) metaphor of the 'false self' may be seen as problematic in that it creates an overly simple impression of a complex interaction of factors. Describing the false self as protecting the true self does highlight the way in which the construction of self relates to feelings of authenticity, but taking the work-self to invariably be a false self ignores the different ways in which individuals construct their sense of self. From Sloan's (2007) findings it seems that for individuals with an impulsive orientation, a false work-self may indeed protect the true self, but this mechanism does not hold for individuals with an institutional orientation who experience the work-self as the true self.

4.3.5.3.2 The emotional exchanges of the workplace are problematic.

Hochschild (1983) discusses emotional labour as occurring in a particular kind of context in which workers are relatively disempowered, and deep acting is inadequately resourced. When applying Hochschild's (1983) theory to other contexts it is therefore necessary to review the autonomy and skill of emotion workers. In healthcare the motivations and the power relationships involved in emotion work are arguably different to those in the service sector analysed by Hochschild (1983). For example, Bolton (2005) points out that emotion work may be done for altruistic reasons (something which Hochschild does not consider), while Theodosius (2008) draws attention to the powerful position of a nurse who performs emotional labour in relation to a sick and needy patient. The emotion worker cannot, therefore, be assumed to be powerless and governed by commercial priorities.

Addressing these issues, Bolton (2005) departs from Hochschild's work to create a new typology of four kinds of work-based emotion management: *Pecuniary*, *Prescriptive*, *Presentational* and *Philanthropic*. Bolton (2005) describes each of

these kinds of emotion management as governed by different sets of feeling rules, enacted in different ways, associated with different motivations, connected to different versions of self, and with different consequences for the practitioner. Bolton (2005) identifies four kinds of feeling rules: *Commercial*, *Professional*, *Organisational* and *Social*.

Pecuniary emotion management is governed by commercial feeling rules. This is emotion management done in the service sector, closely controlled by the organisation, motivated by commercial interests, and producing a superficial emotional performance. It is this form of emotion management which Bolton (2005) compares to Hochschild's concept of emotional labour. Bolton (2005) regards commercial feeling rules as producing a potentially alienating interaction because they are imposed by the organisation on powerless workers, who consequently produce superficial emotional displays.

In contrast, prescriptive emotion management is governed by professional and organisational feeling rules which are internalised by the worker. The members of a profession are socialised into a particular set of feeling rules to which they are personally attached. Similarly, organisational feeling rules function as a script for emotional behaviour within the organisation which are largely implicit and internalised. Bolton (2005) emphasises that in both professional and organisational feeling rules there is space for variation and resistance. Prescriptive emotion management is associated with various motivations including altruism, practical gain or enhanced social status, and so may produce a superficial, or an authentic performance.

Bolton's (2005) final two forms of emotion management, presentational and philanthropic, are governed by social feeling rules, and so form part of the emotional gift exchange described by Hochschild (1983).

Bolton's (2005) typology illustrates her argument that workers mix and match feeling rules in the workplace. By giving attention to the motivations behind the different sets of feeling rules Bolton (2005) explains the agency of the worker, who

may choose to follow a set of feeling rules for reasons other than those ordained by the organisation. Bolton's (2005) typology therefore allows consideration of agency and resistance by complicating the picture of emotion management, and showing the actor as moving between sets of feeling rules. Bolton (2005) provides a more complex account than Hochschild's (1983) description of problematic, alienating emotional labour, suggesting that emotion management in the workplace is not invariably problematic.

4.3.5.3.3 Surface acting produces an inauthentic emotional display.

Hochschild (1983) argues that a major consequence of emotional labour is the estrangement of the worker from his/her emotions. This occurs because the individual can experience some forms of emotional expression as inauthentic, or not true to oneself. Such inauthentic emotional expression is produced through surface acting, which requires the worker to expend considerable effort in maintaining an emotional display which does not match their inner feelings.

Theodosius (2008) argues that through this conflict of inner feelings and outer display, Hochschild equates surface acting with deception. In contrast, Theodosius (2008) argues that her re-conceptualisation of emotion allows for a conflict of feelings without deception. Emotions can work on several levels at once, and so surface acting can be 'animated' by the deeper self, making it an authentic personal expression (Theodosius, 2008). This argument is supported by a study on the experience of authenticity at work by Ashforth and Tomiuk (2000), who found that workers both experienced their work role as reflecting a true self, and also believed that their work involved the creation of emotional display through acting.

Explaining this seemingly paradoxical finding, Ashforth and Tomiuk (2000: 194) suggest that there may be "*two levels of authenticity, surface authenticity and deep authenticity*". When an individual's emotion display reflects their current emotions this is experienced as surface authenticity. When an emotion display reflects the

individual's internalised rules of personal identity, this is experienced as deep authenticity (Ashforth and Tomiuk, 2000). So where an individual feels a deep allegiance to their work role, acting in order to produce the appropriate emotion display is experienced as deeply authentic or true to oneself (Ashforth and Tomiuk, 2000).

Ashforth and Tomiuk (2000) relate their argument to Hochschild's (1983) use of deep and surface acting. Surface acting produces an emotion display which does not reflect the individual's current feelings. It is therefore associated with surface *inauthenticity*. However surface acting may be motivated by personal identification with the work role, and may therefore be associated with deep *authenticity* (where there is no identification with the work role this is associated with deep *inauthenticity*) (Ashforth and Tomiuk, 2000). In contrast to Hochschild's (1983) argument, there is no equation between surface/deep acting and inauthentic/authentic emotions. Instead the authenticity of emotional experience is closely connected to the worker's personal values and motivations. Ashforth and Tomiuk's (2000) argument therefore ties in with Gordon's (1989) theory of orientation of self, and Bolton's (2005) description of the different motivations attached to different forms of emotion management. The work of these scholars serves to expand upon and also challenge, some of Hochschild's original ideas.

4.3.5.4 The Commodification of Emotion

Bolton (2000: 581) has criticised the theory of emotional labour on the grounds that it does not encompass "*altruistically motivated*" healthcare. Like Theodosius (2008), Bolton (2000) critiques the 'labour' part of emotional labour, arguing that its connotation of exploitation is inappropriate to situations in which nurses offer emotion management as an altruistic 'gift' to their patients. Hochschild (1983) locates emotion management as a gift in the private sphere, but Bolton (2000) argues that this kind of gift exchange can also take place in the work sphere (philanthropic

and presentational emotion management). She argues that the emotion work of nurses is not in fact commodified in the way that the emotion work of Hochschild's flight attendants was (Bolton, 2000).

Bolton's (2000, 2005) concept of emotion management as a gift has been challenged by Brook (2009), who argues that Bolton has misinterpreted the Marxist concepts which Hochschild uses to underpin emotional labour. Bolton (2005) argues that only pecuniary emotion management qualifies as emotional labour because this is the only instance where emotions are directly used to make a profit. Brook (2009) however contends that Bolton has wrongly interpreted the exchange of emotion work for a wage as equating to the commercialization of emotions. He sees the key distinction as between 'labour' – where the worker sells "their completed labour in the form of a product" – and 'labour power' – where the worker sells their "yet-to-be realized capacity to work" (Brook, 2009: 538). Emotion workers, Brook (2009) argues, are selling their labour power, that is their capacity to perform emotion work. They are not selling the emotions themselves. Emotional labour is therefore the *commodification* of labour power, not the *commercialization* of emotion, (Brook, 2009). Brook (2009) argues that while the worker may 'sabotage' or 'enhance' their emotion work, the product of the work remains the property of the employer, and so any emotion management performed as part of paid work is emotional labour.

From the Marxist perspective, the sale of labour power engenders a view of the relationship between worker and employer as inherently unstable and subject to an on-going negotiation over ownership and reward (Brook, 2009). In contrast to this dynamic, in which both worker and employer have degrees of power, Brook (2009) argues that Bolton creates an overly simplistic picture in which either the worker or the employer has control over emotion work. Brook (2009) argues that the sale of emotional labour power does not entail the total ceding of power to the employer. At the same time, workers are situated within organisational and social structures which exert power over their emotional performance, and so are never fully in control of their emotional labour (Brook, 2009).

In some respects Brook's (2009) critique does not allow for the nuances of Bolton's account of emotion management. Bolton (2005) does not ignore power relationships in the workplace, she is concerned to explore the possibility of worker resistance to feeling rules, but she does relegate exploitative emotion management to the pecuniary and commercial context, and in her discussion of presentational and philanthropic emotion management, she seems to neglect the fact that such emotion management is done in the context of work. Brook's (2009) critique draws attention to this, and reminds us of the importance of the wage and the workplace as context for emotion management.

Brook's (2009) explanation of the commodification of emotional labour power offers a useful way of contextualising emotion management in the context of healthcare (where practitioners sell their ability to perform emotion management as a part of their work role, and arguably sell this ability as part of their fitness for professional membership), while Bolton's (2005) explanation of the differently motivated forms of emotion management within the waged context, allows understanding of the complexity of emotion management, and challenges the public:private dichotomy.

4.3.6 Emotional Labour in Nursing and Midwifery

In her seminal text on emotional labour in nursing Smith (1992) argued that the emotion work of nurses often went un-noticed and unrewarded, instead being subsumed into the general category of 'women's work'. Since the publication of Smith's (1992) study a considerable body of work has developed which applies the theory of emotional labour to the disciplines of both nursing and midwifery (Hunter and Smith 2007). Supervision in nursing and midwifery is discussed in emotional terms, as a source of support for practitioners (cf. Bégat and Severinsson, 2006, Local Supervising Authorities and Nursing and Midwifery Council, 2008), and clinical supervision is discussed specifically as a way of reducing the risk of burnout (cf. Edwards et al., 2006, Hyrkäs, 2005), however I was unable to identify any

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studies in which the theory of emotional labour is used to analyse the supervision of nurses or midwives.

The application of emotional labour to healthcare work has been critiqued. Hochschild's (1983) theory was originally formulated with respect to service sector work, and Bolton (2005) and Theodosius (2008) have argued that the theory does not adequately accommodate the motivations and power relationships in healthcare. However Grandey et al. (2013) observe that as the field has developed, emotional labour has come to be applied to a spectrum of occupations, and has been used to examine different aspects of emotional work. They argue that researchers should distinguish between use of the specific theory of emotional labour and a broader perspective on emotion regulation at work.

Several decades worth of nursing research has identified nursing as emotional work and made connections between the emotional state of nurses and the emotional state of patients (Smith, 2008), and more recently the emotion work of midwives has also come under scholarly scrutiny (Hunter and Deery, 2009). Nurses and midwives work in emotional contexts, dealing with life, death and suffering, and also work relationally with their clients as emotional individuals (Hunter and Deery, 2009, Smith, 2011). An early influential study by Menzies (1960), explored what happens when such emotional work is not supported.

Menzies (1960: 98) observed that nursing involved "*tasks which, by ordinary standards, are distasteful, disgusting and frightening*", and which may evoke powerful and possibly conflicting emotional responses in the nurse (and also in the patient). Menzies (1960: 100) argued that the nature of their work meant that nurses were at "*risk of being flooded by intense and unmanageable anxiety*". The main stimulus for anxiety lay in nurses' interactions with patients, and Menzies (1960) observed that the organisational structures of nursing operated to protect nurses from anxiety by actually inhibiting emotional engagement with patients.

Menzies (1960) argued that socialisation into the defence strategies of nursing created a situation in which anxiety became sublimated. This meant that reasonable

anxiety could not be distinguished from more pathological anxieties. Consequently, nurses' abilities to cope with problems, autonomy, change and patient interactions were undermined, and their "*capacity for creative, symbolic thought, for abstract thought, and for conceptualization*" (Menzies, 1960: 116) was inhibited. Nurses were left unable to learn productive ways of coping with anxiety and so experienced themselves as helpless and in a state of crisis (Menzies, 1960).

Smith (2008: 368) points out that current exhortations to nurses to be compassionate "*may actually require them to dismantle such systems they have developed against anxiety*". In the 1960s Menzies observed that this dismantling seemed a near impossible task: historically nurses' defence systems made them resistant to change, and such changes as were implemented tended to reinforce existing systems. Smith (2011) argues that nurses can learn better ways of engaging emotionally with their work, but that this "*requires effort, skill and organizational support*". Smith's argument is borne out in the conclusions from the Mid-Staffordshire Inquiry (Francis, 2013), in which the failures in nursing care are attributed to systemic and organizational failures.

4.3.7 Emotional Organisations

Historically the sociology of organisations has focused on organisations as rational structures, and following the tenets of the Enlightenment, reason and emotion have been regarded as in antagonistic relationship (Fineman 1996, Fineman 2000, Gibson 1997). Fineman (2000) argues that it is useful to abandon the dichotomy of reason and emotion, instead understanding these as inextricably entwined. Organisations inevitably exert control over the display of emotion, although the focus may be on rationality rather than emotionality (Gibson 1997). Gibson (1997) argues that while organisations may attempt to structure themselves as rational, such rational structures can create strongly emotional processes, and that organisations are in fact dominated by emotional rather than rational interactions.

Gibson's (1997) argument is supported by Sandelands and Boudens' (2000) finding that when recounting their experience of work, people tend to talk about feelings rather than actions. The authors observe that when talking about feelings connected to work interviewees don't name these feelings: happy, sad, frustrated, contented etc. Instead they tell stories which illustrate the feeling in operation. Sandelands and Boudens (2000) argue that this makes narrative methods particularly suited for inquiry into the emotional experience of work.

4.3.7.1 Organisations as Emotional Ecologies

Frost et al. (2000) use the term 'emotional ecology' to describe the systems, structures and practices through which cultures of emotional practice are created. Norms and rules are established within the emotional ecology, and this "*can facilitate or retard*" (2000: 35) the emotion practices of those working within the ecology. The metaphor of the emotional ecology captures the complex wholeness of the emotional organisation, showing how the individual interacts with and within the wider systems and structures of the organisation. This allows the kind of interplay between individual agency and organisational control which Bolton (2005) describes.

Frost et al. (2000) argue that an organisation creates an emotional ecology which can foster or inhibit certain kinds of emotional interactions. So, for example, a compassionate organisation allows its members to express suffering, and to respond to one another's suffering on a person-to-person level (Frost et al., 2000). Organisational leaders play an important part in facilitating and role-modelling this kind of emotional ecology.

4.3.8 Summary

In this thesis a critical appreciation of theoretical constructs developed in Hochschild's (1983) theory of emotional labour is used to inform a sociological understanding of emotion work in mental health nursing and midwifery. Key critiques of Hochschild's work, such as that by Bolton (2005) are used to expand the picture of emotions at work. These theoretical perspectives on emotion work allow consideration of how emotion management is structured and practised, and the consequences of emotion management for the individual practitioner. This provides a framework for understanding a possible relationship between the emotion work of the practitioner and supervision.

4.4 Subjectification

This section explores the process of subjectification, as articulated by Butler (1997) drawing on Foucault. The concepts of subjectification and the confessional, drawn from the work of Foucault (1976, Foucault, 1977), have been used in the nursing supervision literature to critically analyse the operation of power in supervision (Gilbert, 2001, Clouder and Sellars, 2004, Cotton, 2001), and this section also considers the operation of resistance in relation to supervision.

Subjectification is one of the keystones of Foucault's theoretical project (Heller, 1996). It describes the process by which the subject is both acted upon by power, and constituted by power (Butler, 1997). The 'subject' in this sense is understood as indicating a discursively formed position which the person occupies, and which imposes norms of behaviour upon the person (Butler, 1997). Foucault (1977) uses the example of the prison to explain the working of power in making subjects, and Butler (1997) argues that this focuses attention upon power as a controlling and invasive force, and on the disciplining of the body as the means of subjectification. In contrast, Butler (1997) focuses on the ambivalent nature of power as both

subordinating and making. While Foucault (1977) looks at how different categories of subject are constructed, Butler (1997) is interested in how subjectification constructs the inner person, or psyche⁵. Butler's (1997) perspective on subjectification is informative when considering the mechanisms of supervision, which act upon the inner person, not the body. Butler's (1997) discussion of the ambivalence of subjectification informs an understanding of supervisory power as potentially both oppressive and emancipatory.

Butler (1997) draws attention to Foucault's understanding of the operation of power as making the subject. The subject is therefore both constrained by power, and dependent upon power for its existence (Butler, 1997). Butler (1997) argues that this dependency upon power creates a 'passionate attachment' on the part of the subject towards the power which forms it. For example, in the parent-child relationship, the child depends upon the parent for his/her continuing existence, and therefore must develop love and attachment towards the parent, and consequently towards his/her own subordinate position in regard to the parent (Butler 1997). Subjectification therefore has the paradoxical effect of both subordinating the subject and giving agency through the constitution of the subject: "*Power not only acts on a subject but... enacts the subject into being*" (Butler, 1997: 13).

Simons (1996) follows Butler in exploring subjectification through the mother-child relationship. Simons (1996) argues that Foucault's concept of subjectification is limited by a masculinist outlook, and he "*overlooks the possibility of positive constitution at the hands of others, treating it instead as a loss of personal autonomy*" (Simons, 1996: 184). Instead, Simons (1996) argues that the subjectifying power of the mother can be regarded as an enabling power which creates autonomy in the child-subject.

⁵ Butler (1997) uses the concept of the psyche in the psychoanalytic sense to refer to the inner world of the person. The psyche therefore incorporates the construct of the unconscious, and, Butler (1997) argues, is greater than the subject.

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Butler (1997) argues that this apparent paradox of power as both subordinating and enabling, can be explained through the desires and emotions which provide the mechanisms by which the subject can be attached to, and also resist, the subjectifying power. Butler (1997) observes that Foucault presents two conflicting arguments about the ability of the subject to resist power. In *Discipline and Punish*, Foucault (1977) sees the imprisonment of the body as creating imprisonment of the inner person, while in *The History of Sexuality* Foucault (1976) regards resistance as a consequence of the exercise of power.

In contrast to Foucault, Butler (1997) argues that the psyche resists the attempt to create a coherent subject. Because the enactment of the subject by power is a continuous process, there is a repeated restating of the subject; the subject is never completed (Butler 1997). The subject repeats, internalises and embodies the external conditions of power by which it is formed (Butler, 1997). This act of restating and internalising the conditions of subjectification allows the subject to take possession of power (Butler, 1997). The subject is subordinated by power, but also gains mastery over power because the embodied psyche is not limited to the subject (Butler, 1997). The psyche is able to respond to subjectification with misunderstanding or hesitation, and so the opportunity for subversion or reinterpretation of the conditions of power is created (Butler, 1997).

Clinical supervision has been analysed as a process of subjectification in which the supervisee is made subject to a normalising power (Gilbert, 2001). Supervision in both nursing and midwifery is associated with the inculcation of professional norms, it is a way of constituting the professional practitioner. Gilbert (2001) argues that supervision as subjectification undermines the discourse of autonomy which is associated with clinical supervision. However, the arguments made by Butler (1997) and Simons (1996) suggest that supervision as a process of subjectification could also be seen as enabling, and as creating autonomy. In this way supervision might appropriate a feminist form of subjectification, in which subjectifying power is exercised in order to enable the subject (Simons, 1996). Simons (1996) argues that this form of subjectification is traditionally found in caring occupations performed by women (such as nursing or midwifery). Here a nurturing power is exercised without

the intention to dominate; however Simons (1996) cautions that such power can be exercised abusively, and is itself subject to the context of power. Therefore the mother's subjectifying power is constrained by her location in the context of male domination (Simons, 1996), or alternatively, the subjectifying power of supervision is constrained by its enactment in the context of the power structures of the organisation.

4.4.1 The Confessional

Foucault's (1976) concept of the confessional suggests a mechanism by which supervision functions to subjectify the practitioner. Foucault (1976) envisages the confessional as a key method by which Western societies produce truth. From early confessional practices of the Christian church, Foucault (1976: 59) argues that "*we have since become a singularly confessing society*", with confessional style practices taking place in a variety of social contexts. These practices, Foucault (1976) believes, are an exercise of power which is no longer recognised as such; we take it for granted that we must tell the truth about ourselves. In the confessional the subject becomes their own observer (Foucault, 1976). Butler (1997) argues that this telling of one's story exemplifies the subject's circular position as both within and out with the power by which they are constituted. In order to tell their story the subject must become their own observer and yet the story is about the constituted subject (Butler, 1997).

The confessional enshrines a power relationship, since the confession is always made to another or others (Foucault, 1976). Foucault (1976: 61-62) describes the audience of the confession as being the person who "*requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console and reconcile*". This description includes many qualities which might be assigned to a supervisor.

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A comparison between the confessional and supervision seems inevitable, and this is made by Gilbert (2001) – while in a similar vein Cotton (2001) compares reflection to the confessional. Gilbert (2001) argues that in the literature the discussion of supervision is formed as an emancipatory discourse which fails to take account of ways in which supervision can be used to constrain and control practitioners (Gilbert, 2001). In contrast, Gilbert (2001) argues that supervision and reflection should be understood as forms of surveillance through which the work of practitioners is made visible.

Foucault (1977) introduces the concept of *surveillance* in terms of the disciplining of the body. Examples from post-enlightenment prisons, hospitals and schools show how behaviour was controlled by making every aspect of the body visible to a central power (Foucault, 1977). Foucault (1977) argues that the product of surveillance is normalisation: the institutional construction of detailed rules of behaviour, and the constant observation of behaviour, created subjects in whom the continuous, external pressure of power forced the internalisation of institutional norms.

In the same way the confessional creates self-regulation by making the inner workings of the self available for inspection by others (Foucault, 1976). Gilbert (2001) therefore argues that supervision is a form of surveillance which subjectifies practitioners. Turning to Cotton's (2001) argument on reflection, the supervisee-as-subject can be understood as objectifying him/herself through reflection on his/her practice. The subject reflects upon itself, and in doing so turns itself into an object (Butler 1997). The supervisee's practice is therefore made visible to the supervisor-confessor. This allows the supervisee to be made subject to the discourses of the organisation or profession (as represented by the supervisor).

4.4.2 Resistance

Foucault (1980) argues that power relationships never exist without resistance. Therefore, if supervision is understood as enacting a power relationship, then the

phenomenon of resistance must be considered as part of this relationship. Resistance is often seen as being in opposition to power (Collinson, 1994), but Heller (1996) argues that resistance may be understood as a form of power exercised by those who do not have access to the strongest forms of power. Collinson (2004) argues that resistance is a complex activity which varies according to its context. One person may see an activity as resistive which another regards as compliant (Collinson 2004). Although resistance opposes the controlling power, it may at the same time draw on the same structures or practices which constitute the controlling power (Collinson 2004). In this way resistance can incorporate a degree of consent with resistive behaviours occurring within an acceptance of the organisationally imposed structure.

As observed in Chapter 3, there are numerous references in the research literature to practitioners resisting engagement in supervision. Resistance to supervision is generally framed as a problem belonging to the practitioner, and the relationship between resistance and power is not considered. In a discussion paper, Cottrell (2002) pictures resistance in terms of a relationship rhombus between supervisor, supervisee, manager and organisation. He observes that resistance to supervision can occur from any of these four sources, and that the rhombus can involve various 'collusive' relationships which engender suspicion and resistance towards supervision. Cottrell (2002) details numerous ways in which supervisors, supervisees, managers or organisations can resist supervision. These include activities of non-cooperation, superficial cooperation, and sabotage. Cottrell (2002) suggests that suspicion around supervision is often connected to power relationships, with, for example, supervisees believing that supervision is used to control or monitor practice, or managers believing that supervision is used to subvert organisational control. Similarly Cotton (2001) comments that there are numerous ways in which practitioners 'resist' the activity of reflection: non or partial participation, reflection on superficial matters, or 'sanitized' reflection which avoids difficult topics.

4.4.3 Summary

In the supervision literature there is a dearth of theoretical discussion about the workings of power in supervision, but a few authors have used the Foucauldian theory of subjectification to understand supervision as a form of power. The perspective of this thesis has been informed by Butler's (1997) discussion of subjectification as a paradoxical exercise of power which both subordinates and constitutes the subject, and through the constitution of the subject creates the possibility for autonomy and resistance. The thesis also draws upon Foucault's (1976) metaphor of the confessional, as a way of explaining the power relationship in supervision. Understanding supervision in terms of subjectification and the confessional casts a new light on the phenomenon of resistance to supervision which is observed in the research literature. Resistance is theorised as an inevitable part of power, and a form of power exercised in various ways by the powerless.

4.5 Chapter Summary

In this chapter the theoretical perspectives which have informed the development of the thesis have been reviewed. These are divided into three broad areas: professions, emotions and subjectification. Together these have framed my approach to the topic of supervision, and enabled me to explore the participants' supervision experiences from three different perspectives. Two of these perspectives emerged as significant themes in the data: professions and emotions. The third theoretical perspective (subjectification) has engendered a critical analysis of the operation of power in supervision.

5 Methodology

5.1 Introduction

In this chapter the strategy used to answer the research questions is discussed. Sections 5.2-5.6 discuss the theoretical background of the study methodology, which is framed by a social constructionist approach (Gergen, 1985, Berger and Luckmann, 1966), and Flyvbjerg's (2001) concept of phronetic knowing. The key constructs of experience, discourse and narrative are explored, and their conceptualisation in this study explained. In Section 5.4 the research questions are formulated in light of the gap in knowledge and the key theoretical perspectives used in this study. Section 5.7 introduces the research design, and Section 5.8 discusses the implementation of the design. Finally, in Section 5.9 the process of narrative analysis used in this study is explained.

5.2 Phronetic Knowing

Allen and Lyne (2006) have commented that nursing research continues to be seen inferior to its more powerful associate, medical research. A lack of predictive, explanatory theory is seen as a weakness, and Allen and Lyne (2006) observe that there is a sense among nursing practitioners that the knowledge produced through nursing research does not help them to improve their practice. These questions of what kind of knowledge research should produce, and how to validate the contributions of humanistic, qualitative research, are not confined to nursing, as Flyvbjerg (2001) demonstrates in his re-evaluation of social research in general.

Flyvbjerg (2001: 57) argues that social inquiry should create what Aristotle called *phronesis*: an ethically framed way of knowing which is “*pragmatic, variable,*

context-dependent. Oriented toward action”, it is about the lessons to be learned from specific cases, “*it requires an interaction between the general and the concrete*”. The focus on specific cases is necessary, Flyvbjerg (2001) argues, because attempts to eliminate complexity, and remove phenomena from their context, inevitably fail. Without context phenomena lose their meaning. It is through detail and the analysis of the specific case in context that social research makes a useful contribution to knowledge.

Flyvbjerg’s (2001) thesis of praxis⁶ oriented phronetic inquiry seems ideally suited to nursing research with its touchstone of clinical practice. I suggest that this is the kind of knowledge which Kagan et al. (2009) argue is transformational in nursing because it requires critical reflection and value-based reasoning with reference to practical action. In this thesis, *phronesis* has therefore provided a general guiding principle for the study, which has aimed to produce value-based, situated knowledge which illuminates understanding about an aspect of practice through detailed consideration of specific cases.

5.3 Social Constructionism

In this section the epistemological position taken in this thesis is described, the understanding of discourse is located within a social constructionist framework, and supervision is discussed as a reality constructing activity.

Constructionist epistemology has been formed in response to the critiques of objectivism, positivism and the dominant ideas of the Enlightenment (Crotty, 1998). Broadly speaking, constructionists argue that there is no objective reality waiting to

⁶ The concept of praxis originates in Marxist theory and indicates a combination of thought and action with the explicit aim of transforming the world (Crotty 1998). Mishler (1999: 18) defines praxis as “the dialectic interplay between our dual positions as subjects, first as active agents making and transforming the world, which then becomes the ‘objective’ conditions to which we must then respond, as we adapt, make and transform both ourselves and these conditions”.

be discovered, but that human beings are actively engaged in interpreting and making the world through the construction of meaning (Crotty, 1998). There are various forms of constructionism, including constructivism and social constructionism, and these terms are sometimes used in a similar or inconsistent way (Gergen, 1999). The epistemological perspective taken in this thesis, *social constructionism*, is distinguished by its focus on world-making as an activity which occurs within social interactions, and which is done and expressed through discourse (Gergen, 1999).

5.3.1 A Social Constructionist Understanding of Discourse

A simple definition of ‘discourse’ is “*language-in-use*” (Gee, 2005: 8). Discourse actively refers to something, is by someone, and is situated in time and place (Ricoeur, 1981). Gergen (1999) identifies three features of discourse: *structure*, *rhetoric* and *process*. The first of these refers to the way that language is conventional, and conceals its meaning structures. Metaphors are developed to explain the world, and then become normalised through their habitual use, so that the metaphorical nature of ways of thinking is no longer evident (Gergen, 1999). Metaphor is associated with narrative, a more complex form of discourse. Ricoeur (1983/1984) argues that metaphor and narrative operate in the same way in that both assimilate elements to make new meanings which produce new ways of looking at the world.

Rhetoric, the second of Gergen’s (1999) features of discourse, reminds us that discourse is value laden; it is not transparent and is used to create particular arguments or effects upon its audience.

Gergen’s (1999) third point, that discourse is a process, refers to the continual, everyday negotiations to which discourse is subject. Human beings are seen as intelligent actors, actively involved in negotiating meaning, and so although discourse is structured, it is not fixed.

The discursive processes by which social reality is constructed, explained and negotiated, are explored in the next section through the work of Berger and Luckmann (1966).

5.3.2 Berger and Luckmann's (1966) Social Constructionism

In their seminal work on constructionism, *The Social Construction of Reality*, Berger and Luckmann (1966) explore the relationship between the structures and processes of discourse. They argue that the “*sedimentation*” (Berger and Luckmann, 1966: 85) of meaning which gives language its objective character, creates a habituated, normalised world which we experience as external to ourselves. The individual participates in an already existing socially constructed world, many aspects of which are not under his/her control. The world, therefore, constrains the individual to participate in shared meanings, and these constraints operate not only on the outer aspects of the individual, such as behaviour and self-presentation, but also on the inner aspects, such as how the individual thinks.

Eventually, the habituated activities which make up the external reality form institutions. Berger and Luckmann (1966) make two main arguments about institutions. First, they are created over time, and so have to be understood in the context of their history. Second, they are means of social control which normalise certain ways of behaving. Individuals experience institutions through the internalisation of social roles which enact the institution (Berger and Luckmann, 1966).

The historical nature of institutions means that they eventually become separated from the processes through which they were originally produced (Berger and Luckmann, 1966). When this happens institutions are ‘legitimised’ through the creation of explanations for why things are the way they are (Berger and Luckmann, 1966). These legitimising explanations become increasingly independent of their origins, until they form a “*symbolic universe*” (Berger and Luckmann, 1966: 114)

which the individual experiences from within, as encompassing human existence. The symbolic universe or 'reality' is externalised and internalised, so that it is both objective and subjective. Both internally and externally, the individual's everyday reality is supported by a community of others, who ascribe to the same shared meanings.

Reality may be destabilised by internal experiences such as dreams or emotions, or external experiences such as encounters with others who have a different everyday reality. Berger and Luckmann (1966) argue that it is through relationships with others who share our reality, and most importantly, discourse in the form of everyday conversations, that reality is maintained. The structures of discourse support the norms and assumptions underlying our view of the world. However, by virtue of its everyday function, discourse also modifies and re-negotiates reality.

5.3.3 A Social Constructionist Perspective on Supervision

Berger and Luckmann's (1966) theory of reality construction through discourse allows supervision to be understood as part of a process of reality negotiation. The conversation of supervision involves a negotiation of meaning between supervisee and supervisor. Supervision can therefore be understood as a reality constructing activity. This operates primarily on the supervisee's reality (because it is the supervisee who is expected to carry the effects of supervision back into clinical practice).

In the supervision encounter, it is the thoughts, feelings, memories and stories of the supervisee that are (metaphorically) made visible and worked with. In this way the supervisee's subjective reality can be supported or destabilized. However the action of supervision is not confined to a subjective reality. Berger and Luckmann (1966) argue that subjectively experienced social reality is founded upon the objectively experienced social reality of institutions. Legitimation makes the meanings of the institution explicable and justifiable for the individual (Berger and Luckmann, 1966).

Supervision is therefore not confined to an isolated interaction between supervisee and supervisor. The supervision interaction occurs in an institutional context, and encounters with supervision outside of the supervisee-supervisor interaction also contribute to practitioners' experience of supervision. The supervisee's experience of supervision must therefore be understood as situated within the institutional context. It is from this perspective that the research questions asked in this study are formulated.

5.4 The Research Questions

The review of the literature which is presented in this thesis has identified unanswered questions around practitioners' experiences of supervision, and the interaction between experiences of supervision and the context in which these occur. It is important to understand the practitioner's experience of supervision, because it is through the practitioner that supervision connects with practice, clients, the organisation and the practitioner's discipline. Exploring supervision through the experience of the practitioner therefore allows supervision to be understood as part of a complex network of interconnecting processes. For the purposes of this study I have therefore directed my inquiry towards the practitioner's experience of supervision.

There is a distinction to be made between a focus on the practitioner's experience and a focus on the supervisee's experience. To focus on the practitioner incorporates an understanding of the various roles which s/he enacts – including 'supervisee'. This situates supervision in relation to the wider contexts inhabited by the practitioner, including clinical practice and personal life. A focus on the practitioner also allows greater consistency than a focus on the supervisee, a role which is differently identified in different forms of supervision. For example, in the midwifery literature the supervision dyad is commonly described as midwife-

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supervisor, rather than supervisee-supervisor. This suggests that to approach midwives as supervisees might impose an unfamiliar role.

In light of the arguments made in this chapter, and the gap in knowledge identified in Chapter 3, this study aims to understand experiences of supervision in the institutional context. This study has explored one significant aspect of the institutional context in which supervision occurs: the location of practitioners as members of a profession.

The first research question focuses on exploring individual practitioners' subjective experience of supervision:

1. How do midwives and mental health nurses experience and understand supervision?

In the literature, the constructedness of different supervision practices is often obscured, and concepts of supervision are treated as objectively 'real'. Berger and Luckmann (1966) describe this as reification. This occurs when the objective reality expressed through institutions is believed to be independent of human production (Berger and Luckmann, 1966). Reification, and the legitimising of reality can be challenged when individuals come into contact with others who have a markedly different objective reality.

The literature shows that supervision is a part of different institutional contexts, and varies between disciplines. This study therefore explores supervision in the context of two comparable but contrasting disciplines. Employing these two disciplinary contexts as "*maximum variation cases*" (Flyvbjerg, 2006: 230), allows the study to contrast norms present in each discipline, constructing a critical awareness of supervision tropes.

The second research question therefore situates the experience of the practitioner into the context of a discursive community – the professional community:

2. How can supervision narratives be understood within different professional contexts?

The research questions include two key concepts: ‘experience’ and ‘narrative’. The conceptualisation of experience and narrative in this thesis are discussed in the next two sections.

5.5 Experience

Atkinson and Silverman (1997) argue that there is a danger that researchers assume they can access personal experience, and that such experience has a special claim to truthfulness. This approach entails the assumption that there is a unified self who has authentic experiences, and that these experiences are transmitted unchanged to others. In contrast, a social constructionist approach takes communication between self and other as a meaning-making, reality constructing activity. Experiences cannot be transmitted unchanged, the communicating of experience involves the re-figuring and interpretation of experience in negotiation with the world and other people.

Experience is generally located in the subjective, inner world of the person. If, following Berger and Luckmann (1966), we understand the subjective world as shaped by the internalisation of socially constructed meanings, then experience must also be shaped in this way if it is to be distinguished from mere biological existence, or perception. Stoller (2009: 717) argues that experience requires a continual mental positioning and filtering: “*I see the books on the shelf, but not the spaces between the books*”. Similarly, Middleton and Brown (2005) argue that experience occupies an imaginative realm in that it involves the recall of the past and the anticipation of future. Experience is always interpreted. This means that we cannot directly access the inner experience of another, and to even talk of another’s inner experience is to

speak metaphorically of a continually developing process of interpretation (Middleton and Brown, 2005, Gergen, 1999).

The account of experience given by a research participant to a researcher cannot be used, therefore, as justification of a claim to 'truth'. Instead experience is conceptualised in this thesis as constituting a metaphorical allusion to a subjective, inner, interpretive process which is communicated to others through meaning making interactions.

5.6 Narrative

Accounts of personal experience are subject to external and internalised rules, norms and expectations which are constructed through discourse. A number of scholars argue that one of the most fundamental ways in which we construct these personal accounts is through the telling of narratives (cf. Bruner, 1990, Gee, 1985, Riessman, 2008).

Narrative inquiry is a field rather than a methodology. It is cross disciplinary, and encompasses a broad range of approaches which may be derived from differing epistemological positions (Riessman, 2008). In the social sciences the 'narrative turn' has been motivated by epistemological changes such as the move away from positivism, and political changes, such as the desire to empower subordinated groups (Riessman, 2008). Narrative is used at different stages in the research process, for example, as the form of data to be collected, as a means of analysing data or as a way of presenting findings (Riessman, 2008, Polkinghorne, 1995).

Riessman (2008) observes that as narrative has become popular in a wide range of disciplines so the concept of narrative has become increasingly unboundaried and consequently risks becoming meaningless. In a wide ranging exploration of this problem Hyvärinen (2012) employs the image of a 'travelling' concept to explain

how narrative crosses boundaries between disciplines as diverse as history, literature, sociology and law.

Hyvärinen's constructionist approach to conceptualising narrative draws on Herman's (cited in Hyvärinen, 2012) suggestion that this be thought of in terms of a *prototype* rather than key features. Hyvärinen (2012) argues that narrative theory has developed by taking work which was originally focused on a specific kind of narrative and applying it universally as a prototype. In the social sciences these prototypes have been mainly drawn from Propp's work on the Russian wonder tale, Aristotle's work on Ancient Greek tragedy and Labov's work on oral accounts of personal experience. Hyvärinen (2012) believes that the concepts of narrative created by these prototypes are problematic. Firstly he argues that these prototypes have been uncritically transposed from one genre of discourse to another. Here, I suggest, Hyvärinen's (2012) argument offers an interesting challenge when applied to the uses of Propp's work, but has less force when applied to the work of Ricoeur (1983/1984) (who I discuss in more detail below). Ricoeur (1983/1984) uses concepts taken from Aristotle's treatment of ancient Greek poetry and applies them to narrative in general, but in doing so explicitly considers the implications of this broadened use of the concepts.

Hyvärinen's (2012) second criticism of the current narrative prototypes is that because the prototypes typically originated in work with a specific focus, their wider application has created inflexible and flawed models which cannot adequately accommodate the breadth and variety contained within the narrative field. Again, I argue that this does not apply to Ricoeur (1983/1984), whose work on narrative is striking in its breadth. However I suggest that Hyvärinen (2012) makes a critical point about the way in which the work of Propp and Labov have been used to create abstracted and reified prototypes which do not encompass the multiplicity of narrative.

The breadth of the narrative field, and the disputes over the concept of narrative, mean that it is important to clearly explain how the concept is being employed in a research project. Riessman (2008) recommends that the researcher begin by asking

herself “*what definition of narrative are you working with?*”. The response to this question will inevitably be influenced by the epistemological grounding of the study, and the questions to be answered.

5.6.1 Conceptualising Narrative

When conceptualising narrative I begin by noting that, in this thesis, narrative is used in the context of transcribed, spoken language. Narrative is conceptualised within a constructionist framework in which it is understood as an inherently social, meaning making activity. This thesis draws on the arguments made by (among others) Bruner (1990), and Gee (1985), that storytelling is a fundamental form of human sense making and communication. It is from this position that Mishler (1986) argues that, when given the opportunity to do so, interviewees will produce answers in the form of narratives.

The conceptualisation of narrative in this thesis is primarily guided by the work of Ricoeur (Ricoeur, 1983/1984, Ricoeur, 1991b, Ricoeur, 1991a), who is one of the most influential thinkers in the field of narrative inquiry (Hyvärinen, 2012). His three volume work, *Time and Narrative*, presents an extremely thorough inquiry into the role of narrative in human life in which Ricoeur (1983/1984) uses Aristotle’s concepts of *muthos* (emplotment) and *mimesis* (the imitation of ‘action’⁷), and Augustine’s discourse on time, to create a new understanding of narrative as the configuration of events and time.

Ricoeur’s (1991b: 420) argument begins with the notion of emplotment as the “*synthesis of heterogeneous elements*” to produce a whole. These heterogeneous elements are not only events, but also include context, agents, motivations and

⁷ Ricoeur (1983/1984: 54-55) uses ‘action’ to indicate a “conceptual network” which incorporates not only physical doing, but also “goals”, “motives” and “agents”, and is “always to act ‘with’ others”. The understanding of action is, therefore, a “practical understanding” (Ricoeur 1983/1984: 55).

expectations. Ricoeur (1991b) also argues that emplotment is the synthesis or configuration of different forms of time: an endless succession of events, and a bounded narrative time. The narrative is therefore “*a mediation between multiple incidents and the singular story*” (Ricoeur, 1991b: 421).

The core of Ricoeur’s (1983/1984:53) argument is the role of *mimesis* as an activity, a dynamic process within which emplotment takes place. He pictures *mimesis* as having three connected ‘moments’, which I have attempted to represent visually:

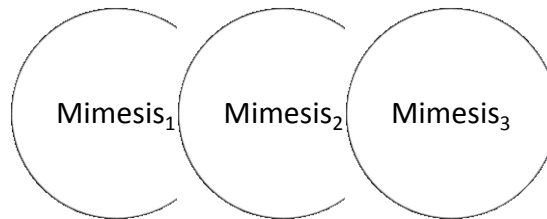


Figure 2. The Three Moments of Mimesis

Firstly Ricoeur (1983/1984) argues that in order to configure events into a meaningful whole we must already have some understanding of them (which is shared with others):

“To imitate or represent action is first to preunderstand what human acting is, in its semantics, its symbolic system, its temporality”

(Ricoeur, 1983/1984: 64).

This is *mimesis₁*. To make narrative is not to replicate experience or cook ‘raw’ experience but to construct a new interpretation from existing interpretations.

Ricoeur (1983/1984) equates *mimesis₂* with emplotment. By placing *mimesis₂* between *mimesis₁* and *mimesis₃*, Ricoeur (1983/1984) draws attention to the way in which narrative mediates between our pre-narrative understanding of the world, and our communication of this to another. It is here that the plot brings together not only the disparate elements of events, actors, motivations and so on, but also the two conflicting kinds of time: time as a linear chronology, and time as a non-chronological wholeness, or in which we can move forward or backward (Ricoeur, 1991a). Because it has an ending, the plot has a point at which the narrative can be

understood as a whole thing, something more than simply the succession of events. The configuring action of the plot therefore allows us to understand events and time in a particular way.

With the third moment, *mimesis*₃, comes the meeting between author and audience. Here Ricoeur (1983/1984) confines his discussion to the reading of a text, however his argument is equally applicable to orally transmitted narrative, and Ricoeur's (1983/1984) 'reader' can also be the 'audience'. In all narratives there must be someone who communicates the narrative, and someone to whom the narrative is communicated, whether this is done directly, or through some form of technology. Ricoeur (1983/1984) argues that it is only with its reception by an audience that the meaning of narrative is completed. Ricoeur's (1983/1984) vision of *mimesis* is therefore inherently social, since narrative requires both an author and an audience, and furthermore, he maintains the dynamism of the mimetic cycle. The audience is not a passive recipient, but actively participates in the meaning-making process begun in *mimesis*₂.

In the final part of Ricoeur's (1983/1984) mimetic cycle we return to *mimesis*₁, and our pre-understanding of the world, including our previous encounters with narratives. The meanings derived from *mimesis*₃ therefore contribute to our pre-existing understanding, and so inform future narratives. Ricoeur (1983/1984:76) envisages this as a "healthy circle" of meaning making, in which each cycle builds upon a previous one. Again, I have created a visual representation of this:

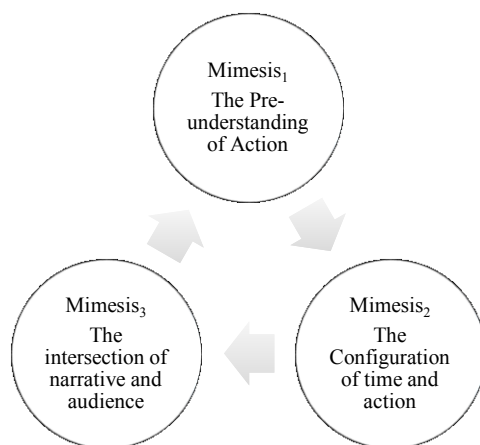


Figure 3. The Mimetic Cycle

For this thesis, the value of Ricoeur's (1983/1984) approach to narrative lies first, in the quality of movement with which he imbues his concept of narrative. At no point is the narrative a fixed entity, it is a communication which only exists between people. This reflects Mishler's (1999) view of narrative as a process of co-construction, which continues every time the narrative is re-communicated. The actively interpreting roles of participant, researcher and audience are made explicit.

Second, Ricoeur (1983/1984) conceptualises narrative as possessing a unique meaningfulness. The creation of the whole through configuration creates something new which communicates more than simply a collection of the parts. This meaningfulness supports the value of collecting and analysing data in the form of narratives. An awareness of this relationship between the parts and the whole also creates a new sensitivity to the process of collecting and manipulating data. Finally, Ricoeur's (1983/1984) understanding of narrative time provides a convincing rebuttal to the widely used Labovian approach to narrative, which contends that narratives have a linear temporal structure.

5.6.2 Summary

To summarise, narrative is conceptualised in this thesis as a form of discourse in which action and time are configured to form a whole account whose meaning is interpreted and re-interpreted through a cycle of interpretation. This understanding provides a foundation upon which to base the use of narrative in this study. However it leaves certain questions unanswered, most significantly: how can narrative be distinguished from other kinds of discourse? This question is considered in Section 5.9.

5.7 Research Design

Sections 5.2-5.6 of this chapter have explored the epistemological and theoretical background to the research methods used in this study. The thesis has been situated within a social constructionist perspective which, together with the gap in knowledge identified in the literature review, has guided the formulation of the research questions to explore practitioners' experiences of supervision in the professional context. The research questions introduce the key constructs of experience and narrative. The conceptualisation of experience as communicated through meaning making narratives leads to the collection of data in the form of narratives which are regarded as co-constructed.

In this section the research design is described, and ethical issues around the research are discussed.

5.7.1 Context

The study population consists of community-based mental health nurses and midwives working in a particular region of the UK.⁸ The region consists of a central city with surrounding suburban and rural areas, and participants worked in both urban and rural settings. The local NHS mental health service runs a one day training course on supervision, and several of the mental health nurse participants had attended this. The midwives' supervision is overseen by the Local Supervising Authority.

⁸ The location of the study is concealed in order to preserve the anonymity of the participants.

5.7.2 Aims of Data Collection

The aims of the data collection were guided by Flyvberg's (2001) concept of phronetic inquiry. The intention was to collect detailed, contextualised data which offered a depth of understanding and presented a variety of perspectives. The study was designed to collect narratives about participants' experiences and understandings of supervision. Narratives incorporate context, interpretation, and explanation, and reference specific events, and so provide an ideal means to create a phronetic understanding of a phenomenon (Flyvbjerg, 2001).

This thesis aims to understand both personal experiences of supervision and the influences of context, and professional discourses in operation around supervision. To achieve this participants were recruited from two different professions, creating distinctive perspectives within the study which allowed the comparison of discourses within each professional group.

5.7.3 The Sample

Recruiting participants from a single area meant that there was a shared context. Having a shared geographical and organisational context helped to highlight some of the individual similarities and differences between the participants, however other aspects of context were also significant. For example, the teams within which participants worked, and the macro-contexts of NMC and government policies.

The aim was to recruit eight to ten participants from each professional group in order to provide a large enough sample to encompass some variety of experience and to garner some sense of the professional groupings, but small enough to allow an in-depth analysis of the interview data from individual participants. The sample was purposive rather than representative, (Mason, 2002). Sampling procedure was intended to recruit participants who could recount a rich variety of experiences of

supervision. Included were community-based practitioners who had more than one year's post qualification experience, and who had some experience of having supervision. Excluded were practitioners who had been qualified for less than a year or who had never had supervision. Community-based practitioners were chosen on pragmatic grounds, because I considered that community-based mental health nurses were more likely to be having supervision.

5.7.4 Data Collection Methods

Data were collected through interviews which were loosely structured according to a topic guide (See *Appendix 2, Interview Guidelines*). Following Mason (2002) I describe these as 'semi-structured' interviews.

Interviews are a popular method of data collection in qualitative research, and are seen as an ideal way of gathering rich data about personal experiences (Mason, 2002). An interview may be defined as a special kind of conversation in which the researcher asks the interviewee questions in order to elicit certain information (Rubin and Rubin, 1995, Mason, 2002). Thinking about an interview as a conversation reminds us that it is a social event; dialogical and interactive. Mishler (1986: vii) describes an interview as "*discourse shaped and organized by asking and answering questions*". This means that the interview is not simply a window onto the inner experience of the interviewee, it is a social practice in which the interviewee interacts with the researcher to produce a meaningful and co-constructed account (Mishler, 1986). This can be regarded as a virtue of the interview method. The meaning making characteristic of interview is an advantage in that it offers the opportunity to explore how this process is happening. The wealth of detail communicated through interview contextualises and so helps us to understand more fully what someone has to say.

Rubin and Rubin (1995) argue that another virtue of interviews lies in the rebalancing of power between researcher and researched through the privileging the

interviewee's account. Mishler (1986: 135) argues that the context sensitivity and flexible structure of qualitative interviews provides an opportunity to shift the focus from the "*investigators' problems*" like the validity of their study, and onto the "*respondents' problems... their efforts to develop adequate and coherent understandings of their experiences*". This approach is highly suited the answering the research questions posed in this study, with their focus on the interviewee's perspective.

Atkinson and Silverman (1997) suggest that Mishler's (1986) ethical project regarding interviews distracts from the methodological assumption implicit in his work: that the narrative discourse constructed through a qualitative interview is more 'authentic' than the decontextualized discourses produced in other disciplines. However, in the light of Haraway's (1988) argument that it is both possible to accept the constructedness of discourses, and yet argue for the validity of one discourse over another, Mishler's (1986) position seems reasonable. Haraway (1988) regards situatedness as being a test of the quality of knowledge, and the narrative accounts collected through interview are situated in their details of context, in contrast to the decontextualized data of, for example, survey research.

Atkinson and Silverman (1997) also draw attention to the contemporary culture of interviewing, in which this question and answer style of discourse is widely accepted as a method for revealing the 'self'. There are two main strands in this argument. First, Atkinson and Silverman (1997: 309) suggest that interviewing is employed in an uncritical way, arguing that researchers do not recognise their embeddedness in the "*interview society*". This is very evident in the field of narrative inquiry, where interviews often seem to be a *de facto* choice, for example in Riessman's (2008) book on narrative methods she only discusses interviewing as a method of collecting narratives. Second, Atkinson and Silverman (1997) take issue with the assumption that the 'self' can be revealed through interview, reminding us that not only are the accounts produced in an interview constructed at that time and in collaboration with the researcher, but also that narratives of self-expression do not exist in isolation but are framed by the same issues of power and norms as other discourses.

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In light of these arguments interviews are approached in this study as a useful and appropriate way of gathering narrative data to answer the research questions. The co-constructed, interpretive data collected is regarded not as representing an objective ‘truth’, but showing how participants make sense of their experiences.

Mishler (1986) argues that a loosely structured interview design encourages the participant to respond to questions at length and in the form of narratives. The interviews were therefore designed to facilitate the gathering of rich and contextualised accounts of personal experiences of supervision. This meant allowing the participants to guide the conversation to the areas which they regarded as important. It was hoped that the privacy of the one-to-one interview would make the research participants feel able express themselves freely, and avoid a group effect of conforming to professional norms and “expressing culturally expected views” (Bryman, 2004: 360).

Conducting semi-structured interviews allowed me to be responsive to each participant on an individual basis, beginning from a broad perspective, and then focusing on the details of what each participant had to say. This responsiveness also had an ethical dimension, engendering a sensitivity to the participant’s process in the interview.

One interview was conducted with each participant, lasting between one to two hours. The choice of a single interview balanced the collection of rich data from each person with including enough participants to provide a variety of perspectives in the study. After the interview each participant was presented with a £20 gift voucher as a thank-you for giving up their time to take part, and as an acknowledgement of the value of their contribution to the study.

To summarise, this study was designed to collect data in narrative form through single interviews conducted with mental health nurses and midwives who work in a single region of the UK.

5.7.5 Ethical Considerations

In this study ethics were approached in two ways. First, in the research design stage, anticipating the ethical issues which might be involved. Second, as an on-going reflexive activity. This activity is of particular importance in qualitative research, where the flexibility and responsiveness of research implementation means that the researcher must engage in a continuous process of evaluation (Cutcliffe and Ramcharan, 2002).

Ethical approval for this study was through the School of Health in Social Science, University of Edinburgh ethics procedures (See *Appendix 3. University of Edinburgh Self-Audit Checklist for Level 1 Ethics Review*). As a group, the participants were not characterised by any particular vulnerability, and did not pose any particular risk to me, and the research procedure did not pose any significant risk to the participants. The study therefore fitted the requirements for the School of Health in Social Science Level 1 ethical review. The research proposal was also inspected by the NHS Research Ethics Officer for the region in which the study was to be carried out (See *Appendix 4. Research Design Reviewed by NHS Ethics Service*). The Ethics Officer determined that according to NHS research guidelines the study should be classified as 'service evaluation', and advised that the study could proceed without going before an NHS ethics committee (See *Appendix 5. NHS Research Ethics Service Letter*).

The major ethical issues identified in the research design stage were the requirement for informed consent, the need to have care for the participants and their wellbeing, and the challenge of preserving the confidentiality of narrative data. It was this third issue which required the most attention as the study progressed.

5.7.5.1 Informed Consent

Israel and Hay (2006: 61) define informed consent as involving two stages: “*participants need first to comprehend and second to agree voluntarily to the nature of their research and their role within it*”. Israel and Hay (2006) point out that while informed consent seems like a simple procedure, the principles underlying both of these stages have been critiqued and questioned. For example, Corrigan (2003: 768), who has researched the consent process, argues that informed consent can be seen as an “*ethical panacea*”, concealing inequalities in power, and the partial nature of information given to research participants.

The principle of informed consent is derived from bioethics, and is based on the assumption that there is an autonomous individual who is able to give free and informed consent (Israel and Hay, 2006). This assumption is challenged by the view of an interaction between two people as co-constructed, and Corrigan (2003) comments that by removing the process of giving consent from its social and cultural context, the bio-ethical approach creates a simplistic approach which does not take account of the unique features of a given situation.

In contrast to the bioethical vision of the autonomous individual, Cutcliffe and Ramachan (2002) emphasise that the consent giving interaction between researcher and participant is relational. The participant is likely to be influenced by considerations such as personal feelings about the researcher or the research topic, or if the researcher is in a position of authority or trust. Corrigan (2003) observes that when participants were recruited for a study immediately after being diagnosed with cancer, they could feel ‘guided’ to participate because they wanted direction and reassurance from their doctor. Corrigan (2003) also argued that for these participants the consent process itself could be experienced as emotionally harmful. Corrigan’s (2003) observations highlight the complexity and inter-subjectivity of giving consent. Asking for consent cannot be considered an ethically neutral activity.

5.7.5.1.1 The Aims of Consent

In this study the aims of consent were that the research participants should understand what the research was about, and what taking part would involve. This included the use of the data collected in interview, and the participants' right to anonymity and confidentiality. The consent procedure also aimed to ensure that participants were involved in the study on a voluntary basis, and understood that they could withdraw from the study at any time. In order to ensure that the participants were clearly and fully informed about the study and their role in the research, an information sheet and a consent form were designed. (See *Appendices 6 and 7. Participant Information Sheet and Participant Consent Form*)

5.7.5.1.2 The Participant-Researcher Relationship

A significant ethical aspect of this study was the relationship between participants and researcher. Unlike Corrigan (2003), my relationship with my research participants did not occur in an emotionally charged situation, and I was not in a position of authority over them. However my identities as researcher, PhD student, and also mental health nurse entailed a degree of negotiation when relating to the participants. I might be seen as an 'insider' by the mental health nurses and an 'outsider' by the midwives. I had also worked for the NHS in the past, and so had some claim to 'insider' status among those participants who were NHS employees.

There are also confusions and misunderstandings of identity to take into account when considering the researcher-participant relationship. For example during the course of one interview it emerged that the participant thought that I was a medical student. Not all the participants were familiar with what is involved in a PhD. Some of the participants were knowledgeable about research, but not qualitative research. These preconceptions framed the participants' understanding of the study.

5.7.5.1.3 Understanding the Research Method

In this study, the basics of the research procedure could be readily understood by the participants. The concept of an interview is widely understood in modern western culture (Atkinson and Silverman, 1997), and the topic of the study was familiar to the participants. The participants were also drawn from a population which has some familiarity with healthcare research.

Each participant was given an information sheet about the study and had the opportunity to ask questions about the research. Where possible I met with the participant before arranging the interview so that we could discuss the research project and I could explain what would be involved, we then read through and signed the consent form and the participant was given a copy of the signed consent form. When participants did not have time to meet before the interview our initial discussion about the project was by phone and email, and we then went through the information sheet and the consent form when we met for the interview. This had the disadvantage in that it did not allow the participant time to reflect between meeting me for the first time and taking part in the interview.

5.7.6 Care for the Participants

It is generally expected that researchers will avoid harm or the risk of harm to their participants, but it is also widely argued that researchers have a responsibility to act with beneficence towards their research participants (Israel and Hay, 2006). Israel and Hay (2006) comment that this is not straightforward; beneficence cannot be unlimited, but often depends upon a particular relationship between two parties, and it may be difficult to balance competing interests in a research project. In this study my main concern was for the wellbeing of the individual participants, and in response to this I adopted an ethic of care towards my participants.

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The ethics of care originates with Gilligan's critique of Kohlberg's abstract law based ethics (Held, 2005). It is characterised by the notion of "*connection... seen as fundamental in human life*" (Gilligan, 1995: 122). The other is recognised a unique person, who is responded to with emotional sensitivity, and there is a particular emphasis on meeting the needs of dependents (Held, 2005). The focus of the ethics of care is therefore on the specific individual, rather than the abstract or the universal (Held, 2005). The relational focus of the ethics of care, emphasising the intersubjectivity of human interactions and the importance given to emotions, contrasts with the rational individualism of bioethics. The individual is seen as embedded in a network of responsibilities. Responsibility for others is seen as both a moral imperative, and an oppressive consequence of social structures. The person is seen as socially constructed, but also as having agency (Held, 2005). This means that the person is seen as capable of making moral choices and exercising a degree of moral autonomy, but within constraints.

The ethics of care is closely connected to the field of feminist research and Gilligan's (1995) observations that traditional ethical thinking was masculine in character and suppressed the perspective of women. Gilligan (1995) distinguishes a feminist ethic of care from a feminine ethic of care. She argues that the feminine ethic of care is located in patriarchal traditions which confine women to a subordinate, domesticated status. In contrast a feminist ethic of care explores the social processes which subordinate women, from the perspective of the interconnected person mediating between subjective and objective worlds (Gilligan, 1995).

Adopting a feminist ethic of care towards my research participants entailed a critical awareness of power. On the one hand I had power as the researcher who determined the topic and nature of the research and requested and handled personal information from the participants. On the other hand the participants had power as the providers (or refusers) of the information which I sought. Adopting a feminist ethic of care means that the agency of the participant is not seen as a fixed state, but something which fluctuates and is influenced by the participant's position as enmeshed in a network of connections. This means that the researcher therefore has a duty of care for the participant at every stage of the research process. At the same time the

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researcher avoids a patriarchal protectionism towards the participant, recognising the strength of his/her agency.

I did not expect to cause distress to anyone involved with the study, but I was aware that when conducting a sustained conversation which focuses on personal experiences – and especially the sensitive topics which might be covered in supervision – there it is always possible that upsetting thoughts or feelings may arise. As a mental health nurse I was confident in my ability to be sensitive to the feelings of my interviewee, and to respond in an appropriate manner should any of the participants express distress during an interview. Avoiding foreseeable harm is not the same thing as preventing the participants from experiencing emotions connected to the study, and Cutcliffe and Ramcharan (2002) comment that it can be equally problematic for researchers to be overly protective to the extent where people are prevented from participating.

The emergent character of qualitative research means that not all risks and not all benefits can be identified in advance (Cutcliffe and Ramcharan, 2002). In the planning stage of this study it was hoped that the interview would be an opportunity for the participants to reflect, and that this would be a beneficial experience.

Israel and Hay (2006) comment that researchers are not only have an ethical responsibility to their research participants, but also bear an ethical responsibility to institutions, cultural groups and the general population. As a researcher in receipt of funding from the University of Edinburgh, I have a responsibility to conduct research which complies with the university code of ethics. As a registered nurse I am also bound by the NMC code of conduct, and am responsible to the professional populations from which I recruited my participants.

5.7.7 Confidentiality and Anonymity

Confidentiality is commonly regarded as a cornerstone of ethical social research (Mason, 2002, Giordano et al., 2007). Confidentiality is essentially concerned with the non-disclosure of secret or private personal information (Mason, 2002). The principle of confidentiality may be said to be of particular significance in social research because the risk posed to the participant is generally a social risk, arising from the collection, dissemination and other uses of knowledge about that person (Robinson, 1991). Robinson (1991) argues that the management of information about people is therefore “*at the core of ethical concern in social research*” (1991: 280). However he goes on to observe that the criteria of confidentiality are not fixed but typically differ between research projects. This reflects a situated, relativistic approach to ethics which poses a challenge to the generalised ethics of codes of practice (Robinson, 1991).

Anonymity is the usual means by which the confidentiality of participants is assured (Giordano et al. 2007). Anonymity reconciles the contradictory activities of collecting personal and private information under confidential conditions and then publishing the information. It is generally assumed that researcher should ensure that an individual’s participation in a research project should not be publically known and that information subsequently published cannot be traced back to an individual, however, Giordano et al. (2007) question the assumption that participants should remain anonymous. They argue that researchers cannot assume that participants want the information they share to remain confidential. To make this assumption objectifies the research participant, depriving them of ethical agency (Giordano et al. 2007).

The ethics of care locates the individual within their social networks. An ethical decision is therefore not made about the participant in isolation but as part of a network of connections. The researcher is required to balance various ‘goods’: the participant’s good, the research good and the common good (Giordano et al. 2007). The participant may wish for their involvement in a research project to be known,

they may want their authorship to be publically acknowledged. Giordano et al. (2007) comment that participation in a research project may have great meaning and significance for a participant. Equally, it may not be possible to publically acknowledge the involvement of one participant without compromising the confidentiality of other participants. Anonymity may therefore deny the individual participant choice, but protect the common good, and the good of the research project.

5.7.7.1.1 Protecting Anonymity

At the design stage of this study I chose not to give the participants a choice over their anonymous status. This was done in order to protect the confidentiality of the entire research sample. Participants were largely recruited from a single organisation, and the research study was widely advertised within the target research population and so anonymity within this context was fragile. Negotiating anonymity on an individual basis might have deterred practitioners from taking part in the study and compromised the anonymity of other participants.

Anonymity was to be ensured through the use of pseudonyms, and by changing any detail within the interview transcripts which would make it possible to identify the speaker or any other person. The information leaflet also informed the participants that I had no wish to collect any information about clients, and I asked participants to anonymise any reference they made to specific cases.

Anonymity was also ensured through the management of data. Data were stored in the form of digitally recorded interviews, interview transcripts and field notes which recorded participants' identities and pseudonyms. All identifiable electronic data were stored on a memory stick, and this together with paper data was kept in a locked cupboard in a keypad entry office. The research design specified that non-anonymised data would be kept for the duration of the research project and then destroyed (in accordance with the University of Edinburgh data protection policy).

When the study design was implemented the ethical strategy of anonymity proved to be more complex than anticipated, and required an on-going reflexive ethical response.

5.7.8 Summary

The ethical position of this study was informed by the ethics of care in which the individual is understood as both socially located and subject to socially constructed discourses, and also as an agent able to make ethical choices. This understanding together with the emergent character of a qualitative research design required a two pronged approach to ethics. Ethical problems were anticipated and addressed at the planning stage of the research, while during the implementation of the research design I maintained a continuous reflexive awareness of ethical issues and the choices made during and after data collection. In this way I aimed to have care for the wellbeing of the research participants while avoiding an unduly protectionist approach which might have inhibited participation.

5.8 Implementing the Research Design

5.8.1 Recruitment

In order to gain access to my study population I contacted various managers and senior practitioners in the local NHS, including the Consultant Midwife and the Consultant Mental Health Nurse. Through these individuals I was able to send out an email advertising the study (See *Appendix 8. Recruitment Email Sent to Midwifery Teams*). The email was sent to the leaders of community mental health and community midwifery teams, and the team leaders then disseminated the email to

their staff, who were invited to contact me directly by telephone or email. This process had the advantage of enabling me to reach a large number of potential participants, however there was the disadvantage that individuals who were in positions of power in relation to the participants took the role of gatekeepers. Since the study involved talking about work, this way of approaching participants may have been seen as inhibiting criticism of their employer. In two of the interviews there were moments where the participants checked themselves and wondered whether their employer might find out what they had said, although there was no connection made between this and the method of recruitment, and other the participants appeared to feel comfortable openly critiquing their employer and organisation.

Despite the number of practitioners who received an email about the study there was a low response rate. This may reflect a number of factors including the fact that – as participants informed me – practitioners were receiving large numbers of emails, there was a degree of uncertainty around changes to some aspects of the service, recruitment through managers may have been a deterrent. When I asked participants about their motivation for taking part most said that they were interested in the research topic, or that they were interested in research generally, or thought that this study was important. The flavour of the sample was therefore one of participants with an interest in the topic. This meant that I was not able to recruit any practitioners who had antipathy towards supervision (practitioners who did not have any experience of supervision were excluded). However although the participants generally had a positive attitude towards supervision, they also had stories to tell about bad experiences of supervision, and so the picture built of supervision was genuinely varied.

Information disseminated about the study explained the research topic, why the research was being carried out, and what the interview would involve. At first response was slow, and I sent out a second wave of emails, this time directly to the community team leaders. Through a contact I was also able to get in touch with independent midwives who work in the region. Eventually, eight NHS-based mental health nurses, six NHS-based midwives and two independent midwives, volunteered

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to take part, making sixteen participants in total. The balance of eight participants from each professional group was coincidental.

I was fortunate to be able to recruit independent midwives to this study as their accounts provided an informative contrast and comparison to the experiences of the NHS midwives, and challenged some of the discourses present among the NHS midwives.

My expectation that the research population would offer a variety of supervision accounts was met. In the case of the midwives, length of service was less important; all midwives have supervision from qualification, and the three most recently qualified midwives were, in fact, the more actively involved in supervision. In contrast, several of the mental health nurses had only begun having supervision at a later stage in their career. Here, therefore, the recruitment of nurses with many years' experience did help in gathering a variety of accounts.

My sense of the sample was that the degree of experience present (thirteen out of the sample had been qualified for more than ten years) contributed a richness of accounts and a maturity of reflection in which experiences were understood in the context of professional development over time (See *Appendix 9. Participants, Areas of Practice and Types of Supervision*).

The purposive and snowballing nature of the sample produced some connections between participants. Among the midwives there were two participants who worked in the same team and both knew the other was taking part in the study (Kate and Jo), and there were also two participants who worked in sub-sections of the same large team, neither of whom mentioned the other. The two independent midwives also knew each other well and worked together, although I was unsure if each knew of the other's involvement. Among the mental health nurses there were three participants who all worked in the same team and attended the same supervision group (Alice, Beth and Clare). Two of these three knew that they were both taking part but the third did not seem to know of her colleagues' involvement.

These connections firstly posed a challenge in maintaining confidentiality (see Section 5.8.3). However they also formed mini-case studies within the sample. For example, through the accounts of Alice, Beth and Clare I was able to explore their ‘CPN supervision group’ story from three different angles. This highlighted the individuality of the meaning making process, but also gave rise to some aspects of a group story, for example in the similar perspective which all three had on a new member of their group.

5.8.2 Conducting the Interviews

Using interviewing as a method of data collection was a comfortable choice. In my work as a mental health nurse I had conducted interview-like conversations on a daily basis. An assessment involves many of the same tasks as a research interview, from time-keeping, to the ability to weave questions into the conversation while also allowing the interviewee space to express themselves. I had already interviewed three mental health nurses about their experience of supervision as part of a university masters course. These interviews functioned as a pilot in the process of developing the research design for this study.

Although I was confident in my interviewing skills, I was not entirely aware of the extent to which I am immersed in an interviewing culture. It was only when I began conducting interviews with midwives that I became aware of some of the norms within which I was operating. For example, as a mental health nurse I am accustomed to spending an hour in an interview-like conversation. For the mental health nurses I recruited this also seemed an unremarkable activity, but when discussing the interviews with prospective midwife participants several expressed surprise at the length of time required, leading me to wonder if the different ways of working among these two groups had created different expectations of this kind of conversation. In the light of this speculation it is interesting to note that neither of the independent midwives showed surprise at the length of the interview, and these

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interviews were the longest of the midwife interviews. The nature of the independent midwives' practice means they tend to spend more time with their clients than NHS midwives.

The fieldwork took around two months to complete. I interviewed some of the participants in their place of work, and some on university premises. I spoke on the phone to all those who volunteered to take part, and where possible met participants before the interview to discuss the study and consent form. This was not always possible, particularly with the midwives, for whom it was difficult to find time for the interview. In these cases I met the participant for the first time on the day of the interview and we discussed the information sheet and consent form before beginning the interview. In these cases it was important to ensure that the participants understood that they could decide not to participate in the interview. This illustrates the 'process' nature of consent, whereby consent was not a single event, but occurred through a process of phone calls and meetings, and the consent procedure had to be adapted to accommodate the needs of the participants. All participants were given a copy of the information sheet and signed consent form.

The interviews all took place in a private room, however some of the interviews which were carried out in the participant's workplace were interrupted by colleagues walking in. There did not seem to be any marked differences between the interviews which were done at university and the interviews in the participants' workplaces. The interviews were recorded and then transcribed by me.

The interviews were designed to encourage full and detailed narratives of experience, and to allow the participants the opportunity to recount their experiences freely. Rubin and Rubin (1995) recommend that that an account which may, at the time of the interview, seem off-topic and meandering, is likely, upon closer inspection, to show the process by which the narrator is making sense of his/her experiences. This was borne out in this study. Narratives which seemed to lack relevance at the time of the interview proved to be informative during analysis.

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The structure of the interviews was loose, and I did not adhere rigidly to the topic guide (See *Appendix 2*). The prepared questions were most helpful in starting the interview (I used the same question to start all of the interviews: ‘what does supervision bring to mind?’), and in bringing the interview to a close. Some of the interviews were more structured in tone, requiring me to play a more actively questioning role. However the majority took a conversational form with the participant doing most of the talking.

I had hoped that the interviews would provide an enjoyable opportunity for participants to reflect on their experiences, and when conducting the interviews several participants commented that they found talking about supervision and their practice useful. Some also discussed actions they might take as a result of discussing issues in the interview, and this was not something I had anticipated.

5.8.3 Ethical Reflections

During the data collection process it became evident that the major ethical problem in this study was how to maintain confidentiality and anonymity. This was partly due to the people who were recruited to the study, and partly to the nature of the data collected.

The participants were all recruited from a single geographical region, and most from the local NHS. This inevitably compromised the anonymity of participants. This was a problem because of the kind of data which I was collecting. It is a virtue of narrative data that it is detailed and contextualised, but this also makes it difficult to anonymise since meaning is located in wholeness. Some details such as names or place names can be changed without affecting the overall meaning too much. Changes like these effectively anonymise the data for anyone outside the regional NHS, although within the local services a mention of a specialist area of practice, or involvement with a particular kind of service make it easy to identify the participants.

Anonymisation was less effective for the independent midwives. There are very few independent midwives working within the UK, and they are also a vulnerable professional group. This meant that not only were the independent midwives the most easily identifiable of the participants, but that anonymity was also a particularly important issue for them. Discussing this at the time of the interviews, one of the independent midwives said that she would be happy to be identified in the study, while another was concerned that her anonymity should be protected. I therefore made an ethical decision, weighing up the various ‘goods’. I decided that it was most important to protect the participant who wanted to remain anonymous, and allowing the other independent midwife’s identity to be known would have compromised her colleague’s anonymity. In order to protect the confidentiality of the independent midwives I needed to increase the research population. Given the small numbers of independent midwives active within the UK I decided to anonymise the entire location of the study, merely specifying a region of the UK.

5.9 Analysing the Data

5.9.1 Introduction

This section describes the process of analysis created in this through the amalgamation of work by Gee (2005), Polkinghorne (1995), Bruner (1986) and McCormack (2004). This approach to analysis has also been described in the paper “Fracturing and Configuring: Storying an Interview” (See *Appendix 10*), which has been accepted for publication.

The section begins with an articulation of the difficulties encountered in the narrative analysis of data. The use of Gee’s (2005) work to create a transcription of the data is discussed, and the stages of analysis are described. These include the storying of each interview, the identification of key narratives across the interviews and the

construction of composite stories which present the study findings. Finally the process of identifying feeling rules in the data is discussed.

5.9.2 Narrative Analysis

Beginning data analysis I found myself in a dilemma over how to unpick the complex web of accounts which formed each interview. In taking the position that narrative derives a unique meaningfulness from wholeness, the problem which emerged was how to capture the nuances of meaning which formed through the juxtapositions and layers of narrative in the interviews. This problem is crystallised by an early definition of ‘analysis’ as the separating of something into parts (Oxford English Dictionary, 2012). This is the kind of action which Polkingthorne (1995) points out is common in the qualitative tradition of analysis where coding involves the separation of data into small parts. This fragmenting action seems to place analysis in opposition to the configuring action of narrative, creating a problem for the narrative researcher who seeks to reconcile analysis and narrative.

The ‘storying’ of data offers a solution to this problem. Bruner (1986), Polkingthorne (1995) and Ricoeur (1983/1984) all argue that narratives produce a way of knowing which is distinguished by subjectivity, contextualisation, and wholeness. Bruner (1991) contrasts this with the way of knowing which he calls the ‘paradigmatic’, and which is concerned with the division of things into constituent parts and the creation of generalised types and categories. This is the kind of knowledge which thematic coding creates. In contrast, narrative knowing is produced by an analytic process which creates wholeness by emplotting the separate elements into a coherent account (Polkingthorne, 1995). This is called storying (McCormack, 2004).

The production of a storied analysis makes explicit the role of the researcher in the narrative process. The research process involves more than one mimetic cycle. There is the initial telling of the narrative in the interview in which the participant

forms the narrative from his/her already interpreted living experience (mimesis₁ to mimesis₂). The narrative is told to the researcher who also interprets it (mimesis₂ to mimesis₃). The researcher then takes the narrative and uses it to form something new, ultimately the narrative of the research findings. By producing a storied analysis, this ‘something new’ is clearly shown to be a new mimetic cycle in which the researcher moves from being audience to author. The narrative is not simply transmitted through the researcher, but is actively heard, interpreted and re-constructed by the researcher. The narrative of the research findings is a representation of the data.

Before engaging with this kind of presentation of research findings, however, I was presented with the more fundamental problem of how to identify those parts of my data which were in narrative form.

5.9.3 Identifying Narratives in Speech

As discussed earlier in this chapter, Ricoeur’s (1983/1984) conceptualisation of narrative explores the basic qualities and functions of narrative, and provides a good starting point from which to approach a narrative analysis, but when confronted with a large amount of transcribed speech, Ricoeur’s (1983/1984) concept of narrative as the configuration of action and time only partly helps to distinguish narrative from other kinds of discourse. The danger of ‘everything’ becoming narrative returns, and it is therefore necessary to create a more detailed picture of the features of narrative.

There are numerous approaches to this task, most classically those derived from Propp and Labov. As noted above, Hyvärinen (2012) problematises the use of Propp’s structure as a template for narrative in general, and Ricoeur (1991b: 429) argues that such narratological approaches do not address the fundamentals of narrative, but “*are always preceded by a narrative intelligence which issues from creative imagination*”. Labov and Waletzky’s (1967) primary assumption that narrative is a linear temporal sequence is problematic because it does not reflect the

way in which human beings experience time. In fact, Polletta et al. (2011) point out that spontaneously told oral narratives tend to play around with the structures and conventions identified by narratologists. Mishler (1986) critiques Labov's argument that when someone recounts a personal experience they relive those experiences. This ignores the work of co-construction which is taking place between author and audience (Mishler, 1986).

In a more recent discussion of spontaneous oral narratives, the literary theorist Fludernik (1996) argues that a weakness of Ricoeur's approach to narrative is that he ignores the role of human experience in narrative. Fludernik (1996) contends that the most fundamental feature of narrative is not plot, but the embodied mimesis of experience. Fludernik's (1996) point about experientiality is useful when considering the loosely structured narratives which occur in the course of conversational style interview. However by displacing the notion of plot, Fludernik (1996) has also displaced the significance of configuration, and so does not explain *how* narrative functions as a means of interpreting experience.

In the social sciences scholars have argued that there should be more emphasis on narratives as social productions and sites of power (cf. Ewick and Silbey, 1995, Plummer, 1995, Polletta et al., 2011). Plummer (1995) describes narrative in terms of social *production*, and adds a third role to the author-audience dyad, that of the 'coaxer'. This draws attention to the activity of those who invite or provoke the telling of a story: "*the coaxers, coaches and coercers*" (Plummer, 1995: 21). In Plummer's (1995) model the researcher is not only an audience who receives a narrative, but also a coaxer who encourages the telling of the narrative. This underlines the co-constructed nature of the narrative, and the location of narrative production in a network of social relationships. Plummer (1995:22) argues that narratives are situated in "*interpretive communities*" which may support or inhibit the production of a narrative, and which continually change as new narratives are told. Narrative, therefore is a communal product as well as an individual product, which moves through degrees of telling between private and public (Plummer, 1995). Like Ricoeur (1983/1984), Plummer's (1995) idea of narrative is characterised by fluidity

and change. Narratives are always acting and being acted upon, and their production and reception are always located in a specific context.

The influential narrative scholar, Bruner (1991), identifies ten features of narrative. Some of these (e.g. the role of time, interpretivity, the presence of the audience, and the configuration of parts and whole) have already been covered in the discussion of Ricoeur's (1983/1984) theory. However some of these features add to Ricoeur's (1983/1984) work.

Bruner (1991) argues that the subject of a narrative must have, or be assigned, agency. He calls this "*intentional state entailment*" (Bruner, 1991: 7). The agency of the character provides the interpretive context through which the audience may formulate explanations for the character's actions. Thus both Bruner (1991) and Fludernik (1996) give narrative an inherent anthropomorphism.

Bruner (1991: 11, 15) also proposes that narratives contain the related features of "canonicity and breach" and "normativeness": a narrative creates the normal and also shows how the normal has been disrupted. By putting a breach of the normal into the form of a narrative, the breach becomes psychologically containable. An experience which seems strange, or wrong, or contradictory "*by being made interpretable, becomes bearable*" (Bruner, 1991: 16).

Another of Bruner's (1991: 13) features is "*referentiality*". Here he addresses the issue of validity in narrative. Ricoeur (1985) has argued that narratives of real life or historical events, and narratives of fiction essentially function in the same way. This creates a problem when considering the 'truth' of a narrative. Ricoeur (1985) suggests that a historical narrative may be judged on the quality of the references it makes to the evidence. Bruner (1991) suggests that we judge the validity of a narrative in a different way to the judging of single facts. Because the narrative is a complete thing, it creates its own 'sense', and so, Bruner (1991) argues, the individual references are not validated in isolation, but in the context of their narrative. The validity of narrative is therefore supported by its "*context sensitivity*" (Bruner, 1991: 17). This feature brings together several of the qualities of narrative:

the intentional state of the agent; reference to detail; and the creation of a sense-making whole. These qualities enable the audience to judge the practical credibility of a narrative.

Bruner (1991: 17) also argues that context sensitivity makes narrative an everyday “*instrument for cultural negotiation*”. By its very nature, a narrative makes its origins in the subjective world of its author explicit. This enables the audience to accommodate the narrative without experiencing it as a threat to his/her own subjective world (Bruner, 1991).

The arguments made by Fludernik (1996), Plummer (1995) and Bruner (1991) help to expand my understanding of narrative, but much of what they have to say about narrative is in terms of narratives as practices and narratives as socially situated. This does not solve the problem of how to distinguish narrative from other forms of speech. Socio-linguistics offers more help here. Scholars such as Labov (Labov and Waletzky, 1967) have examined the linguistic structures of narrative, and considered how to identify narrative speech, but this approach is weakened by a narrow and rigid concept of narrative.

5.9.3.1 Gee’s (1985, 1986, 1991, 2005) Approach

An alternative to Labov’s model is offered by the socio-linguist Gee (Gee, 1985, Gee, 1986, Gee, 1991, Gee, 2005). Unlike Labov, Gee (1985, 1996, 1991, 2005) does not formulate a schema of narrative functions, but examines how the structures of speech indicate the meaning of a narrative.

Gee (1985: 11) begins by making the argument that the most important way in which “*human beings make sense of their experience is by casting it in a narrative form*”. This allows him to assume that when people recount their experiences these are likely to be in narrative form, and will make sense. This assumption has political implications. Gee (1985) notes that because storytelling is a cross-cultural activity it

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is done in different ways by people from different backgrounds. The narrative of a person from background A may sound incoherent to a person from background B, but if person B assumes that person A *is* making sense, then they can examine the structure of A's speech in order to understand the sense of the narrative. Gee (1985) uses basic features of speech to show how a speaker communicates and structures meaning.

First, Gee (1991) divides speech into idea units. Within an idea unit there is a single pitch glide where the tone goes up or down. The pitch glide indicates which part of the sentence the speaker intends as new or important information. Idea units are then grouped into lines (similar to clauses or sentences). A line contains a central topic or idea. For example, in the line below, there are three idea units. These are indicated by the boxes, while the bolded words indicate the pitch glides. Together the idea units and pitch glides form a line whose central topic is 'making changes'. 'you=know'⁹, 'and' and 'so' are discourse markers, their significance does not lie in their meaning, they indicate the formulating of ideas which accompanies speech (Gee, 1986).

*Faye:*¹⁰

*you=know it's very difficult to **make** changes and to **recognise** the small changes*

*that you **do** make so*

Gee (1991) goes on to identify larger chunks of speech: 'stanzas' and 'parts'. 'Stanzas' are formed of groups of lines which are about one topic and contain one perspective. 'Parts' consist of chains of topically connected stanzas. These divisions show how a narrative has been constructed, how topics have been linked together and themes developed – how the parts of the narrative combine to form the whole.

⁹ The representation of the non-lexical you=know with a equals sign follows Mishler (1999).

¹⁰ All data extracts in this chapter are taken from the narrative "The High Risk Client" which was told by Faye, one of the mental health nurses.

Gee's (1991) method is based on a fairly broad conception of narrative. Following this method we can assume that a conversational interview is likely to contain mostly narrative forms of discourse since it allows the interviewee to respond freely and at length, and so may be expected to engage in a narrative form of discourse as the everyday form of human sense making. Although this concept of narrative is broad, it is also bounded, in that Gee's (1986, 1991) method is specifically designed for use with oral accounts of experience. An advantage of this broad approach is that it treats narratives not as an either/or, but as an emergent form of discourse. An account may have some, but not all of the features of narrative.

5.9.3.2 Summary

To summarise, the storying of data was chosen as a way of reconciling the fragmenting action of analysis with the configuring action of narrative. By working with the tension between the parts and the whole, storying creates an awareness of how meaning is constructed through the fragmentation and configuration of data. This is discussed further in section 5.9.5. The work of Gee (1991) offers a way of identifying narrative discourse in speech through the socio-linguistic features of narrative. For the purposes of this study Gee's method was adapted, and the analysis presented here attended to 'idea units' and 'lines' which help to show how the speaker is constructing meaning. The process of transcription used in this study is described below.

5.9.4 Transcription

The first step in the storying of an interview is transcription. The concept of a transcript as a replica of speech has been problematized (Riessman, 2008), and Mishler (1991: 277) argues that we must resist "*the tendency to reify transcripts*".

Instead, the complexity of speech (Ricoeur, 1976) means that transcription involves the selection of those parts of speech which are methodologically relevant. Transcription is a stage of analysis, and “*a transcript is a theoretical entity*” (Gee, 2005: 117).

Gee’s (2005) method of transcription produces what I have called a ‘prosodic’ representation of speech in which the transcript is structured according to performative features. An advantage of this prosodic representation is, as Richardson (Richardson, 2000) has argued in a different context, prosodic/poetic writing draws attention to the constructedness of a text and the reader becomes more aware that what is recorded on the page is a representation not a replica of speech.

A disadvantage of Gee’s (1991) method of transcription is that it is extremely time consuming, and this study produced too much data to use Gee’s method in its entirety. Gee’s method also keeps the analysis at the level of the individual narrator, and although this study began at the level of individual experience I intended to move the analysis up to a cross-case analysis which would enable me to identify shared discourses. I therefore adapted Gee’s method, remaining at the level of idea units and lines, and also used pauses to identify lines as well as pitch glides. This meant that I was unable to engage in the detailed analysis of story construction which Gee (1991) makes, but using Gee’s method at the level of idea units and lines acted to sensitise the analysis to the ways in which participants were constructing their stories, and the meanings which were being emphasised.

Part of this adaption of Gee’s method involved using pauses to identify chunks of speech. Pauses are part of narrative structure (Gee and Grosjean, 1984). Gee and Grosjean (1984) found that pauses tend to operate hierarchically so that lines are divided by small pauses, stanzas are divided by longer pauses and so on. In this study pauses were used in a simple way to identify the ends of lines rather than identifying idea units then combining them into lines. This makes for a less rigorously produced transcript, but is much quicker and so has made it possible for me to transcribe a substantial amount of data in this way. Several times Gee (1986) makes the argument that his divisions reflect how we hear speech. We intuitively

pick up on the information of lines and idea units, and I argue that this intuitive listening supports the credibility of my simplified version of Gee's method.

It is because Gee's method makes explicit the aspects of narrative which we intuitively understand which makes it such a useful way of exploring a spoken narrative. Paying such close attention to the interview stories showed that the structure and style of the participants' narrations were highly intricate. For example, the first few lines of the "High Risk Client" narrative contain a surprising amount of information:

Faye:

a previous client of mine was

particularly high risk of

suicide but also accidental death

due to kind of self-harming behaviours

em

and she was particularly difficult to manage...

We learn facts of the story (the client, risk, behaviour, death), but we also learn that the narrator distinguishes two kinds of death. Both are caused by the client herself, but one is intended and the other accidental. A further distinction is made between self-harm and suicide. This conveys some understanding about the teller of the story and her expertise in this area which leads her to distinguish death by suicide from death by self-harm.

The first four lines also provide an explanation for the sixth line: the client was difficult to manage. From the perspective of the audience the information that the client was difficult to manage makes sense to us because we have already learned how risky the client was. Interviewees often told stories in this way; beginning with information which could be used to explain 'why' or 'how' before giving the 'what'

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information. This allows the audience to feel that they are discovering something for themselves rather than being directly told what to think.

Unlike Gee (1986) I chose not to ‘clean-up’ the text and included repetitions, false starts and non-lexical expressions. This was partly an attempt to preserve some of the richness of speech in the written form. Although Gee (1986) doesn’t include these features of speech performance in his transcription he does regard them as a meaningful, indicating events such as a change in focus, or the formulation of a new idea. For example, in one section of the ‘High Risk Client’ narrative, the hesitations and non-lexical expressions seem to frame an emotionally difficult part of the story:

Faye:

she ←————— Hesitation

she was so high risk

and I just kept trying all these different avenues

and it was really refreshing to go to clinical supervision

and sometimes I would come away with new ideas or

just the fact that I was doing things right

and the things that I was doing

em ←————— Non-Lexical Expression

you=know ←————— Non-Lexical Expression

I was always putting a lot of work into

┌ *so it was very reassuring*

└ *that client specifically actually died later em*

└ *due to the risks*

so... ←————— Non-Lexical Expression

Visually, in the transcript, the hesitations and non-lexical expressions isolate the four lines in which Faye talks of the client's death. The first two lines of this small section (marked with a dotted line) repeat what Faye has already said several times in the course of talking about this client: that she worked hard at trying to help her client, and supervision was a source of reassurance and support. The next two lines convey the entirely new information that this person died. It is noticeable that here the 'how/why followed by a what' narrative structure is weaker. Faye's hard work doesn't explain the client's death, the explanation is further back in the repetition that the client was high risk. I suggest that this contributes to the slight sense of shock when Faye says that the client died, the information arrives unexpectedly, the preceding narrative doesn't build up to it.

Using Gee's method of analysis produced transcribed data which reflected structural and performative features of the participants' speech. The next stage of analysis involved identification of the narratives which threaded through each interview.

5.9.5 The Stages of Analysis

As discussed above, Ricoeur (1983/1984) describes narrative in terms of a tension and balance between concordance and discordance. A narrative is both its parts and a whole which is more than the parts. The unique quality of narrative knowing lies in the configured nature of narrative, it is this configured wholeness which produces a special way of knowing. It is a way of knowing which depends on both the meaning of the parts and the meaning of the whole. The analytic process developed in this study embraces this dynamic interplay between the parts and the whole.

The analysis began with the wholeness of the interview. The process of analysis fragmented this wholeness and re-formed the interview discourse into a new narrative structure. In order to make a cross-case analysis the new structure of the

interview was fragmented and the parts were reconfigured together with parts from other interviews to create a new whole in the form of composite stories.

Returning to my original problem of how to capture the meaning found in juxtaposition, I conclude that adopting a narrative approach did not allow me to escape fragmentation of the data. It instead involved me in a cycle of fragmentation and configuration. Thinking in terms of narrative meant that I framed analysis as coming from and returning to, a whole, and so paid attention to the implications of the configuration process.

In this section the three stages of the analytic process used in this study are described: Storying the interviews; identifying key narratives and constructing composite stories; and identifying feeling rules.

5.9.5.1.1 Stage One: Configuring Interview Narratives and Storying the Interview

This stage of the analytic process was focused on the individual case, and the aim was to produce an analysis of the interview which unpicked the construction of the interview narratives, but also identified the meaningful juxtapositions within the interview.

In this section the process of analysis is explained using examples extracted from Faye's interview. The process by which the narrative of the *High Risk Client* was constructed is explained, and this is connected to the final storied version of the interview. All examples can be found in *Appendix 11*.

As described above, the first step was to produce a basic transcription of the interview. At this point I included non-lexical expressions, but did not punctuate the transcription or divide the speech up in any way. *Example 1* (see *Appendix 11*) shows a section of interview text at the first stage of transcription. This section is extracted from about one third of the way through the interview. At this point of the

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interview Faye has already mentioned the high risk client to on two occasions, both times quite briefly. Here she refers again to this particular client, and this time her account is much longer.

Listening to how Faye spoke this section of discourse, I noted that the line “*and certainly with the client I discussed before*” was preceded by long pause, and was then spoken more loudly than her preceding remarks. I therefore identified this line as the beginning of a narrative. I then looked for the end of this section of narrative, and observed that the line “*and you haven’t kept that person safe you know so*” was followed by a long pause. I had also already observed that the final “*so*” was characteristic of Faye’s speech, she often ended her accounts in this way. I therefore identified this line as the end of the narrative. This produced a chunk of narrative discourse which is shown in *Example 2* (see *Appendix 11*).

Having produced this chunk of narrative I then looked for connected chunks in the interview. I found four in total. The first two chunks appeared early in the interview and were fairly short, and less storied in character. Then came the longer chunk which I have shown in *Example 2*, and the final chunk came later in the interview and was also lengthy. Putting together these chunks of narrative made a single topically connected account. At this stage I then re-transcribed the text into ‘lines’ by listening for pitch glides and pauses. This produced the final version of *A High Risk Client* including structural and performative features of the narrative. The final narrative is shown in *Example 3* (see *Appendix 11*).

I repeated this process identifying the narratives within each interview by topic. Within Faye’s interview there were six main narratives:

1. Peer Support
2. The High Risk Client
3. One to One Clinical Supervision
4. Caseload Supervision
5. Feeling Supported, Feeling Unsupported
6. Managerial Supervision.

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As with *A High Risk Client*, these narratives were each composed of chunks of narrative which either explicitly led on from one another, or else were connected by a similar theme. *One to One Clinical Supervision* was composed of four discrete but thematically connected chunks each with a clear narrative structure. These formed sub-sections of the longer interview. Putting these smaller chunks together in this way enabled me to configure Faye's separate accounts of having one to one clinical supervision, so that each account could be understood in juxtaposition to the others. This highlighted some of the contextualised meaning created in the interview.

Putting the interview narratives together in this way re-configured the interview into a new wholeness in which the rearranging of the parts created new and informative juxtapositions. Putting the interview narratives back together into a whole representation of the interview placed limitations upon the analysis of the narratives, ensuring that they had to be understood in terms of their original context within the interview. In order to show the outcome of this process I adapted McCormack's (2004) pictorial representation of a storied interview (*Example 4 in Appendix 11*). In this way the interview was fragmented and then configured into a new whole designed to uncover and highlight certain aspects of the interview meaning.

A disadvantage of this analytic approach was that the social role of the narratives was largely ignored. The analysis tended to focus on narrative 'primarily as a tool for individual meaning-making' (Polletta et al., 2011). This creates a danger that rhetorical functions of narrative are forgotten. For example, the four sections of *A High Risk Client* were told for different reasons in the interview, to illustrate different arguments which Faye was making. By extracting the sections and putting them together the reasons behind their telling have been obscured. However, the advantage of extracting the sections from the white noise of the interview was to illuminate aspects of Faye's account while preserving some degree of context.

5.9.5.1.2 Stage Two: Identifying the Key Narratives and Creating Composite Stories

This stage of the analysis moved beyond the individual case to make a cross-case comparison. This took the analysis into a new cycle of fragmentation and configuration. In order to compare accounts of supervision between the interviews, the storied interviews were fragmented, and the topic centred interview narratives became the new unit of analysis. The topic centred interview narratives were analysed for points of comparison and difference. Narratives with similar themes or motifs were gathered together, and I called these 'key narratives'. The shared aspects of the key narratives showed the presence of shared discourses among the participants. At the same time the contextualised details of the narratives, and the preliminary analysis of these in the context of the whole interview, limited the range of interpretations and prevented the second stage of analysis from "doing too much with too little" (Mishler 1999). The key narratives showed both the shared discourses and the variety of personal experiences recounted by the participants.

The identification of the key narratives was not configuration. Although the topic centred interview narratives were gathered together, they were not arranged into a narrative whole, but gathered into a thematic collection. The next step in the analytic process was to configure the cross-case analysis to form narrative knowing. In order to do this I created four composite stories from the key narratives. Each story featured a fictional central character (two midwives and two mental health nurses). The story of the fictional character brought together the experiences recounted by the participants, and put them into a storied, fictionalised form. The stories also reflected the conclusions drawn from the analysis, presenting the findings in a storied form.

Composite case studies are used within the discipline of psychoanalysis to report on clinical processes (Wharton, 2005). For example, Orbach (1999) and Mitchell (2000) both create accounts which amalgamate the stories of several clients into a single fictionalised story. These amalgamated and fictionalised accounts are

intended to communicate the experiences which occur within the private space of therapy in a way which both evokes the meaning of these experiences and preserves the anonymity of individual clients (Orbach, 1999, Mitchell, 2000).

This final moment of configuration performs three functions: the composite stories create narrative knowledge; they present the study findings in a succinct and accessible form; and through the rhetorical function of narrative they serve to highlight certain aspects of the findings.

5.9.5.1.3 Identifying Feeling Rules

The analytic process used in this study was developed for the purposes of the study. This meant that the analysis was partly emergent in character, developing as the research project progressed. 'Emotions' as a sociological concept influenced the focus of the study and Hochschild's (1983) theory of emotional labour acted as a theoretical and political influence on the study. Having conducted the first two 'storying' stages of the analysis it became clear that Hochschild's (1983) concept of 'feeling rules' (see Chapter 4) could contribute another layer of interpretation to the storied findings. An aim of this study is to identify shared discourses about supervision within or between the two groups of participants. Feeling rules can be understood as showing the operation of discourses around emotions.

Emotions entered this study in three ways: First, as a theoretical influence during the development of the study sensitising me to certain aspects of the supervision experience. Second, the narratives told by the study participants expressed a range of emotions which connected to the experience of supervision and the wider context of professional work. Third, it was suggested by some of the participants in this study, and also by nursing and midwifery scholars, that supervision offers a way of supporting the emotion work undertaken by practitioners in the caring professions. In the third stage of analysis emotions connected to supervision were explored in terms of the feeling rules which operated around supervision.

In the key narratives there were instances where participants clearly showed an awareness of being expected to feel a certain way, and the requirement to work on their emotions in order to meet this expectation. Other feeling rules had a more subtle presence, and I used Hochschild's (1983: 60) concept of "wrongness" to alert me to their presence. In doing this I reflected on the role played by my own set of feeling rules, my own sense of what I deemed appropriate for my participants to feel in a given situation. I maintained a critical awareness of my emotional presence in the analysis through close readings of the narratives. This required me to consider whether my sense of emotional wrongness was caused by the contradiction of my own feeling rules, or whether the participant was expressing a sense of wrongness. Hochschild (1983: 250) suggests that in cases where there is no sense of emotional wrongness this may be because no rule is being broken, or the individual is not consciously aware of the feeling rule, or else the rule is "weak or non-existent".

I was conscious of the influence of my own mental health nursing background on my reading of the data. This connects me with a particular emotion culture, although having been out of clinical practice for three years I am also distanced from this culture. Reading the midwives' data helped to highlight and challenge some assumptions about the role of emotion in practice and in supervision.

5.10 Methodology - Summary

This chapter has presented the research design and methodology used in this study. The study has been located within the epistemological framework of social constructionism, which influenced the forming of the research questions as connecting individual experience to institutional context. The study has been designed as a form of narrative inquiry, and a qualitative research design has been described, in which data were collected through interviews. Data were analysed using a theoretical understanding of narrative as creating meaning through the configuration of separate elements into a whole account. The process of analysis

created in this study has worked from the fragmentary narratives told in individual interviews, to identify key narratives across the interviews, and then to represent the study findings in a narrative form. In this way the analysis has engaged with a cycle of fragmentation and configuration of the data. The storying process of analysis is pictured in *Appendix 12: Constructing a Composite Story*. In a final stage of analysis the theoretical construct of feeling rules has been used to identify aspects of the emotional context described in the participants' narratives.

The findings produced through the stages of analysis described in this chapter are presented in the next two chapters. In Chapter 6 the storied findings are presented in the form of key narratives and composite stories. In Chapter 7 the feeling rules identified in the narratives are discussed.

6 Findings One: Key Narratives and Composite Stories

6.1 Introduction

In this chapter I present a narrative analysis of the data. Preserving the dynamic tension between fragmentation and configuration, the findings from the interviews are illustrated through four composite stories. Each story concerns the supervision experiences of a fictional central character. Two of the characters are midwives (Grace and Fiona), and two are mental health nurses (Gillian and Susie). The stories draw on the analysis of data from all the interviews to form a new whole. The two midwife stories largely draw on narratives from the midwives' interviews and the two mental health nurse stories largely draw on narratives from the mental health nurse interviews, but the analysis of data from each profession enriches the understanding of the other. The composite stories therefore present findings which have emerged through a process of analysis in which the experiences of the participants are compared and contrasted both within and between disciplines.

The composite stories draw on key narratives from the interviews. These narratives have been identified as significant either because they occur across several or all of the interviews, or else because they provide a point of contrast (a 'black swan' case), or are particularly informative about an aspect of supervision.

In this chapter sections 6.2-6.5 each begins with a composite story. The key narratives upon which the story is based are then discussed. Next, extracts from the data from which each key narrative was constructed are presented, alongside my analysis of these data. This is presented in tabular form:

Analysis	Data
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Figure 4. Format for Presenting Data and Analysis

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In this way I show how the composite stories have been constructed from the data: through analysis of the individual narratives in each interview, and then identification of the key narratives, and finally construction of the story.

6.2 A Composite Story: Grace

6.2.1 “Grace” Part One

Grace had been working as a midwife in the NHS for eight years when she decided to move into independent practice. Although she was reluctant to leave the security of the NHS, she wanted to provide a kind of holistic, one-to-one care for women which she could not give within her local NHS maternity service. Whilst making her decision Grace spoke to some local independent midwives and they each recommended that she think carefully about who her supervisor of midwives would be after she left the NHS.

Grace already had a supervisor. On qualifying, she and her classmates had all been assigned supervisors of midwives. She liked her current supervisor, who always reminded her when their annual meeting was due. The meeting tended to focus on completing the relevant paperwork, but after they had done this there was usually time for a chat about work in general, and Grace had always appreciated this opportunity to talk to a knowledgeable and sympathetic listener who was not her manager or a close colleague. She had also found it reassuring to know that if something went wrong she could contact her supervisor of midwives, and she personally believed that supervision was an important part of being an autonomous practitioner.

Although she regarded supervision as important, Grace was conscious that in her NHS role she usually turned to her colleagues or her team leader for advice and support. In eight years of practice she had only needed to phone the on-call supervisor once, when there was a problem getting a second midwife out to a home birth, and she had never had any contact with her own supervisor of midwives other than for the annual meeting.

Grace knew that when she started to practise independently she would lose the support which comes with working in a team. The other independent midwives in

the local area were very helpful and supportive, but they impressed on Grace the fact that as an independent midwife she would be in a vulnerable position. There were numerous examples of independent midwives being treated with mistrust by those in the statutory services, and Grace knew from her reading about the subject that independent midwives were more likely to be subjected to disciplinary proceedings. She decided, therefore, that she would need a supervisor of midwives who was supportive of independent practice, and who would be prepared to be slightly more involved than with the average NHS midwife.

She considered approaching a local independent midwife who was also a supervisor of midwives, but in the end she decided to choose a supervisor who worked in the NHS. This meant that she would be able to maintain some connection with the NHS, and if she did become involved in any difficulties she felt that an NHS based supervisor would have a more respected position. She also wanted someone who she could rely on to critically challenge her practice when necessary.

6.2.2 “Grace” Part Two

Grace had been working as an independent midwife for nearly two years when she attended a home birth during which the woman required an emergency transfer into hospital. When the woman was admitted to hospital Grace had an unpleasant interaction with the admitting midwife, who treated her with a lack of respect, insisting on redoing an examination and observations which Grace had already carried out. Happily in the end the birth had a good outcome.

According to local protocol, transfers from home were routinely reviewed by the supervisor of midwives who was on-call at the time of the transfer. Grace was confident that she had acted properly, and followed correct procedures in the case, but nonetheless she was anxious about the prospect of a review. She was particularly concerned that the reviewing midwife wouldn't have experience of home births and so wouldn't understand decisions which she had made. She therefore contacted her

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own supervisor immediately and told her what had happened. Her supervisor offered to go over the case notes, and they met the following week. They went through the events of the labour and transfer, and Grace's supervisor asked her to justify some of the decisions she had made, but said that overall everything was fine, she had acted properly. After the meeting Grace felt much better prepared to talk to the reviewing midwife.

Grace was shocked, therefore, to learn that the reviewing midwife had referred the case directly to the NMC. She couldn't understand how this could be justified. She immediately contact the LSAMO to find out why she had been referred. After investigating the situation, the LSAMO agreed with Grace that a direct referral to the NMC was unwarranted as no significant issues had been identified with the case. It seemed that the referral had occurred because Grace had not followed an aspect of local NHS protocol – even though as a non-NHS midwife this was not a requirement for her. With the intervention of the LSAMO the case was resolved, however Grace felt very upset by this experience and felt that supervisory procedures had been used in an unjust way to discipline her as an 'outsider'.

6.2.2.1 The Key Narratives

The sample of midwives incorporates two groups who are part of the same profession, and undertaking broadly the same work, and yet who have significantly different experiences because of their location within or without statutory services. Grace's story is intended to illustrate some of the ways in which the independent midwives' stories of supervision illuminated aspects of the NHS midwives experiences, and vice versa. The story draws on three narratives which were present in both the NHS and the independent midwife interviews: *Choosing a Supervisor*, *We Are Autonomous*, and *The Annual Meeting*; and on a fourth narrative drawn from the independent midwife interviews: *Being Referred*.

These key narratives have been primarily drawn from the midwife interviews, although in some instances the mental health nurse interviews have shed light on issues discussed by the midwives. The story of Grace also draws upon more minor narratives in the interviews, including the importance of peer support, the presence of the on-call supervisor, and the interaction between community practice and labour ward as a source of tension.

The key narratives *We are Autonomous* and *The Annual Meeting* emerge in all of the midwife interviews. The sentiment of *We are Autonomous* appears to form an uncritically accepted tenet: that supervision legitimises autonomous practice. Historically the midwifery profession has fought hard for, and valued, its claim to autonomous practice, and this discourse was expressed in the interviews. Here it is useful to compare the midwives to the mental health nurses who did not express the same pride in being an autonomous profession, or make the same claim about supervision as supporting autonomous practice. This is despite the fact that most of the mental health nurses were in fairly autonomous roles: working independently in clinics or responsible for their own caseload. The lack of an autonomy story among the mental health nurses illuminates the presence of the autonomy story among the midwives.

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The narratives of *We Are Autonomous* assume that supervision supports autonomous practice, but do not explain how this occurs. *The Annual Meeting* functions as an exploration of this process.

The brevity of the midwives' stories about the annual meeting indicates the lack of significance the meeting really has for day to day practice. For some the meeting is merely an obligation, for others it is experienced as supportive and an opportunity for practice, but in all cases the story of the annual meeting hinges on the fact that it only happens once a year. Outside of this time the main sources of support are not a supervisor but colleagues and managers. The participants' accounts show that statutory supervision makes only a very small part of midwives' practice visible to the regulatory body. I suggest that this forms a significant challenge to *We Are Autonomous*.

We Are Autonomous and *The Annual Meeting* are representative of commonly told stories among the midwives, while in contrast *Choosing a Supervisor* and *Being Referred* reflect the stories only told by a few. I have treated them as key narratives, however, because they explore important aspects of the supervision system which were absent from the majority of midwives' accounts.

Choosing a Supervisor shows the different degrees of involvement with supervision which were present among the midwives. A contrast with the mental health nurses helps to give this issue a new perspective. Where several of the mental health nurses discussed the personality and role of their supervisor as being of great importance, for most of the midwives this choice had been delegated to a centralised system of allocations. However, three of the midwives (the two independent midwives and one NHS midwife) had chosen their supervisor. Their stories highlight some of the important characteristics of a supervisor: making the supervisee feel supported, a shared philosophy of practice, and being critically challenging of practice. The fear of 'something going wrong', which underlies these and other midwife narratives, is explored in 'Fiona'.

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A common theme in *We Are Autonomous*, *The Annual Meeting*, and *Choosing a Supervisor* is that the midwives see the surveillance of their practice as being beneficial, not only to them as individual practitioners, but also to a wider 'system'. The value placed on supervision as supporting autonomy, the positive way that the midwives speak of the annual meeting (even though there is little evidence that it had any impact on day to day practice), and the fact that the challenging of practice is a desired characteristic of supervisors, all demonstrate how positively the midwives engage with the notion that their practice should be subject to scrutiny.

The fourth narrative, *Being Referred*, only draws on stories told by the two independent midwives, however I have treated this as a key narrative because it explores an important aspect of statutory supervision as a legally empowered system with the authority to discipline individual midwives. *Being Referred* shows the power of supervision, but it also shows that in a single case supervision can be a source of both threat and protection, and the independent midwives' engagement with supervision involves a tension between these two phenomena. On the one hand the independent midwives had the most contact with supervisors, and were the most actively involved in supervision. On the other hand they were the only participants who had been subject to the punitive power of supervision. *Being Referred* illustrates the intense scrutiny to which the independent midwives' practice is subjected, and we see in action the process by which this scrutiny has some good effects on practice (for example in the excellence of the independent midwives' documentation), but at the emotional and psychological expense of the practitioner.

6.2.2.1.1 Choosing a Supervisor

In Grace's story, supervision becomes more important to her when she decides to work outside of the NHS, and this leads her to choose a new supervisor of midwives. Only three of the midwives in the sample had done this, Sarah and the independent

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midwives (Molly and Lynn). For most of the NHS midwives, the supervisor was centrally allocated.

Analysis	Data Extracts
<p>Jo's comment exemplifies the attitude among the NHS midwives. They were allocated their supervisor, and there was no evidence that this was regarded as a problem. Kate in fact had recently requested a change of supervisor, but didn't express any desire to have been involved in selecting her new supervisor. The allocation system seemed to be accepted quite uncritically.</p>	<p>Jo: you just get allocated... I'm not sure if you're allowed to choose</p>
<p>In contrast the independent midwives had both selected their supervisor on the basis that they would be an important source of support.</p> <p>Among the midwives it was the independents who were most actively involved with the supervision system. None of the NHS midwives had regular contact with their supervisor outside of the annual meeting. In contrast, both Molly and Lynn had some kind of contact with their supervisors every few months. They had also established lines of communication with the Local</p>	<p>Molly: I picked my supervisor and a lot of midwives don't know that you can do that they-they especially when you're newly qualified you go straight into you just wait to be allocated your supervisor I knew from the other independent midwives "make sure you kind of get somebody</p>

<p>Supervisory Authority, and as they worked across more than one region they had contact with supervisors of midwives outside of their local area. Furthermore at the time of our interview Lynn had decided to train to be a supervisor.</p>	<p>that you know will be supportive of independent practice”...</p>
<p>Lynn and Molly used similar criteria in choosing their supervisors. They both wanted someone who would support independent practice, and both wanted a supervisor who would <i>challenge</i> their practice. For Sarah this challenging role was also important, she emphasised the fact she wanted her supervisor to be “strict” as well as emotionally supportive.</p> <p>The need to have their practice challenged and overseen which Sarah, Lynn and Molly express, suggests a degree of anxiety about something going wrong. For the independent midwives this anxiety is particularly acute. Both Lynn and Molly talk about the vulnerability of independent midwives. Molly also values the seniority of her supervisor, and suggests that this may help protect her from being victimised in the NHS.</p>	<p>Molly:</p> <p>...there is an independent midwife locally who is a supervisor</p> <p>it would have been very easy for me to say</p> <p>“oh I’ll just have her cos she’s my friend and it’ll be easy”</p> <p>I thought “no I want somebody who is within the NHS”...</p> <p>...[my supervisor] was quite senior in the NHS and I thought</p> <p>that’s the kind of person that</p> <p>and she’s very challenging as well</p> <p>she wouldn’t have given me an easy time</p> <p>she wouldn’t have let me off the hook</p>

<p>All three midwives also considered it important that their supervisor support their philosophy of practice. It is perhaps significant that all three were to some extent resisting the dominant medical model of maternity care. This may have created a greater need for support.</p>	<p>with anything...</p> <p>Lynn:</p> <p>...although my own personal midwife is very very supportive and very helpful and fair</p> <p>I know that if I did it wrong she would tell me</p> <p>You=know she's not pandering to me in any way...</p> <p>...I hoped that she would be somebody who would give me a balanced view as an independent midwife</p> <p>cos she had an understanding of how that worked</p> <p>and I wanted somebody who understood that</p> <p>to supervise me...</p> <p>Sarah:</p> <p>...there was a lecturer there who's very um very thorough</p> <p>would give you a hard time you had to know your stuff</p>
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	<p>and she was also a supervisor of midwives</p> <p>and because I wanted to keep kinda like the natural focus of midwifery</p> <p>when I qualified I didn't want to kinda fall into becoming too medicalised</p> <p>I wanted a balance</p> <p>I specifically picked her as my supervisor of midwives cos</p> <p>I knew she was quite kind of strict...</p> <p>...I didn't want somebody cold</p> <p>I wanted somebody kind of nurturing and supportive and somebody quite strict as well...</p>
<p>Among the mental health nurses, Faye discussed issues around being allocated and choosing a supervisor.</p> <p>She had the experience of being allocated a supervisor on two occasions, for her clinical supervision (described in the extract opposite), and for her caseload supervision.</p> <p>Faye's clinical supervision worked out well and she has continued with it in the</p>	<p>Faye:</p> <p>my [clinical] supervisor was selected for me or suggested for me</p> <p>em and actually admittedly kinda</p> <p>had a bit of resistance to that because</p> <p>I didn't feel that that should be selected for me I felt that it should be somebody that I should select</p>

<p>long term, but her caseload supervision has been less successful, and she has coped with the situation by limiting the scope of the supervision sessions.</p> <p>Unlike most of the midwives, Faye had a strong sense that being able to choose her supervisor was important, and having a supervisor allocated problematic. Like Molly, Lynn and Sarah, Faye saw the supervisor's philosophical approach to practice as being important in determining the success of supervision, however she also saw the supervisor's approach to supervision itself as being important.</p> <p>In this regard the mental health nurses had more complex ideas about the nature of a supervision relationship.</p>	<p>I wasn't sure that I wanted her to be my clinical supervisor</p> <p>however we decided to give it a try and in actual fact I'm still with her now so it's worked really well</p> <p>...we had to be very honest I had to said to my manager I wasn't happy to have somebody selected for me</p> <p>em</p> <p>and I said that I thought we worked from very different approaches</p> <p>and we decided between the manager and myself to have a meeting with her</p> <p>and discuss that further</p> <p>we kinda agreed that you know she would need to be flexible with that</p> <p>and what supervision meant for her and what supervision meant for me...</p>
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6.2.2.1.2 We Are Autonomous

Grace believes that supervision supports her role as an autonomous practitioner, and most of the midwives expressed this sense of supervision as in some way legitimising their professional status.

Analysis	Data Extracts
<p>Kate and Jo each made a very clear connection between supervision and the autonomous status of midwifery practice. However it was difficult to see the causal connection between these two things. Later in the interview Kate explained that she didn't find statutory supervision a supportive process, and both Kate and Jo only saw their supervisors once a year, suggesting that the oversight of practice which Jo attributed to supervision must be necessarily limited.</p> <p>It is interesting to compare Kate and Jo's sense that midwives <i>need</i> to be supervised, with Molly, Lynn and Sarah's wish for their supervisors to challenge their practice. In both cases the midwives have an awareness of themselves as needing some form of surveillance, and in Jo's comment we can see that she viewed supervision from two perspectives: the <i>midwives</i> and the <i>system</i>.</p>	<p>Kate:</p> <p>...as midwives you are responsible for your own practice nobody else is responsible for it you are um and that's why the supervision was brought in to make sure that midwives are meeting their requirements...</p> <p>~</p> <p>... I think is very reassuring having that the monitoring part of it...</p> <p>[supervision] is necessary it's part of the em statutory requirements as a midwife but it's almost just a bit of a pain really...</p> <p>Jo:</p> <p>...I think it's a good thing for both sides</p>

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	<p>for the-the midwives it's really good to have that support</p> <p>but it's also good for the system</p> <p>that we are supervised to a degree</p> <p>because we work auto-autonomously (I can't say that) em so much of the time em</p> <p>that somebody has to keep an eye on it</p> <p>I think it's good</p>
<p>Rose also connected supervision to the protection of professional legitimacy; this time through the on-call supervisor. Like Jo, she incorporated a view of supervision from the perspective of the system/service, as well as from the perspective of the midwife. In her description, the role of the on-call supervisor as a source of support (rather than surveillance) was foregrounded, although there was still a connection made between supervision and something going wrong in practice.</p>	<p>Rose:</p> <p>[midwives contact the on-call supervisor] if we are faced with something that we sort of kind of deem that em our accountability is at risk...</p> <p>at the end of the day our professional accountability is most-most important to the individual midwife and to the service...</p>

<p>Making practice visible through supervision was presented by the NHS midwives as important and beneficial, although a little meaningless for their everyday practice. In contrast, for the independent midwives this kind of scrutiny of practice had a more day to day impact. This level of scrutiny (described here by Lynn) does not only derive from the supervision system, but from the healthcare system in general.</p> <p>Lynn and Molly both spoke about feeling that the NMC and the NHS have historically regarded independent midwives with suspicion, and this has created the feeling of vulnerability which gives rise to the detailed record keeping which Lynn described.</p> <p>Lynn is also making the point that supervision has the potential to benefit independent midwives by challenging preconceptions about their practice. The scrutiny of practice can therefore be a way in which evidence can be provided to challenge prejudice.</p>	<p>Lynn:</p> <p>[my supervisor] has gone to the supervisors' meeting...</p> <p>and said "d'you know the independent [notes] that I review are gold standard compared to most of the others that I review</p> <p>the level of documentation</p> <p>the level of detail that they put in is far superior to anything coming from anybody else"</p> <p>and that's partly because we're so scrutinised</p> <p>um</p> <p>we just make sure that everything's covered...</p>
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<p>In this study Lynn and Molly were the most truly autonomous practitioners since they work for themselves. In many ways they experienced supervision as supporting this autonomous practice in the face of misunderstanding or hostility from the statutory services, and the relationship with the supervisor seemed in some ways to fill a gap left by the fact that they did not have managers to turn to for advice or support.</p> <p>For Molly supervision also helped to legitimise her role by providing her clients with reassurance that they were still linked into some official framework. Again the surveillance function of supervision is presented as beneficial: Molly found it helpful that she could show her clients that her practice has some institutional back-up.</p>	<p>Molly:</p> <p>I explain it at the beginning of the process when I book a client</p> <p>and on the front of their notes I will have all the contacts</p> <p>like my phone numbers my second midwife's phone numbers</p> <p>and my supervisor's phone number as well</p> <p>and I'll say oh "this is the number here and this is why it's there</p> <p>this is what supervision is"</p> <p>and I explain about that that role</p> <p>and why you might need to contact a supervisor would be</p> <p>if you had any issues about my practice or</p> <p>your pregnancy that you felt you couldn't speak to me about</p> <p>so that they've got that contact</p> <p>that they feel okay you're coming out of the NHS to a certain degree</p> <p>but you're not completely out there that you've got somebody else that you could</p>
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	<p>... speak to if you had any concerns</p>
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6.2.2.1.3 The Annual Meeting

The midwives presented supervision as legitimising their professional status and their practice, but how is this actually achieved? In Grace’s story (part one) her sense of supervision as supporting professional legitimacy is mainly felt through the annual meeting with her supervisor. For most of the midwives the annual meeting was their sole point of contact with their supervisor, and so was the main way in which the supervision system could scrutinise their practice.

Analysis	Data Extracts
<p>In the interviews, stories of the annual meeting tended to be short (several midwives commented that they didn’t have much to say about the meeting). For some the meeting was primarily bureaucratic, while for others it was an opportunity to talk about their practice.</p> <p>Rose’s description of the meeting shows this balance between bureaucracy and talking. Both of these activities were described in a slightly disparaging way as ‘ticking off bits of paper’ and ‘moaning’.</p>	<p>Rose:</p> <p>...we generally use it as a moaning session</p> <p>and we sort of tick off the bits of paper relevant bits of paper</p> <p>to make sure we’ve paid our money and our education requirement sort of are kept up to date...</p>

<p>Nina's summary of the meeting as 'ticking boxes' gives a similar impression to Rose's description, and Kate's description continues this presentation of the meeting as fairly superficial and routine, with the emphasis on meeting statutory, bureaucratic requirements.</p>	<p>Nina: it's really just are you up to date with your em you- your training your PDP have you got all the documentation that you need and publications from NMC... have you paid your registration that kind of thing so it's-it's a I would say it's more a legal sort of side of things where it's ticking boxes... Kate: ...there's the supervisor of midwives meeting which is looking more to make sure that you are meeting your mandatory requirements for education and keeping up PREP and things like that...</p>
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<p>Olive's description gives more weight to the meeting as an opportunity to talk about practice, and elsewhere in the interview she alluded to the importance of the supervisors as offering the opportunity to talk about practice.</p>	<p>Olive:</p> <p>apart from just the practicalities of you=know telling them what you've done</p> <p>cos you=know you tell your team leader you=know your PDP that sort of thing</p> <p>but you go over what you've done and then you can just have a general discussion about midwifery in general</p> <p>about how you're getting on...</p>
<p>In contrast to the other midwives, Sarah didn't mention the bureaucratic aspect of the meeting but emphasised the emotional outcome.</p>	<p>Sarah:</p> <p>you meet her</p> <p>and she's very good at giving you a poke to go and you=know</p> <p>and if you feel there's more stuff you should do she's also</p> <p>leaves you very confident and very encouraging [sic] and very happy after the meeting...</p>

<p>The midwives' stories of the annual meeting don't offer much explanation as to how supervision supports their autonomous practice.</p> <p>Among the mental health nurses, Beth gave some thought to how her supervision affects her as an autonomous practitioner working alone with her clients. She believed that having her practice scrutinised (in her CAT supervision, each stage of the case is discussed) meant that the supervisor became an internalised witness to her practice.</p> <p>Like the midwives, Beth regarded scrutiny of her practice as beneficial, but unlike in the midwives' stories about choosing a supervisor, the fear of 'something going wrong' is not present in Beth's story. Instead the focus is on improving what she does in a therapy session.</p>	<p>Beth:</p> <p>...when I'm seeing a client and doing specific CAT work</p> <p>and I know I'm going to be reporting back</p> <p>on it</p> <p>I think it</p> <p>gives me a boost of energy to do the best that I can...</p> <p>...I think almost the supervisor's in the room with you</p> <p>if you know that you're going to represent it</p> <p>to the group...</p> <p>...I think that shifts your stance</p> <p>and-and makes you think</p> <p>and remain professional and you know</p> <p>and um</p> <p>give of your best standards</p>
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6.2.2.1.4 Being Referred

In Grace’s story she is referred for a supervisory review for reasons which quickly turn out to be spurious. This aspect of the story is drawn from Molly and Lynn’s experiences of being referred for review. Both believed that the referrals had been used as a way of exercising control over them as midwives practising outside the statutory services. The supervision system was therefore operating punitively. However for Molly and Lynn supervision was also a source of protection. Contact with their own supervisors, the LSA and other local supervisors allowed them to challenge the referrals and exonerate themselves.

None of the NHS midwives had been referred for a supervisory review, although at the time of the interview one had been the subject of a complaint which was being investigated by her managers. In this case the supervision system was not involved, the requirement to oversee and discipline practice was being accommodated by the structure of the statutory services.

Analysis	Data Extracts
<p>Lynn had two stories to tell about being referred for a supervisory investigation. In the first story the referral was made when Lynn had to transfer a client into hospital. On this occasion she wasn’t sure whether the referral was standard practice or whether it had been made purely because she was an independent midwife (this was the opinion of her supervisor). In the second story, however, the supervision system was clearly being used punitively, to bully Lynn after she had worked a bank shift</p>	<p>Lynn: Referral Following a Transfer ...I got a letter saying you have you’ve been referred for a supervisory investigation... ...I had to write a report and do all this and the first thing I did though when I got this letter was phone my named supervisor and arrange to meet with her the next day</p>

<p>on labour ward.</p> <p>In a similar experience, Molly found that she had been referred for a supervisory investigation after she did not comply with a minor aspect of NHS protocol. As a non-NHS employee there was no need for her to comply with this, and she was able to speak to the LSA MO about the referral, who agreed that it was inappropriate. Molly believed that in this instance supervision was being used as a management tool, as a way to control her practice.</p>	<p>and go through everything I'd done and all my notes...</p> <p>...she said "I think this is a case of they don't understand how you work because you're out with the system"...</p> <p>...so in the end I wrote a report</p> <p>did all the things</p> <p>put it all through</p> <p>and I got a letter back saying "we have no concerns about what you did and thank you for your time</p> <p>and sorry for any inconvenience"</p> <p>which was which was mild to [laugh]</p> <p>way to put it</p> <p>cos I sort of had about three weeks in huge anxiety thinking</p> <p>"oh dear what're they going to do"</p> <p>Being Bullied Through Supervision</p> <p>I was reported again</p> <p>for not having done something on the computer properly even though I'd said I've never used the computer system in the hospital before</p> <p>and you know again that went straight to</p>
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	<p>another supervisor...</p> <p>...and I met with her</p> <p>and again she had no problem she understood what had happened</p> <p>she said "it's reasonable there's no problem here"</p> <p>and she actually stated that I'd probably been bullied in that instance</p> <p>and the person who did it was somebody who's known</p> <p>in that situation</p> <p>to do that not just to me but to other people...</p>
<p>Molly had also had experience of a case review by a supervisor (a level down from a supervisory review). When her client had an emergency transfer into hospital during labour the case review was automatically triggered. Like Lynn, Molly immediately turned to her supervisor for support in reviewing her notes and preparing to answer questions. This time the review was a positive experience and an opportunity for Molly to receive some good feedback on her</p>	<p>Molly:</p> <p>... [the supervisor of midwives] go through the notes</p> <p>speak to whoever was involved in it</p> <p>and decide from there</p> <p>does it warrant</p> <p>further investigation</p> <p>do they need to instigate a formal</p>

<p>practice.</p> <p>In these stories supervision appears in different lights: as something which is used to control and bully, as a source of support in the form of the named supervisor of midwives and the LSA MO, and as a source of critical reflection through the case review.</p>	<p>supervisory investigation...</p> <p>...I phoned my own supervisor and said</p> <p>“this is what’s happened</p> <p>can I go through it with you first...</p> <p>...she went through the notes</p> <p>and made some points about</p> <p>“okay maybe would have done that differently”</p> <p>and “on reflection yes I agree with you”</p> <p>that’s and that’s really good the benefit of hindsight was fabulous</p> <p>so we made some notes and that was fine...</p> <p>...I didn’t actually meet with [the reviewing supervisor of midwives] in person she just had the notes and then we spoke on the phone</p> <p>and the points that she raised</p> <p>were similar to the ones that had already been raised...</p> <p>...it was a two way process which was good</p> <p>because it didn’t I didn’t feel</p>
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	<p>like I was being managed</p> <p>or</p> <p>told off...</p> <p>...she said um “your documentation’s brilliant it’s really good it’s really clear it’s easy to follow” so</p> <p>I got good feedback as well as...</p>
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6.2.2.2 Summary of ‘Grace’

In *Grace*, supervision is understood in the context of professional autonomy and the surveillance of practice, and on a level beyond the individual practitioner and their supervisor. A significant aspect of the way in which the midwives experience supervision is as an institutional system which supports the credibility of midwifery as a discipline.

The narratives of *The Annual Meeting*, *Choosing a Supervisor*, and *Being Referred* show that there is also an intersection between the supervision system and the individual practitioner. In *The Annual Meeting*, supervision functions as a point of contact between the ‘institution’ of midwifery legislation and the practitioner. In *Choosing a Supervisor*, the practitioner actively tries to personalise the supervision system. In *Being Referred* the power of the supervision system is exerted upon the practitioner, and yet the practitioner is also able to use the power of the system in support of their position.

The *Being Referred* narratives are unique to the independent midwives, and so function as a ‘black swan’ case, illustrating an aspect of the supervision system which was not experienced by the NHS midwives. This shows the influence of the

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institution on the way midwives experience supervision. *Grace* highlights this contrast between midwifery practice located within the institutional framework of the NHS, and midwifery practice which is done outside of this framework. The two institutions (midwifery supervision and the NHS) are situated not only in relation to the practitioner, but also in relation to one another. Although all midwives are theoretically of equal position within the supervision system, in practice, midwives who work outside the NHS have a different interaction with the supervision system.

The midwives' attitude towards being subject to surveillance through supervision shows them situating themselves within the midwifery workforce as a whole. The midwives see the scrutiny of their practice as not only necessary, but also reassuring. Despite the presence of the *Autonomous* narrative, this need for surveillance seems to actively demote the autonomy of the practitioner, and privilege the disciplinary gaze of the institution. Again, the independent midwives' narratives provide a contrasting case. They experienced surveillance not only from the supervision system, but also from the NHS, and it was surveillance from the statutory services which seemed to have the most impact on day-to-day practice. The NHS midwives did not describe or problematise having their practice scrutinised by their employer. It is possible that the independent midwives are more scrutinised. But it might also be possible that the independent midwives are more aware of a scrutiny which the NHS midwives have internalised?

6.2.3 A Composite Story: Fiona

Fiona's midwifery team was going through a difficult time. There were budget cuts and staff shortages in the local health services, and one of her colleagues had recently been subject to a complaint by a client. On top of this, there had recently been a high profile case in the news about serious problems in a maternity unit in London. All of these elements had combined to make Fiona and her colleagues feel insecure in their professional role. They did not feel supported by their organisation; stories had been circulating about midwives who had taken the blame when a case went wrong, and their local health service was currently promoting a strongly risk-averse policy in maternity care. Fiona felt that this was undermining her expertise as a midwife and inhibiting a woman-centred approach by making her practise defensively. Like her colleagues, Fiona felt under enormous pressure in managing her caseload. She frequently worked overtime to complete admin, and sometimes felt isolated, for although her colleagues were supportive, the midwives all worked in their own clinics and spent little time at their base.

At this time Fiona had a first appointment with a woman who had only presented herself in the latter stages of her pregnancy. The woman was a drug user with complex needs, and during her assessment Fiona had the sense that there might be domestic violence occurring, although the woman denied this when she asked her directly. There were obvious child protection issues, and so Fiona put in a referral to social work, and also alerted the health visitor and tried to make contact with the woman's substance misuse worker. This all turned into a highly time consuming process, as Fiona had to do a lot of follow up work to get various agencies on board. The social work referral seemed to take a long time to go through, and Fiona was increasingly concerned that there would not be time to put a plan in place before the woman gave birth.

This case was causing Fiona a lot of stress, and she felt out of her depth with the complex referrals process. Outside of this particular case she had a heavy caseload anyway and was starting to feel overwhelmed by her work. She approached her team

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leader with her concerns, but the team leader's response made Fiona feel that she was being blamed for not being able to cope with her caseload, and this undermined her confidence in her ability to manage her work.

As it happened, Fiona's annual supervision meeting was due shortly after this, and after they had completed all the requisite paperwork, Fiona took the opportunity to talk to her supervisor about how stressed she was feeling. Her supervisor was very sympathetic and mentioned that some of her other supervisees were also struggling and that it was a difficult time for midwives in the organisation. She also sympathised with Fiona's difficulties over the child protection case, the supervisor said that she also found these cases difficult, and suggested some options which Fiona might explore.

After her annual meeting Fiona felt much better. Being able to talk things through with someone who was non-judgmental had been very helpful, and it had reassured her to hear that other midwives were also struggling to cope. The talk with her supervisor helped to restore her confidence somewhat, and she felt a bit clearer about what her role was in the child protection case. Her supervisor had also said that Fiona could contact her if she felt very stressed again, however although Fiona was grateful for her supervisor's offer, she was uncertain about when it was justified for her to get in contact, and she felt guilty about taking up her supervisor's time – she knew that the supervisor was just as busy as she was. She did think about emailing once shortly after their meeting to ask for some advice about an aspect of the child protection case, but in the end was able to ask a her team leader. After that nothing really urgent came up which would have justified her getting in touch, so she had no more contact with her supervisor until the following year.

6.2.3.1 The Key Narratives

Fiona's story is based on three key narratives: "*Despondency, Blame and Fear*", "*She's There If I Need Her*", and "*A Dream of Support*". I have also drawn on a

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collection of the unique narratives told by the midwives about their experiences of supervision, and these are brought together under the title “*Individual Narratives of Supervision and Support*”.

The *Despondency, Blame and Fear* narrative describes the context in which the midwives are working, both organisational and professional. Descriptions of the working context alluded to a communal anxiety, as depicted in Fiona’s story. Participants’ accounts suggest that this anxiety is created by an interplay of influences including the demands of day-to-day clinical work, the priorities of the employer, professional organisations and national policies. For the independent midwives there was also the experience of working outside a dominant organisation. Practitioners are affected by their local working environment, but as members of a nationally organised profession, and as employees of a major national organisation which is under state control, they are also situated in this larger context.

Narratives of *Despondency, Blame and Fear* are not confined to the midwife interviews. Some of the mental health nurses also identified aspects of the work culture which created a sense of anxiety and vulnerability in practitioners. This suggests that the anxiety experienced by practitioners is not confined to any one profession or part of the health service. The *Despondency* narrative therefore builds upon data from both the midwife and the mental health nurse interviews.

The narrative of *She’s There if I Need Her* was commonly told among the midwives. We see this represented in Fiona’s story where the supervisor is a source of support, but almost accidentally so. It is chance that Fiona happens to have her annual meeting at a time when she needs support, and the structure of the meeting is still primarily bureaucratic. She finds it helpful to talk to her supervisor, but although there is a possibility of further support she does not feel justified in extending this contact. In *She’s There*, supervision is conceptualised as supportive, and may on occasion be *actually* supportive, but is more often support *in potentia*, the midwives *may* contact the on-call supervisor but rarely do so, they *may* have more frequent contact with their named supervisor but do not. Interestingly the background

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presence of the supervisor or even the supervisory system as a whole does appear to be experienced as beneficial, and the possibility of contact has a supportive effect.

She's There has three elements. Firstly there is the presence of the supervisor as allowing the possibility of support. Secondly there is the fact that this support is generally not accessed outside of the annual meeting. None of the NHS midwives had any kind of regular contact with their supervisors apart from the annual meeting, and contact with the on-call supervisor was rare. Thirdly contact with the supervisor is associated with something going wrong. Contact with the named supervisor was seen as occurring after a serious problem, and contact with the on-call supervisor is inevitably the result of an emergency or other significant problem.

The collection of *Individual Narratives* shows the diversity of experience represented in the midwife interviews. In these narratives the midwives have found their own ways to make use of the supervision system and the opportunities of support which are available to them. In Fiona's story her annual meeting happens to occur at the time when she needs support, and she makes good use of this. This reflects the ways in which the midwives each responded to a unique set of circumstances in maximising their opportunities for support.

A Dream of Support is drawn from just two of the midwife interviews (Nina and Rose). I have treated these accounts as a key narrative because they uniquely explore what support or supervision could be like. In re-imagining supervision for midwives, *A Dream of Support* enhances our understanding of supervision as it currently is. The *Dream* narratives also express the need for support. In this way they are closely connected to the collection of *Individual Narratives*. While the *Individual Narratives* show some of the ways in which midwives are finding support, *A Dream of Support* suggests some of the things which midwives might be looking for.

6.2.3.1.1 Despondency, Fear and Blame

Fiona’s story is about needing and finding support within a high pressure organisational culture, and she is depicted as responding to features of the working environment which were described by both the midwives and the mental health nurses. In the story she is presented with a complex case in which there are significant risks, and this reflects comments made by several of the midwives about the challenges of dealing with child protection cases.

Analysis	Data Extracts
<p>Sarah draws a vivid picture of a professional culture beset by anxiety and insecurity. Elsewhere in the interview she describes how this culture then affected her when she made a minor clinical error. Despite support from her senior colleagues she felt very distressed about the error, and places this in the context of an anxious midwifery culture.</p> <p>(~ indicates that these extracts come from different parts of the interview)</p>	<p>Sarah:</p> <p>...you hear so many stories of [midwives] being practically d’you=know murdered or drawn over the coals for any mistake...</p> <p>~</p> <p>...fear and midwifery seem to be very kind of closely related...</p> <p>~</p> <p>...there’s a lot of I think there’s a lot of anxiety in the hospital...</p>
<p>Sarah further explains this culture by describing how she observed the fear of things going wrong developing in senior students, then experienced this herself and subsequently observed the same fear</p>	<p>Sarah:</p> <p>...I remember noticing the second years and thinking what’s happened to them...</p>

<p>among midwives on labour ward.</p>	<p>there's like a change in them</p> <p>and then we got to second year myself</p> <p>and we did the complications module</p> <p>as in what can go wrong in the birth</p> <p>and that kind of put the fear of god into me and about ten different fears on top of it...</p> <p>and when you go into labour ward...</p> <p>...there's a lot of fear about the whole d'you know about birth</p> <p>and what can go wrong...</p>
<p>In terms of a fear of things going wrong, Kate thinks that in recent years midwives have become more acutely aware of the possibility of litigation.</p>	<p>Kate:</p> <p>...you're fairly aware um</p> <p>that if you make a wrong um reading of the CTG um</p> <p>that can could be shown up in court</p> <p>um one of the midwives recently</p> <p>has had a case going back from possibly about 16 years ago</p> <p>when she was in the labour ward</p> <p>and the baby was born with a bad</p>

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	<p>outcome</p> <p>and it's now gone to court...</p>
<p>Nina identifies an attitude of defensiveness among midwives, which is caused by a “culture of blame” within the organisation.</p> <p>It is difficult to present her remarks succinctly, because she illustrates her point in a roundabout way by referring to child protection cases and the complicated administrative work which these cases require. However in Nina’s extended account there is a general sense that it is difficult to challenge practice because of defensive attitudes, and that the culture of blame imposes a heavy burden of responsibility on the individual midwife.</p>	<p>Nina:</p> <p>It’s a culture of defensive practice...</p> <p>...I think the culture of blame is still very very rife within the the service...</p>
<p>Nina and Jo both describe the clinical pressures which cause them to feel stress. Most notably: lack of time, paperwork and child protection cases.</p>	<p>Nina:</p> <p>...I work a lot with substance misusers and child protection</p> <p>I really enjoy that although</p> <p>em</p> <p>I find it very stressful because time is very much of the essence and it’s</p>

	<p>difficult to find time to do it well</p> <p>and I do regularly work at least an extra day a week</p> <p>trying to fit in the work that I do...</p> <p>Jo:</p> <p>time management</p> <p>to fit it all in</p> <p>em it can be a huge problem em</p> <p>and there's more pressures on us now em</p> <p>with regards using the computer system</p> <p>em</p> <p>an awful lot more to do with child protection and things like that</p> <p>that can bring huge stresses...</p>
<p>Rose's story about return from sick leave interviews also refers to the feeling of being in a high pressure working culture, and demonstrates a sense of powerlessness as a practitioner. She shows how the organisation inhibits the midwives' opportunity to be fallible (sick) human beings.</p>	<p>Rose:</p> <p>I think there's lots of despondency in the [organisation]</p> <p>among midwives</p> <p>just because of pressure of work...</p> <p>now if you're off three times in a year</p>

	<p>we're um having to put be put under pressure by going for an interview now</p> <p>why were you sick?...</p> <p>and the most terrifying thing that happened recently was em</p> <p>that one of my colleagues was off sick and she didn't</p> <p>she negotiated and came in another day when she should have had a day off...</p> <p>it's not a healthy place I mean that's for sure...</p>
<p>Lynn describes almost an exchange of anxieties around her position as an independent midwife. On the one hand she feels vulnerable as part of a professional sub-group who are often targeted for disciplinary action. On the other hand Lynn identifies that midwives in the statutory services feel anxious about the outsider position of independent midwives, and the challenge which independent midwives pose to the standard way of structuring maternity care.</p> <p>It is noticeable that here Lynn's use of the word "supervised" indicates something controlling.</p>	<p>Lynn:</p> <p>I'm aware</p> <p>as an independent midwife</p> <p>that sadly em statistically...</p> <p>em independent midwives are reported and supervised much more frequently than NHS midwives</p> <p>and that may be just because</p> <p>we're-we're less controllable</p> <p>we're out with the- we can't be observed in the same way when we're not working within the system</p>

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	<p>so there's a level of fear I think about how we might be working...</p>
<p>Lynn (who sometimes takes bank work as a community midwife for the NHS) sees midwives in the statutory services as being in a vulnerable position in stressful working conditions and as the objects of blame.</p>	<p>Lynn:</p> <p>[community midwives] feel rushed from pillar to post</p> <p>and worried they're not doing a good job</p> <p>and they're frightened that they're gonna miss something cos they're so stressed um</p> <p>and midwives are missing things</p> <p>and they get blamed rather than supported</p> <p>it's a huge mess...</p>
<p>When her practice was investigated, Molly's experience of the blame culture was made worse by her sense of vulnerability as an independent midwife.</p>	<p>Molly:</p> <p>...the case review with the emergency transfer</p> <p>that was quite a highly emotional time because obviously I was</p> <p>um</p> <p>a kind of element of "thank goodness that was okay"</p>

	<p>nobody died” em</p> <p>but also</p> <p>“oh god am I gonna get in lots of trouble here?”</p> <p>and “even though I haven’t done anything wrong as an independent midwife am I going to get hauled over the coals?”</p> <p>because I’ve seen that happen to other independent midwives</p> <p>there’s this instant look to blame somebody and the independent midwife’s usually the the easy target so</p> <p>lots of crying on phones to other independent midwives who</p> <p>you know you can get an element of support from your NHS midwife friends but</p> <p>only another independent midwife would know that aspect of why you’re so scared...</p>
<p>The experience of being in an anxious working culture was also recounted by some of the mental health nurses. At the time of our interview Faye’s team was part of a large-scale service</p>	<p>Faye:</p> <p>...there’s massive changes going within the community at the moment</p>

<p>reorganisation which was creating a high degree of uncertainty and worry among practitioners, and this was something which Faye had discussed in her regular supervision session.</p>	<p>so there's a lot of stressors</p> <p>there's also a lot of uncertainty just now about</p> <p>what that means for our jobs and our roles...</p> <p>there was also talk of redundancies very very recently</p> <p>which was broken by an email...</p> <p>which was not discussed with us</p> <p>it was a Monday morning email we got to say</p> <p>to offer us redundancies so the panic of that...</p>
<p>Beth pithily describes the formation of a general institutional anxiety with a focus on obeying rules and not attracting complaints rather than the quality of practice. She connects this anxiety to the wider structures of government. Beth argues that this creates a depersonalising work environment, a situation in which the organisation operates in an authoritarian way.</p> <p>The inundation of rules and policies</p>	<p>Beth:</p> <p>...[the organisational culture is] panicky and it's anxious and as</p> <p>you just get inundated with-with policies um and</p> <p>and procedures and er kind of thinly veiled threats...</p> <p>...I think the managers have have picked up from the anxiety of-of-of politicians</p>

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<p>which Beth describes was also mentioned by some midwives who felt they struggled to keep on top of the large number of organisational communications and new policies. I took copies of the NMC supervision guidelines into each interview. Among the midwives 6 out of 8 asked if they could take a copy of the guidelines away with them. None of the mental health nurses did this. It seemed to me that the midwives' desire to hold on to this piece of information expressed a degree of insecurity.</p>	<p>and-and</p> <p>it cascades down um</p> <p>so-so there's a lot of "you must do this"...</p> <p>...I think it's got the fight and flight thing going on all at once [laugh]</p> <p>it's probably almost in full blown panic attack as we speak</p> <p>the NHS needs to blow in a brown paper bag [laugh] at once and cool off...</p>
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6.2.3.1.2 She's There if I Need Her

How does supervision relate to this difficult working environment? Fiona's story draws on the accounts of several midwives, where supervision is seen as a good thing, but as not having a strong connection to day to day practice. There was also a sense that contact with a supervisor was associated with there being a problem, or with something going wrong.

Analysis	Data Extracts
<p>Jo thinks statutory supervision is “good”, but her contact with her supervisor is confined to the annual meeting. More frequent contact is a possibility which might be realised if there were a specific need, but Jo has not needed her supervisor in this way.</p>	<p>Jo: ...I think [supervision's] great I think it's really good em particularly I mean I've never had any problems or any needs as such it's nice to meet up with them once a year and chat over different-different things em and I know if I needed [name of supervisor] in the meantime she would make herself available...</p>
<p>Sarah was the only NHS midwife to have selected her supervisor. She has a good relationship with her supervisor (who she</p>	<p>Sarah: she is somebody I would trust</p>

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<p>already knew from her university course), but as with the other midwives, her contact with the supervisor is confined to the annual meeting. There is the possibility of further contact and Sarah describes this possibility in positive terms. However, although the possibility of support is described positively, actually needing a supervisor is closely associated with something going wrong.</p>	<p>she is somebody that if I had a problem I would phone up</p> <p>even if I was out on a home birth or whatever and god forbid things had gone very badly wrong or whatever</p> <p>she is somebody I would phone up...</p>
<p>Olive feels fortunate that she has never needed to make contact with a supervisor outside of the annual review. In fact Olive later tells me that she recently emailed then met with her supervisor to discuss an issue with labour ward. It is interesting therefore, that when I ask her about contact with her supervisor it is <i>not</i> having contact which stands out for her and which has a positive significance.</p>	<p>Olive:</p> <p>...I've maybe just been lucky</p> <p>but I've never required her [supervisor of midwives]</p> <p>and I've never required to call touch wood the on-call supervisor for any instance...</p>
<p>Rose describes why she might contact the on-call supervisor. Support from a supervisor of midwives is connected to there being a problem, but also to a bureaucratic process. Elsewhere Rose says that the supervisor of midwives may</p>	<p>Rose:</p> <p>[contacting the on-call supervisor] it's a kind of chain of of events that we have</p> <p>we have to go through</p>

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<p>not have community experience, so although contacting the supervisor is a matter of professional accountability, they may lack the specialist knowledge to really support her.</p>	<p>if we are faced with something that we sort of kind of deem that em our accountability is at risk...</p>
<p>Kate describes the ways in which the statutory system of supervision offers the possibility of support to midwives – if needed. However contact outside the annual meeting tends to be associated with the on-call supervisor, and hence with there being an immediate problem.</p>	<p>Kate: ...in midwifery we're lucky in that we've got the supervisor of midwives we all have our own supervisor of midwives so and there's always a supervisor of midwives on call so if you need support in any way with one of your cases...</p>
<p>Nina has recently been through a period of more frequent contact with her supervisor, but supervision has now reduced to the annual meeting and more frequent contact has returned to being a possibility rather than an actuality.</p> <p>It is worth noting here that when Nina did have more frequent contact with her supervisor, she categorises this as really being outside the supervisor's usual role</p>	<p>Nina: ...now it's back to sort of <u>annually</u> but I can <u>email</u> her at any time...</p>

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<p>(see <i>Individual Narratives</i> below).</p>	
<p>The exceptions to this picture of supervision as the possibility rather than the actuality of support were Molly and Lynn, the independent midwives, who did have more frequent contact with their supervisors.</p> <p>However, as Molly describes, even this more frequent contact appears to be on the basis of <i>ad hoc</i> need rather than a regular, planned contact.</p>	<p>Molly:</p> <p>we all have an annual review</p> <p>anyway</p> <p>but em fr- I would maybe meet with her slightly more frequently than that</p> <p>depending on</p> <p>what has hap- if I've had a situation crop up that I want to reflect on</p> <p>so I probably meet with her two to three times a year</p> <p>em</p> <p>and chat with her on the phone if there's something that I just want to talk through</p>
<p>Olive talks directly about the need for support in the specific form of being able to talk about practice, and particularly about an emotionally difficult aspect of practice. She depicts the supervisor as fulfilling this need, again on an <i>ad hoc</i> basis.</p>	<p>Olive:</p> <p>...there'll be times when you feel you've let your woman down</p> <p>or let somebody down</p> <p>or she feels let down or things like that</p> <p>and you can just go and speak to your supervisor and just let off steam...</p>

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<p>Later Olive says that she does believe that supervisors provide emotional support for midwives, although this doesn't happen very often. She comments that this is fortunately the case, because of the logistics of giving supervisors time away from their work to attend to the needs of supervisees. The possibility of support through supervision is therefore compromised by the other role of the supervisor as a practicing midwife.</p>	<p>Olive:</p> <p>...luckily it's rare</p> <p>but we can let the supervisor go to her supervisee</p> <p>for emotional support...</p>
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6.2.3.1.3 Individual Narratives of Supervision and Support

Fiona finds support where she can. She makes use of her supervision meeting, her team leader and her midwifery colleagues as sources of support. In the absence of structured support mechanisms, the midwives were seeking support in a variety of ways including some practices which resemble clinical supervision.

Analysis	Data Extracts
<p>Kate found support for her practice through an annual appraisal with her team leader, and she described this as a kind of supervision.</p> <p>For Kate, therefore, support with practice is made a reality through supervisory contact with her team leader. Support in statutory supervision is experienced through the possibility of phoning the on-call supervisor when needed and the presence of Kate’s named supervisor whose main role is to support Kate in keeping to the statutory requirements of being a midwife (PREP, notification of intent to practise, the annual meeting).</p>	<p>Kate:</p> <p>...the yearly [meeting] with the team leader</p> <p>which again is supervision</p> <p>but she is looking more at um</p> <p>interaction in the team um</p> <p>whether or not we feel that we have any needs</p> <p>and we look each time at um</p> <p>we put aims for the year and objectives for the year</p> <p>as in education clinical practice and things like that...</p> <p>...I kind of look at the-the two different things</p> <p>and I said about the support because that’s* supervisory support um and the</p>

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	<p>kind of monitoring</p> <p>which I look more as the-the year-the annual one as to looking whether you've kept up with your PREP and things like that...</p> <p>* Refers to Kate's annual meeting with her team leader.</p>
<p>Nina described a recent time when she was being bullied at work and her supervisor was a source of support for her, accompanying her to meetings about the problem. However in doing so, Nina said that her supervisor was acting outside her statutory role. Supporting Nina is given the characteristics of the private domain – being “a friend”, and distinguished from the work domain: “not as a supervisor, not as a manager”</p>	<p>Nina:</p> <p>I was</p> <p>em</p> <p>a victim of a bullying harassment situation</p> <p>em</p> <p>and she</p> <p>supported me from the point of view of</p> <p>really</p> <p>someone</p> <p>just-just another person to be with me...</p> <p>and she came with me [to meetings] as another person not as a supervisor not as a manager just as</p>

	<p>if you like a friend...</p> <p>I think that was maybe</p> <p>a role that she took</p> <p>out with her role as a supervisor</p>
<p>The independent midwives had to be active in seeking out support because they are self-employed.</p> <p>Here Molly emphasised the importance of having support from other midwives. It is interesting to note that at the independent midwives' meetings for support they talked about the national situation as well as their own cases. Out of all the midwives, the independents had the most to say about their position in regard to the national context of midwifery.</p>	<p>Molly:</p> <p>it's the kind of job that</p> <p>you do seek solace and emotional support from other midwives because</p> <p>none of your non-midwifery friends can ever understand</p> <p>even hus-husbands kind of nod and say "oh yes dear" and never really get it</p> <p>they don't understand the stresses and strains so I think it's only other midwives</p> <p>and probably in certain circumstances only other independent midwives who would</p> <p>understand the the stresses of what</p> <p>you're going through so...</p> <p>~</p> <p>...we've tried to meet em</p>

	<p>on a semi-regular basis</p> <p>and have like a half day or a full day of a very informal</p> <p>get together have a lunch and chat about what's happening</p> <p>on a wider basis</p> <p>UK wide politically</p> <p>what's happening amongst ourselves what kind of what clients we've got</p> <p>and um occasionally we've brought along a set of notes and reviewed each others'...</p>
<p>As a team leader, Olive was in the position of responding to the support needs of other midwives. She had one-to-one meetings with her staff every few weeks which functioned as an opportunity to reflect on practice, but in which more personal issues were also discussed. The midwives' emotional lives were therefore regarded as important, and having an impact on their work.</p>	<p>Olive:</p> <p>the clinical manager started [1:1 meetings]</p> <p>and I thought how helpful it was for me</p> <p>and by chance we just had some some of the girls had some personal issues...</p> <p>...I thought there's no harm in keeping this on and it's a chance to you=know meet</p> <p>it's just good to catch up for personal reasons as well as you know professional reasons...</p>

	<p>I feel that is</p> <p>they do know that the door is open</p> <p>because you've taken an interest without being too nosy in what's going on in their lives</p> <p>which does affect their work and in</p> <p>they can speak about it then I know that</p> <p>...if they're feeling low or anything like that that's gonna affect their work</p> <p>but talking about it</p> <p>meeting with them and talking about it they know I know about it...</p> <p>they have a chance to say "well you know I've had 3 child protections in the last 2 weeks and I'm really struggling with this"</p> <p>and they can reflect on their practice that way...</p>
<p>As a background to these meetings Olive described a culture of reflection in her team.</p>	<p>we do reflect every Monday [at the team meeting]...</p> <p>sometimes it will be informally just you and I sit in the office...</p> <p>...I'd say we do a lot of reflection...</p>

6.2.3.1.4 A Dream of Support

Fiona’s story has a ‘tragic’ structure, because ultimately her need for support is not really met. However she is briefly supported by her supervisor, and so the story also shows how support might work. In *She’s There* the statutory supervision structure is described as offering the possibility of support. In *A Dream of Support* we can understand the possibility of support in a way which illuminates a felt need for support.

Analysis	Data Extracts
<p>Rose learned about the practice of clinical supervision through meeting practitioners from other disciplines. She distinguished <i>clinical</i> supervision from <i>statutory</i> supervision, which, like many of the other midwives, she described in terms of bureaucracy. Rose believed that an opportunity to reflect on practice would be useful. However she demonstrated an ambiguity towards directly expressing a desire for support herself.</p>	<p>Rose:</p> <p>I would like for somebody to come along and I’ve got two hours of clinical supervision</p> <p>and every month I can take my caseload you=know along</p> <p>...I think [that] would be better</p> <p>and an absolute great thing to do</p> <p>not that I need it in m- in my caseload but I think</p> <p>as a-as a tool for a midwife particularly that has em a high-a high risk caseload...</p> <p>that’s you=know</p> <p>what I would dream of...</p>
<p>The drug addicted client in the <i>Fiona</i></p>	<p>Rose:</p>

<p>story is based on Rose’s account of a client. She described this client as an example of the kind of person she would like to be able to discuss in supervision. The client was complex and high risk, and the story functioned as a vivid substantiation of her argument about the need for clinical supervision, and also connected the risk and urgency of work with the need for support.</p>	<p>...[I’d like] a one to one so that you can say that em that you that “these are the three em women that I would like to go through” particularly if you carried as caseload that was of high risk... I mean I’ve a complicated woman to try and sort out this morning that em she’s thirty six weeks pregnant she spent [period of time] in [prison] her last child was adopted and I’m left em floundering who to contact so that em there can be a speedy case conference...</p>
<p>Nina recalled her experiences as a newly qualified midwife. She painted a picture of feeling guided and cared for with more experienced midwives available to give advice. She contrasted this with her current position as a senior midwife who has more experience than many supervisors of midwives. Nina showed how her need for support had changed</p>	<p>Nina: ...you were kind of nurtured along um when you first qualified and you first worked in labour ward you were a lot on your own but there was a lot of very experienced</p>

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<p>over the course of her career. She did not directly say so, but there is a sense that her current needs as a senior midwife are not met by the supervisory system.</p>	<p>midwives in the area who were were supportive of newly qualified midwives... there's always been I suppose in some ways a senior person that you could go to but as life goes on and you become senior there isn't but I've never really known a supervisor who at you know on the coalface I could go to and say "I'm not happy about this you know I don't know what to do here" you've always kinda had to get on and make your decisions yourself</p>
<p>Nina went on to discuss how the supportive role of a supervisor could be better developed. She drew on her student experience of the clinical teacher, someone who was expert in practice but who did not have to manage a caseload alongside their teaching and supportive duties. She contrasted this with the</p>	<p>Nina: ...I think the role of supervisor in some ways has been taken from the what I saw as the clinical placement teacher</p>

<p>current role of the supervisor who is in clinical practice. Nina asked if the bureaucratic aspects of supervision could not be carried out by managers. She was interested in how a more supportive supervisory role could be developed and who could undertake it.</p>	<p>and I think that clinical placements specialised practitioner or teacher is something that would be a much better role than a statutory supervisor because most statutory supervisors I just think it could be done the supportive role of a supervisor could be done much more effectively by someone who was in clinical practice...</p>
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6.2.3.2 Summary of Fiona

Fiona explores the context in which midwifery supervision operates. In comparison to mental health nurses midwives are less involved with supervision on an individual level, but are involved in a structured supervisory system. Supervision therefore functions as a part of the wider context within which the midwives work, and context is of particular importance in understanding the operation of midwifery supervision. In the midwife interviews the emotion culture of the organisation, and of midwifery in general, was described in mainly negative terms – although participants also described a deep personal commitment to midwifery and enjoyment and pleasure in their work with clients, particularly during birth.

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Alongside the emotion culture is a need for support, and this is expressed in *A Dream of Support* and the *Individual Narratives of Supervision and Supervision*. These narratives offer an opportunity to explore how midwives seek support, and how the supervision and support of midwives might be developed.

Fiona also carries forward the theme of the annual meeting (identified in *Grace*), and suggests an answer to the question raised in *Grace* as to *how* midwifery supervision supports midwives. In *She's There if I Need Her* participants described their supervisor of midwives as a resource. They could contact her if necessary. This possibility of support contrasts with the actuality, which was that there was usually little or no contact outside of the annual meeting. Perhaps surprisingly, this possibility of support was experienced positively, suggesting that midwifery supervision has a symbolic value which extends beyond the immediate supervisee-supervisor contact.

She's There also shows supervision as being closely identified with something going wrong. Not having contact with a supervisor was something to be grateful for, because contact would have meant that there was a serious problem. This contrasts markedly with the emphasis in the mental health nurse narratives on supervision as a normalised process of reflection on practice. However some of the mental health nurses also expressed a need for such *ad hoc* support in response to problems or crises, suggesting that the problem/crisis focus of midwifery supervision may offer a particular kind of support. (Mental health nurses' accounts of *ad hoc* support are discussed in *Susie*.)

6.2.4 A Composite Story: Gillian

A community mental health nurse, Gillian, was studying for a psychotherapy qualification. As part of the course she was required to have supervision, and she was given a list of available supervisors in her area to choose from. At first she felt apprehensive about having supervision. In her previous post she had been involved with a supervision group and had found this an unpleasant experience. The group had been facilitated by her team leader, and there had been an uncomfortable atmosphere which had differed markedly from the usual friendly, easy-going interactions in the team. Several of the people in the group had been visibly awkward and reluctant to speak, or had adopted a defensive manner. Gillian had felt under pressure to prove herself, and to show that she could cope, and so had only discussed her practice in a limited way. When she had needed more support she had found this among her colleagues, but outside of the supervision group.

The first time Gillian met her psychotherapy supervisor her past experiences meant that she was keen to discuss the boundaries of supervision, and what the respective roles of supervisor and supervisee would involve. Her new supervisor was willing to spend some time discussing this, and afterwards Gillian felt much more confident about what the remit of her supervision was. She was also agreeably surprised by how comfortable she had felt during the supervision meeting. Her supervisor had a calm, welcoming manner which had made her feel able to speak openly about her feelings of ambiguity around supervision, and she felt that he had really listened to what she had to say.

Over the next few months Gillian noticed that although she only used supervision to discuss her psychotherapy clients, some of the things she learned through her supervision were influencing her nursing practice. This was particularly the case around the nurse-client relationships. Through psychotherapy supervision she was exploring how she responded to her clients and how aspects of her personality affected the way she worked, and this informed her nursing practice.

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Gillian felt privileged to have supervision. This was the first time in her career that she had been given an opportunity like this to spend time reflecting on her practice in a structured, supported way. She was enjoying her psychotherapy course and she admired and respected her supervisor, who she regarded as having real expert knowledge. She felt that her course was providing her with a greater depth of knowledge, and in comparison her nursing knowledge seemed patchy and superficial. In particular she felt much more at home with the psychotherapy model than with the medical model of mental health which she had previously experienced as very dominant in her area of work. In her nursing role she managed a busy caseload with limited resources and her psychotherapy practice and supervision felt like precious time away from this, in which she could think more carefully and deeply about what she was doing.

As her psychotherapy course came to an end, Gillian considered how she would continue with her supervision practice. She decided that she would like to begin discussing both her nursing and her therapy work in supervision. She thought about whether she should look for a new supervisor, or whether she should arrange a second kind of supervision for her nursing work. Although she liked her current supervisor very much, she also liked the idea of having a supervisor who was also a nurse. In some ways she found it useful having a supervisor from a different discipline because he offered a different perspective, and challenged some of her assumptions, however she also thought that it would be wonderful to have a supervisor who could be a nursing role-model. Like other CPNs in her team, Gillian increasingly felt that her role as a nurse was rather ambiguous, and seemed to be evolving into a kind of junior psychologist role. This had been causing tension within the team for some time, and Gillian thought that if she had a supervisor with nursing experience this might give her a stronger sense of her role as a nurse.

With this in mind Gillian enquired around for someone who might be able to be her supervisor. However she found that there were no nurses who had experience providing the kind of supervision she was looking for, or who could offer supervision on a regular basis.

6.2.4.1 The Key Narratives

Gillian's story draws on three key narratives which were each told by several of the mental health nurses: "*Being Stoical*", "*My Default Setting*", and "*An In-Built Inferiority Complex*".

Being Stoical draws on narratives which emerge in several of the interviews in which the nurses identify a need to be seen to be coping. This is illustrated in Gillian's story by her initial, poor, experience of supervision. There is a lack of emotional safety in the group, and Gillian and her colleagues feel unable to display their vulnerabilities. A culture of stoicism is created.

However for Gillian this stoicism is challenged when she begins to develop a new professional role as a psychotherapist. This aspect of Gillian's story reflects the strong presence of other professions in the mental health nurse narratives. This presence was both external to the nurses (working in multi-disciplinary teams and having supervisors from other disciplines), and internal (a personal association with more than one disciplinary identity and/or style of practice). The key narratives *My Default Setting* and *An In-Built Inferiority Complex* draw upon the mental health nurses' accounts of negotiating the presence of other disciplines, both internally and externally.

My Default Setting draws on the narratives nurses told about practicing in more than one discipline. This was expressed not only as a strong sense of allegiance to psychological therapies, but also in terms of problematising the medical model. All of the mental health nurses had experience of using a psychological therapy in practice, and some were registered as therapists. For some their therapy practice and supervision had contributed a lot to their philosophy of practice and to their understanding of mental health care, to the extent that their thinking was more 'psychological' than 'nursing'.

An In-Built Inferiority Complex also explores the issue of working in a multi-disciplinary setting. In the mental health nurse interviews the profession which they

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saw as being in opposition to, or in relation to, mental health nursing, was mainly clinical psychology, although medicine was also mentioned. The professions of clinical psychology and medicine are both of a higher status than nursing and their practitioners tend to be paid more than nurses. This creates a power imbalance between the professions and the operation of this imbalance can be seen in the *Inferiority* narratives. Sometimes this power imbalance was described as problematic, resulting in feelings of vulnerability or diffidence. At other times, however, it did not seem to be experienced as problematic, especially around interactions between a nurse-supervisee and a psychologist-supervisor.

The *Default* and the *Inferiority* narratives contrast markedly with the midwife narratives in which there is only the briefest mention of other professions, and in which there is no ‘inferiority’ discourse. In fact for the midwives there is almost the opposite sentiment in the ‘autonomy’ discourse. Even in the case of the independent midwives, who had more to say about negotiating their role in relation to other professionals (that is NHS midwives), there was no suggestion that they had the internalised sense of themselves as an inferior profession which is present in the mental health nurse interviews.

6.2.4.1.1 Being Stoical

The title of this narrative is adapted from a remark made by Dilys about how she and her fellow student nurses dealt with the emotional consequences of their course: “how stoical we were”. Below I have quoted at length from Dilys’ narrative about her experience of being in a reflective supervision-style group as a student nurse. In this narrative Dilys explored not only what happened in the group but also simultaneous events on placements and on her nursing course in general. Hindsight enabled Dilys to compare her experience of the group with subsequent experiences of supervision. This narrative has an explanatory function, it is contextualised and analytic, and shows how the emotion culture of the group was influenced by a

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complex of factors. Dilys' narrative shows how the reflective group was unable to create itself as a safe space, it was permeated by the environment in which it operated, an environment of insecurity and anxiety, and in response the students adopted the self-protective strategy of stoicism.

Analysis	Data Extracts
<p>Although Dilys described the group as generally a positive experience, it is evident that the students did not feel emotionally safe in the group. The 'need for protection' in Dilys' story suggests that the group could have been an emotionally exposing situation – elsewhere she described the students as feeling “vulnerable” in the group. The students had a need to resist emotional exposure: supervision was experienced as a potential threat.</p> <p>This contrasts with other experiences Dilys has had, where fellow supervisees have felt more able to share their emotions.</p>	<p>Dilys:</p> <p>I think generally we very much protected ourselves in those discussions cos I've been in peer group supervisions since with colleagues and there have been a lot more there has been a lot more evidence of emotions present in the room... ..as a student it was more</p>

	<p>I think it was more a practical</p> <p>“this happened” or</p> <p>“I’m not sure about that and I don’t understand that”</p> <p>you know quite a concrete thing maybe</p> <p>rather than “I’m worried about” “I feel uncomfortable”...</p> <p>...a lot of the protecting ourselves that went on was probably</p> <p>that we didn’t appear</p> <p>that we weren’t on top of our emotions or that we couldn’t cope with</p> <p>being a nurse</p> <p>we dealt with the emotional part of</p> <p>em</p> <p>our practice I think</p> <p>elsewhere</p> <p>like in the coffee shop...</p> <p>...there was much more heated conversations about what we’d seen in practice and what we were worried about</p> <p>outwith</p>
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	our supervision or reflection group...
<p>Dilys also positioned supervision in a larger context. The students' course, the university, and the students' own developmental stage affected their being in the group.</p>	<p>Dilys: part of the context of it was that the drop-out rate on our course was quite outstanding so maybe there was a bit of I'm going to do this course and I'm going to be all right and I'm not letting my peers know anything that's going on...</p>
<p>Explaining more about the context of the group, Dilys illustrated a general lack of emotional safety within the university with two stories. The first, about a lecture on child sex abuse shows the students' feelings about this subject being handled insensitively.</p>	<p>Dilys: ...[the lecturer said] "okay this is a very difficult subject I'm gonna go round the room and I want to know if your experience of this subject is personal or professional" three people got up and left so it was that kind of</p>

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	<p>“I’m not sure that this is particularly safe”...</p>
<p>The self-protective culture of the group was part of a wider culture of needing to be seen as ‘okay’.</p> <p>Dilys’ second story, about an incident on placement, shows the strength of the ‘stoicism’ culture among the students. Even when she was truly distressed by events on her placement this would not be shared in the group.</p>	<p>...I remember feeling quite de-skilled and quite inadequate em</p> <p>and crying</p> <p>you know I ended up kind of</p> <p>moving myself out the ward and going into the duty room</p> <p>in a corner</p> <p>and just tears coming</p> <p>and being really embarrassed</p> <p>and thinking “there’s absolutely no way that I’m telling anybody that this has just happened”...</p>
<p>Gina also described the stoicism present in mental health nursing. Although she would like to have supportive supervision, acknowledging this need is difficult. Previously in the interview Gina had discussed the difficulties of establishing supervision in her team where the members of staff took the approach of “we’re okay we don’t need</p>	

<p>supervision”. She compared this to her experience of working in clinical psychology where supervision is a matter of course. Asking for supervision within the nursing culture is not normalised, and so becomes an admission of failure.</p>	
<p>On reflection Gina wondered if supervision in her team hadn’t worked because it was operating in two contexts, the supervision and the team. Team members therefore had difficulty negotiating the roles of being fellow supervisees and also colleagues. In the team, staff were supposed to ascribe to a stoical group culture, so the critique of shortcomings and the discussion of difficult feelings which occurs in supervision became a taboo. Supervision breaks the taboo, making it uncomfortable for practitioners to move between the two.</p>	<p>Gina:</p> <p>...I think that’s probably why we sit in group supervision here and it just doesn’t work</p> <p>because people don’t want to be honest truly honest</p> <p>about how they feel cos there’s that group effect of</p> <p>“oh we can cope with everything cos we work in a crisis team”...</p>
<p>In Dilys’ narrative (above), the students’ need for self-protection led them to adopt an emotionally closed attitude. In these extracts Emma made a similar connection between a lack of acknowledgement of nurses’ emotions,</p>	<p>Emma:</p> <p>...there is less um focus and concern in the nursing world about how we as nurses deal with the</p>

<p>and a lack of support for work related emotions, and a subsequent self-protective, emotionally closed response from mental health nurses.</p>	<p>emotional impact of working with people...</p> <p>...in the counselling world it's well acknowledged</p> <p>that the impact the impact of clients on us as counsellors is well acknowledged</p> <p>in a way that it's not</p> <p>so well recognised in the nursing world...</p> <p>...I think um what can happen is that nurses can become</p> <p>um in order to survive and you=know and cope with</p> <p>with their work</p> <p>that they can become a bit...</p> <p>distant or less involved or a bit removed...</p> <p>if their emotional needs aren't being fully acknowledged by their own leaders and managers then</p> <p>there is less scope for them to have the capacity to</p> <p>to manage all the emotion that comes from their patients</p>
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	<p>so they have to have a way of kind of you=know putting a barrier up</p> <p>so that they can not be overwhelmed...</p>
<p>Emma felt the consequences of this stoicism culture in her nursing supervision. She described an exclusion of emotions from supervision as inhibiting her emotional engagement with her clinical work.</p> <p>Interestingly Emma's supervisor here was a clinical psychologist not a nurse, showing that the stoicism culture can operate in more than one professional context.</p>	<p>Emma:</p> <p>...it felt less personal</p> <p>um</p> <p>than what I was used to in my counselling supervision so</p> <p>it was much more focused on the patient and the problem...</p> <p>...I think it sort of gives me the feeling that</p> <p>I'm not allowed to bring all of me into that work...</p> <p>...the boundary if you like between me as a person and me as a professional is</p> <p>is I don't know um</p> <p>higher...</p> <p>...or-or it's more it's further away from me as a person...</p>

<p>In Beth's account about a client who was murdered we can see the stoicism culture in action. Beth had received informal support around the client's death from her colleagues, but she never discussed the death in her supervision group.</p> <p>At the end of this narrative there was a brief exchange in which Beth gave voice to the stoical approach. Even though the client did in fact die, there is the attitude of "no one's died".</p>	<p>Beth:</p> <p>...I think there is a bit of that in nursing</p> <p>a bit of a macho culture</p> <p>just get on with it you know</p> <p>no one's died</p> <p>so um</p> <p>Jessica:</p> <p>Except when they have</p> <p>Beth:</p> <p>Except yeh [laugh]</p> <p>except when they are</p> <p>and then you still get on with it cos what can you do</p> <p>they have</p>
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6.2.4.1.2 My Default Setting

In Gillian's story, supervision combines with learning about psychotherapy to create significant changes in the way that she thinks about her nursing practice, she develops a new professional allegiance and a new way of working. In the *Default Setting* narratives, it is difficult to separate out the effects of the supervision and the practice of a therapy as they are mutually dependent. Supervision in this context

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becomes part of a whole experience which includes learning a particular discipline, practicing in a different way and being supported in a different way.

Analysis	Data Extracts
<p>Like several of the mental health nurses, Emma felt herself to be very much influenced by her practice as a therapist. She described how sometimes these roles can overlap in practice, something which she sees as not necessarily beneficial. It is interesting that for Emma her counselling role seems to take precedence over her nursing role: it is the counselling role which forms her “secure base” and helps her nursing work.</p>	<p>Emma:</p> <p>...I can't pretend I haven't got all these different counselling skills and experience</p> <p>em but in many ways what I'm doing as a nurse</p> <p>is is not the same as what I'm doing as a counsellor...</p> <p>...I can get distracted perhaps</p> <p>and be tempted to behave as a counsellor when actually</p> <p>that's not what I should be doing</p> <p>because I've got a different role as a nurse...</p> <p>...I mean I d- the counselling experience definitely helps me in my nursing work...</p> <p>...I suppose it kind of um gives me like a</p> <p>becomes part of my secure base...</p> <p>...it kind of fills out the nursing role...</p>

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<p>Although Alice used aspects of various modalities, CBT was particularly influential. The experience of studying and practicing CBT and having CBT supervision are intertwined, they are experienced as a whole.</p>	<p>Alice:</p> <p>...we're exposed to other therapies as well</p> <p>you=know I've done courses in motivational interviewing</p> <p>solution focused interpersonal therapy</p> <p>done a bit of cognitive analytical therapy...</p> <p>you go on these courses and it's quite experiential and then you experiment a wee bit</p> <p>so that all kind of influences how you operate as well so</p> <p>I CBT I would say</p> <p>CBT is my default setting...</p>
<p>Gina's CBT supervision has been a formative experience for her mental health work. Gina's account shows how the experience of being a CBT practitioner and having CBT supervision, are inextricable. She did not depict these two things separately.</p> <p>However Gina did argue that having a supervisor who is of a different discipline is actively beneficial, and helped her to alter her thinking about mental health</p>	<p>Gina:</p> <p>...I think there are a lot of inexperienced or</p> <p>only working in one way kinda mental health nurse</p> <p>who does want to solve it</p> <p>and I guess</p> <p>you=know</p>

<p>care.</p>	<p>kinda doing the cognitive behavioural therapy bit</p> <p>I was kinda moving away from that need to solve things for folk and make it all all right...</p>
<p>Beth's remarks underline the plurality of disciplinary and professional allegiances present among the mental health nurses. In many ways this plurality appears to indicate professional openness and flexibility, however in Beth's account we see how certain professional allegiances continue to exert a greater degree of power even in a multi-disciplinary setting. As a CAT practitioner, Beth was conscious of the current dominance of CBT in the mental health service, and felt the need to play down her involvement in an alternative modality.</p>	<p>Beth:</p> <p>...I think it filters in an colours most things I do but</p> <p>I wouldn't kind of use the language of it um</p> <p>and I suppose I'm very conscious of not appearing a bit CAT¹¹ arsey [laugh]</p> <p>cos CBT rules sort of thing...</p> <p>...but i- informally I think it informs most things I would say in supervision um</p> <p>in the general supervision</p> <p>I just don't label it and keep it subtle...</p>
<p>Some of the mental health nurses expressed their allegiance to a</p>	<p>Iain:</p>

¹¹ Cognitive Analytic Therapy

<p>psychological way of working through a critical comparison to the medical model.</p> <p>Iain regarded the psychological approach as desirable, and something he found beneficial. He did not make any similarly positive comments about the medical model, and although he said that the two models can work together, he described the power of the medical model, and the possibility for conflict between the models.</p>	<p>...I think it's really useful to speak to somebody on the team who's expert on that</p> <p>and can</p> <p>can offer me things</p> <p>cos I like to think that I've got a psychological approach</p> <p>that I like the psychological model for working with people that are with our team</p> <p>I think the two can work quite well together...</p> <p>...the medical model</p> <p>is the dominant model</p> <p>er certainly in</p> <p>I would say in [this region] at the [hospital] eh but I think</p> <p>I think there's much less of a conflict here um in our team...</p>
<p>Here Iain compared his practice in a specialist therapy with the boredom of the routine tasks of nursing. In contrast therapy practice was described as an</p>	<p>Iain:</p> <p>...sometimes it feels it's</p> <p>a lot of the time that [what we do is]</p>

intellectual challenge.	really all just down to medication and depots and clozapine and who's on a compulsory treatment order and is the care plan up to date you=know that can be let's face it it can be a bit boring em any old monkey could give somebody a depot injection [laugh] so it's nice to I suppose stretch yourself and I suppose use different approaches to try and improve things for people...
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6.2.4.1.3 An In-Built Inferiority Complex

Gillian feels that her psychotherapy work is a privilege, and precious time, and that the knowledge she is gaining is of more worth than her nursing knowledge. She also admires her supervisor as an expert. This illustrates some of the ways in which the mental health nurses talked about working with other professionals and practicing psychological therapies. Sometimes a sense of admiration for the quality of knowledge in psychological therapies seemed to boost the nurses' own estimation of the value of their practice, while at other times this admiration triggered insecurity about the nursing role.

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Analysis	Data Extracts
<p>Iain had two kinds of supervision interaction with members of more powerful, higher status professions: as facilitator for a specialist therapy group, and as a supervisee in his one-to-one supervision.</p> <p>In the specialist therapy supervision Iain was in the position of supervising members of the group who are of higher professional status. This triggered a sense of himself as belonging to a low status profession, even though at other times he felt himself to be assertive and confident in his skills as a nurse.</p>	<p>Iain:</p> <p>...I sometimes find it quite challenging because eh intimidating I think rather because the supervision is</p> <p>you=know it is very multi-disciplinary there's a few psychologists there there's a few psychiatrists...</p> <p>...I guess I get intimidated by other people's knowledge and expertise and I just see myself sometimes as a lowly nurse em</p> <p>facilitating the supervision with people that've you=know</p> <p>got a lot more not necessarily experience but a lot more qualifications...</p>
<p>Iain also had supervision with a psychologist as his supervisor, and here he experienced the perceived expertise of the psychologist as beneficial.</p>	<p>Iain:</p> <p>...I would value</p> <p>probably yeh having clinical supervision more with</p> <p>a psychologist than anybody else</p> <p>because I feel particularly you know with</p>

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	<p>psychologists em</p> <p>you know they do have a-a-a-a</p> <p>a huge amount of experience and knowledge...</p>
<p>Clare experienced some discomfort in her CAT supervision group, and attributed this to her sense of the relative professional status of the group members. Although this was not something which consciously impinges on her professional relationships, she nevertheless noticed it in certain aspects of the group interaction, for example agreeing with another member of the group against her own better judgment.</p>	<p>Clare:</p> <p>...that kind of in-built inferiority you feel anyway as a nurse...</p> <p>I don't I don't necessarily em kinda naturally feel that way to be honest</p> <p>I usually feel really quite confident with other professionals but</p> <p>em</p> <p>I think there is a kinda in-built thing in you that makes you just being a nurse kind of makes you feel inferior in the first place</p> <p>and that other people might</p> <p>you- you know that you would be much more likely to think that other people are right and that you maybe might've got it wrong</p>
<p>Wondering why the CAT group led her to be less assertive, Clare concluded that</p>	<p>Clare:</p>

<p>being the only representative of her profession made her feel disempowered in the group, undermining her confidence.</p> <p>It is interesting to note that elsewhere in her interview Clare expressed a strong sense of her identity as a nurse, and valued working with other nurses. She was the only one of the mental health nurses to have had a good experience of reflective, supportive supervision with another mental health nurse as her supervisor. For many of the other mental health nurses the ‘discovery’ of supervision as a beneficial practice came courtesy of involvement with a psychological therapy or therapist as supervisor.</p>	<p>...I’m pretty assertive when it comes to other disciplines but</p> <p>for some reason in that environment I can feel qu- more vulnerable</p> <p>I think because there’s no other nurse the supervisor by background is a nurse but she more a</p> <p>like she’s known as a therapist now because she’s always worked in the [specialist] Centre and</p> <p>and that kinda therapy environment so I suppose being the only nurse maybe some- makes you feel less power- that you have less power in that situation...</p>
<p>Gina was apprehensive about the potential power/status difference with both her CBT supervision (with a psychologist) and her nurse prescribing supervision (with a psychiatrist). However in fact she found that the supervision “reinforced” her sense of her nursing role. Perhaps the high status of these professionals meant their respectful attitude towards Gina’s nursing role had</p>	<p>Gina:</p> <p>both these sets o’ supervision</p> <p>there was this perception of</p> <p>‘they’re further up the hierarchy</p> <p>and they’re gonna be judging what you’re doing</p> <p>it’s not gonna be as good as it could be’</p>

<p>a greater impact on her.</p>	<p>both of them were quite respectful of the fact that I'm a nurse</p> <p>and so they were goo- you=know it actually felt much <i>much</i> more equal</p> <p>because they were coming back with things</p> <p>that</p> <p>“that’s good cos you pick up on that and maybe that’s cos of your nursing skills”...</p>
<p>For Beth, having CAT supervision in a group with higher status psychologists was an opportunity to challenge assumptions about the relative value assigned to their work. However it is noticeable that her starting point was the assumption that a nurse does inferior work.</p>	<p>Beth:</p> <p>as a nurse doing psychological work</p> <p>you can fantasise that</p> <p>psychologists for instance</p> <p>are doing</p> <p>amazing work</p> <p>and you’re doing pretty loose sub-standard work</p> <p>and it’s a nice challenge to that to be in</p> <p>multi-disciplinary um</p> <p>supervision</p> <p>and think oh actually [laugh]</p>

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	<p>yeh yeh</p> <p>you've not got this kind of like</p> <p>amazing</p> <p>knowledge tucked under your sleeve</p> <p>that other people haven't got...</p>
<p>Alice also described a situation in which supervision helped mental health nurses to challenge a feeling of inferiority and threat to their professional role from another profession (psychology). In this instance the supervisor (a psychotherapist with past experience of nursing) used the discussion in supervision to help the nurses reformulate a sense of their professional identity.</p>	<p>Alice:</p> <p>...we were struggling as nurses to find em</p> <p>I guess our role in this team</p> <p>it was being questioned perhaps by other professionals...</p> <p>...it was very reassuring to have [supervisor A] on board and he focused a lot on what nursing was about...</p> <p>...we were approaching different clinical situations differently perhaps</p> <p>than from a psychologist</p> <p>trying to find our role professionally em</p> <p>you=know in some way nursing is seen</p>

	as being caring and about and we'd kinda lost that I think and he kinda brought us back to what nursing was about rather than being perhaps a psychologist's assistant or a a lesser psychologist...
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6.2.4.2 Summary of 'Gillian'

Gillian addresses an important aspect of the context in which the mental health nurses experienced supervision: their relationship with the disciplines of psychotherapy and psychology. Four of the eight mental health nurses interviewed were registered therapists as well as nurses, and seven of the eight had extensive experience of practicing within a psychological or psychotherapeutic model.

In this respect the mental health nurses contrast with the midwives. Where the mental health nurses had a plurality of disciplinary allegiances, the midwives described a largely singular disciplinary context, with other disciplines such as medicine being on the periphery of the midwives' accounts. The mental health nurses also described conflicts with other disciplines. Several of the participants problematised the medical model and preferred psychological or psychotherapeutic models. At the same time as psychological models became dominant in the health service, participants found that nursing identity and the nursing role were threatened. The relationship with other disciplines was complex, creating feelings of both empowerment and inferiority.

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Gillian has an initial bad experience of supervision, and then a later, good experience. This captures the career-long relationship with supervision which the mental health nurses described. All of the mental health nurses interviewed had been practicing for several years, and over this time several had experienced supervision in different ways, both positive and negative. The experience of supervision must, therefore, be understood in terms of its development over time. *Gillian's* previous experience of supervision prejudices her against it, but participants also described previous good experiences as preparing them to seek good supervision at a later date (and to avoid bad supervision).

6.2.5 A Composite Story: Susie

Susie was attending her monthly supervision meeting. She arrived at the team base early, so she went to have lunch in the coffee-room. There she found Diane, a CPN in her team who she hadn't seen for a couple of months. They chatted for a while, catching up on each other's news. Diane had just been away on holiday and had some photos to show off, and they shared some gossip about the staff night out. Then they started talking about some changes which had been proposed for their area of the mental health services, and which were causing quite a lot of uncertainty among the CPNs. Diane said that she'd be retiring soon, so she didn't mind what happened, but Susie said she was worried about the future. Diane suggested that she bring it up in their supervision group.

Susie wasn't sure about this. She had intended to discuss a difficult case which she needed some advice with, and this seemed more important than worries about possible service changes. Anyway, she explained to Diane, she was probably being overly-anxious about the changes because she was feeling stressed generally. Her father was in hospital and she was finding it difficult to concentrate at work because she was so worried about him. Diane asked what the difficult case was, and Susie explained some problems she was having with a client who was self-harming. Diane was able to give some helpful advice about how to respond to this behaviour, and suggested a charity who might offer the client some extra support. Susie was very grateful for the suggestions, and as they got up to go into their group she joked that she didn't really need supervision now, she'd had it over coffee.

After her talk with Diane, Susie didn't feel that she needed to bring up her difficult case in the group, so she decided to mention her concerns about the service changes after all. She was diffident about mentioning this because, as a new member of staff, Susie still felt uncertain about what issues were appropriate for the supervision group. Several members of the group were also attending other kinds of supervision, for example for their CBT practice, and they seemed to have a clear sense of what issues they would discuss in their different kinds of supervision. Susie felt that in

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some ways she was at a disadvantage because the group was her only form of supervision.

However as it turned out the other members of the group sympathised wholeheartedly with Susie's concerns about the changes. Immediately they started talking about what might happen, and Susie was relieved to find out that she wasn't the only one who was anxious about the changes. The CPNs agreed that none of them liked the proposed changes, and a plan to shorten appointment times was particularly unpopular. Several of the group members reported that they already finished clinics late because of paperwork.

These remarks stimulated an impassioned discussion about the amount of admin the CPNs had to do, and the lack of time and support they had to do it. Eventually Susie started to feel impatient. Issues over admin were a *bête noir* for several members of the group, and nearly every supervision session she had attended had ended up as a discussion about admin which never seemed to resolve itself. This session was no different. Every member of the group had a lot to say about the situation, and although they did talk about some possible solutions to the problem, ultimately nothing was resolved, and the CPNs spilled out into the coffee room still chatting.

Thinking about that day's meeting, Susie had mixed feelings. On the one hand it had been good to air her worries and find out that others had similar concerns, and the sympathy of her team members had been very supportive. However on the other hand she felt unsatisfied with the lack of resolution. A lot of what had been said was repetitive and harked back to similar discussions in previous supervision sessions. Susie would have preferred the group to work on a solution to the problems under discussion. Instead she felt that it had all been a bit moany.

6.2.5.1 The Key Narratives

Susie's story is formed from four key narratives: *Watercooler Conversations*, *The Moaning Shop*, *What We Talk About*, and *A Pocketful of Feelings*. A common thread in these narratives is the differentiation made between communication in an informal setting and communication in supervision. Susie engages in both, informally talking to Diane over lunch, and then talking in a formal supervision group. On each occasion she responds to an emotional need. She talks to Diane because she's feeling overwhelmed by her client's problems, and because events in her home life are affecting her response to work. She raises an issue in supervision because she's anxious about the service changes.

In *Watercooler Conversations* we can see this need for emotional expression and support in action. All of the participants described the value of *ad hoc* and informal support with practice. For some of the mental health nurses this was more valuable than supervision, for others supervision had a uniquely supportive quality which could not be found through informal support. For the midwives, support was mainly framed in terms of informal support rather than supervision, and there is also a contrast between the importance of informal support from colleagues on the one hand, and experiences of not being supported or being bullied by colleagues on the other hand.

But is there a difference between informal support and support through supervision? This is a central question in Susie's story, and in the mental health nurses' stories about supervision. Susie's conversation with Diane seems to resemble supervision, and she jokes that she has already had supervision 'in the coffee room'. Conversation in the supervision group itself centres around complaining, and Susie feels that it has been unproductive. It was clear in the mental health nurses' stories that simply calling something supervision does not necessarily create a supportive or productive practice.

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The Moaning Shop brings together data from the mental health nurse and the midwife interviews where the participants described certain interactions in informal terms such as moaning or chatting. The possibility for supervision to turn into chat seemed to cause the mental health nurses a degree of discomfort, several were at pains to explain how supervision is not chat, or should not be allowed to be chat. This discomfort perhaps reflects the transgressive character of supervision, in which elements normally confined to the personal domain (such as emotional expression or the personal narrative) are allowed into the work domain. In contrast the midwives did not display the same discomfort over this, and there was no evidence that the midwives saw this as a boundary to be negotiated. The personal expression aspect of their supervision is, I suggest, somewhat dismissively described using colloquialisms. However, some of the midwives also said that this aspect of the meeting was supportive. The catch-up or moaning function of the annual meeting suggests that midwives experience a need to talk about practice and express feelings about practice.

In *What We Talk About* the mental health nurses consider how supervision should operate, and how the communication in supervision is different from the informal chat of the moaning shop. The negotiation of the boundary between formal and informal, work and personal, raises the question of what norms and expectations the mental health nurses have about supervision. In Susie's story, as a new member of her supervision group she is aware that there are certain rules operating about appropriate conduct in the group, however she is still trying to work these out, the group does not seem to speak about itself. The narratives in *What We Talk About* illustrate rules, norms and expectations operating in supervision, but show that these not usually discussed. Most of the mental health nurses told me that they had never set ground rules or discussed the aims of their supervision. In the mental health nurse narratives, the existence of rules was most clearly shown when they were broken, such as when a new member joined a supervision group.

Susie is experiencing emotions in response to her work: anxiety about a client and about proposed service changes. She is also experiencing strong emotions outside of work (around her father's illness) and she thinks that these are influencing how she

feels in work. In *A Pocketful of Feelings* mental health nurses explained how supervision could offer the opportunity for emotional expression, and how this became part of an on-going process of emotion management which carried through contact with clients and everyday work, to supervision and back again. *A Pocketful of Feelings* suggests an answer to the question raised by the previous three narratives of this section: does supervision have a uniquely supportive quality? The *Pocketful* narratives suggest that supervision can have such a quality, and it is the continuity and consistency of supervision practice which make a unique contribution to the mental health nurses' emotion work.

6.2.5.1.1 Watercooler Conversations

For Susie her conversation with Diane feels like supervision, and in both mental health nurse and midwife interviews informal *ad hoc* support was regarded as important; sometimes because it filled a gap where supervision should be, and sometimes because it was seen as uniquely supportive.

Analysis	Data Extracts
<p>Emma critiques nursing supervision as not providing enough of an opportunity for practitioners to discuss the emotional aspects of practice. Here she describes how the need to express the emotional response to practice comes out in informal conversations.</p>	<p>Emma: there's sort of informal support from colleagues so um you=know along the lines of you=know I heard a really or saw somebody new yesterday and it was you=know they'd had a really tough life and it was hard to listen to what they had</p>

	<p>to say</p> <p>you know that just having a bit of a conversation in an informal way</p> <p>a watercooler conversation...</p>
<p>But is supervision about the degree of formality, or can informal interactions also be supervisory in nature? Here Clare discusses the value of being able to have what she describes as “<i>ad hoc</i> informal supervision” with a difficult case.</p>	<p>Clare:</p> <p>...to be perfectly honest</p> <p>I think the the thing that I get most out of is actually <i>ad hoc</i></p> <p>informal supervision from people...</p> <p>...[with a difficult client] there was points where I was really struggling with them</p> <p>so I would go to the psychologist</p> <p>here in the team</p> <p>who’s very approachable</p> <p>and sorta say “look I’m really struggling with this person when you’ve got a bit of time could I have sorta half an hour or so?”</p> <p>and she was like “yeh no problem” so</p> <p>and we’ll sit down together</p>

	<p>and we'll go through it...</p> <p>...that's the kinda actual supervision</p> <p>it's at the time it happens</p> <p>and it kinda feels em it's live you=know</p> <p>and you're using real examples and all that kinda thing</p> <p>and I probably get the most out of that...</p>
<p>In Iain's interview he expresses a certain ambivalence towards supervision. While he values having supervision, and thinks it an "ideal" for all nurses, he also doesn't always find it particularly supportive. Instead he finds that a mutually supportive team is more important.</p>	<p>Iain:</p> <p>I think knowing that people are</p> <p>people are dependable</p> <p>and people are around</p> <p>and that people are happy to help out</p> <p>I think's probably the most important thing</p>
<p>In contrast to Iain, Faye gives more importance to supervision, and she finds that there is little support for practice outside of supervision, but she also identifies support from her team as important and as providing an opportunity for emotional expression.</p>	<p>Faye:</p> <p>Do you know there <u>isn't</u> a great deal that supports you <u>really</u> [laugh]</p> <p>to deal with the kind of caseload that you do</p> <p>apart from the <u>team</u> you work with</p>

	<p>em</p> <p>if I <u>didn't</u> have clinical supervision it would be it would <u>very</u> much the team you work with</p> <p>and having</p> <p>a <u>good</u> team a team that you get on with</p> <p>em</p> <p>I'm very lucky in the sense if I-I really was having an issue</p> <p>or pulling my hair out specifically with somebody the team are</p> <p>very understanding of that...</p> <p>...you could cry within the team if you were really getting that stressed out and the team would support you with that so...</p>
<p>Informal and <i>ad hoc</i> support was important in the midwife interviews. Like Faye and Iain, Jo the identifies good relationships in her team as very supportive. She attributes this to the fact that the midwives all have a lot in common, and have all worked together for a long time. The good team relationships provide an environment in which informal, supportive conversations</p>	<p>Jo:</p> <p>[we get support] just by discussing things</p> <p>...we'll all sit about and have a coffee and eat some cake</p> <p>and we'll chat about different stuff and if somebody's had a hard case they can talk about it</p>

<p>can take place. Jo depicts these as occurring frequently (“most days”), but on an <i>ad hoc</i> basis, when the midwives meet in their staff room.</p>	<p>em if there are any problems</p> <p>we’re a very close team here</p> <p>and we all get on very well</p> <p>we all talk to each other</p> <p>and that helps to off-load a wee bit I suppose</p>
<p>However in the midwife interviews, support from colleagues was offset against accounts of not being supported, or being bullied by other midwives, this was something Sarah experienced in her first post as a newly qualified midwife.</p> <p>Here Sarah described feeling very supported by her colleagues in her current post, although the support she described was more practical than personal (Extract 1). But Sarah also said that sometimes other midwives don’t want to talk about emotive or risky aspects of midwifery (Extract 2). These kind of conversations are more likely to occur with midwife friends with whom she trained.</p>	<p>Sarah:</p> <p>Extract 1</p> <p>...they’re two very lovely people that I work with</p> <p>they’re actually really really lovely</p> <p>very open you=know you can say “look d’you know”</p> <p>you can ask</p> <p>again you can ask “can you tell me</p> <p>I don’t know about this</p> <p>and do you know whatever”</p> <p>and like I-I do if I’ve found something out I’ll go and tell people</p> <p>so it’ll save them time and then you find they’ll do the same back</p>

	<p>so it's good</p> <p>Extract 2</p> <p>if you were saying to some colleagues you=know "I'm anxious about this"</p> <p>they almost wouldn't want to hear that in a way</p> <p>...it's more the people that you trained with</p> <p>that you would say</p> <p>"oh god we feel the same"</p>
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6.2.5.1.2 The Moaning Shop

Susie is unhappy with the way the supervision group becomes dominated by unresolved complaints. This was a common sentiment among the mental health nurses who spoke disparagingly of using supervision to 'moan' about things. Although the informal watercooler conversations were regarded as important, the mental health nurses were concerned to distinguish these from supervision. This contrasts with the midwives, who did not problematise supervision interactions in this way.

Analysis	Data Extracts
Iain created a succinct argument about the division between supervision and a chat. In his example of colleagues who are also friends who also supervise each	<p>Iain:</p> <p>...I know people who get supervision</p>

<p>other, he drew attention to the potential for a blurring of the public/private or work/personal boundary to occur within supervision. Meeting in a café locates the activity of supervision outside of the usual work environment and so perhaps increases the likelihood of such a blurring of boundaries. Iain's use of the colloquialism "bitching session" emphasised the transgression into the personal domain.</p>	<p>"oh I had supervision last week I went out with so and so" And you=know I know that they see each other outside work Em Their kids play with each other and they er They went and they had supervision and they had lunch In a café You=know I'm not saying that's wrong But I wouldn't I wouldn't get anything out I would probably turn something like that into a bitching session...</p>
<p>Dilys also used a colloquialism "moaning shop" to describe an undesirable characteristic of her student reflective group. She made a subtle distinction between the moaning shop and what the group was supposed to be for, which she described in emotionally neutral terms. The term 'moaning shop' carries the suggestion of complaints and</p>	<p>Dilys: [the reflective group was] very much em being looked on as a space to come and talk about primarily anything that'd happened in</p>

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<p>negative emotions and perhaps it is this negativity which seemed undesirable.</p>	<p>your placement you know in clinical practice but sometimes it might be something relating to your work as a student nurse you know some course or some aspect of the course or interactions maybe with peers sometimes the group did turn into a bit of a a moaning shop if we were getting to the end of a placement that had been particularly long or those kind of things that it might have got to a kind of moaning shop em type atmosphere...</p>
<p>Like Iain and Dilys, Beth described the undesirable style of supervision in informal terms, as “chat” and “gossip”, and distinguished this from good</p>	<p>Beth: ...we needed someone to pull [the group]</p>

<p>supervision. She described how in the early days of her CPN group supervision, the CPNs encountered a difficulty in distinguishing their supervision interactions from their usual work interactions. She connected nursing culture to a more informal style of interaction, and suggested that this worked against establishing the practice of supervision.</p>	<p>out of the realms of chat</p> <p>we all wanted it to be beyond that</p> <p>but we needed someone to help change the culture...</p> <p>...we couldn't shift the tone ourselves...</p> <p>...I don't think nurses <i>per se</i> are particularly good at [supervision] you see</p> <p>I don't think we've been brought up historically to take it seriously...</p> <p>...we're good at informal chat</p> <p>and we're good at gossip...</p>
<p>Gina and Faye had both given some thought to what distinguishes informal conversation from supervision.</p> <p>Like Beth, Gina considered that nursing culture tends towards the informal. She believed that this had inhibited her attempts to establish supervision in her team, because her staff didn't understand the division between supervision and chat.</p> <p>Although Faye believed that supervision should be personal and include personal and emotional responses to work, she</p>	<p>Gina:</p> <p>They don't know what good supervision is</p> <p>They think that good supervision is just about</p> <p>being able to talk openly to a person you're working with</p> <p>occasionally saying</p> <p>"I can't be bothered today" or</p> <p>"I'm not in the right place to deal with</p>

<p>was also concerned that the focus should remain on work. However, as she went on to illustrate with a story about returning to work from sick leave, there is no clear cut division. She discussed some aspects of her sickness in terms of how it had affected her work, but considered other aspects to be inappropriate, for example the details of her illness.</p>	<p>this” or “I can’t stand that person” but not look at the wider things of how does that effect what you do next Faye: ...I think personal stuff is a big a big thing although unless it’s impacting on your workload... ...I think you’ve got to be very careful with that aspect of things and being pr- I think you’ve got to be really professional I think you=know it would be quite easy to make it a friendly chat and to have a bitch and a moan and a leave you=know...</p>
<p>Rose’s description of an aspect of her supervision meeting as a “moaning session” located it in a similarly informal realm. The colloquialism of moaning session also suggests a degree of dismissiveness. Unlike the mental health nurses Rose did not discuss moaning as problematic in supervision, but at the</p>	<p>Rose: ...and yeh we generally use it as a moaning session...</p>

<p>same time her description does not depict this aspect of supervision as important or valuable.</p>	
<p>In contrast Olive used the colloquialism of “let off steam” to indicate a beneficial process. Although this did not result in any concrete action to be taken, the letting off steam had a benefit in itself in that it supported Olive to continue with her work. In fact not needing to take any action was presented as a virtue of this kind of interaction with the supervisor, suggesting that it fulfils a need for emotional release. Nevertheless it is also worth noting that Olive said letting off steam is not about “complaining”. This perhaps indicates a discomfort about the discussion of negative emotions similar to the one suggested in Dilys’ account.</p>	<p>Olive: ...you can just go and speak to your supervisor and just let off steam and come away you don’t need to do anything about it... it’s not that you’re com- really complaining you’re just you are in a way but you’re just letting off steam which means you can go back then and get on with the job...</p>

6.2.5.1.3 What We Talk About

Susie is aware that some rules or norms are operating in her supervision group, but she hasn't been able to work these out. In the interviews, having problematised a certain kind of interaction in supervision, several of the mental health nurses went on to consider what should be discussed in supervision, and how this might be distinguished from other interactions.

Analysis	Data Extracts
<p>In <i>The Moaning Shop</i> Faye considered the difference between informal chat and supervision. Here she identified a key difference between a discussion in supervision and a chat as being found in the outcome of supervision. Supervision should create some sort of change for the supervisee, either solving a problem or developing a new understanding.</p>	<p>Faye: ...it's about being able to come out with something whether it's an answer whether it's a em having been able to reflect and actually see other ways of dealing with things...</p>
<p>In a similar vein Gina also considered what the characteristics of supervision are, distinguishing them from from those of more everyday communication. While Faye distinguished supervision as having some kind of beneficial outcome, Gina gave more attention to the special context provided by supervision. She identified supervision as an emotionally "safe" environment which facilitates</p>	<p>Gina: ...If I asked staff why they didn't feel they needed supervision they would say "because we work in that intensity and so closely together in such high stress situations</p>

<p>reflection and emotional expression, and is removed from the heightened emotions of a crisis situation. This then facilitates a kind of learning which she believed does not occur in day to day work.</p>	<p>we discuss issues all the time and we resolve issues all the time as we go” basically I would have to say as managing that team, and having watched it happen over the last couple-a years I think they do manage a lot of issues at the time and I think they would learn a lot from then reflecting much later on and being able to re-explore it cos I think at the time some people can explore stuff but some people miss things that were important and don't feel they can go back to address these issues that are important for themselves and are important for the treatment of</p>
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	<p>that case</p> <p>um</p> <p>and I've seen issues come up with staff where they</p> <p>get more and more fed up with somebody</p> <p>or some response from a team member</p> <p>and it's just never getting addressed</p> <p>whereas if they'd had regular supervision it probably wouldn't have got to that point</p> <p>cos they'd have been able to express</p> <p>in a more safe environment</p> <p>how they actually felt...</p> <p>...whereas when you're in the heat of dealing with an emergency</p> <p>and everybody's really emotional about "Should we do this? Should we do that? What's really going on?"</p> <p>They don't reflect on it fully</p> <p>you reflect on things better when some of that heat of that stress and emotion's out of that a bit more...</p>
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<p>Clare described the process of negotiating roles in supervision from the point of view of the supervisor. She made a subtle distinction between the kind of emotional reflection which is appropriate and the kind which is overly personal.</p>	<p>Clare:</p> <p>sometimes in a supervision situation you can be pushed into being the parent...</p> <p>that's not the focus of what you're doing</p> <p>and neither are you a personal counsellor and neither are you=know</p> <p>you shouldn't be discussing sorta</p> <p>somebody's all their pers- personal emotional stuff...</p>
<p>Alice described how a CPN who had recently joined her supervision group had a different understanding of what should be discussed in supervision. This conflict of expectations about supervision has caused discomfort in the group. Although the group had never formulated a set of overt ground rules for itself, the unwritten rules become evident when they were broken by the new member.</p>	<p>Alice:</p> <p>...with the group supervision just now</p> <p>there tends to be maybe one person that could dominate it quite a lot</p> <p>and so we're always prepared for that</p> <p>cos sometimes this person brings cases to supervision</p> <p>might bring a pile of notes</p> <p>brings cases to supervision</p> <p>and for most of us it's straightforward</p> <p>our in our heads we're saying why is this person bringing</p>

	<p>this case to supervision</p> <p>so it has changed</p> <p>it has changed recently so</p> <p>so we are prepared</p> <p>we have to bring a case because you don't always want to let this person have the space...</p>
<p>Beth was part of the same supervision group as Alice, and also described the situation with the new group member. Beth believed that in some ways the new group member had positively encouraged a new way of working in the group: by bringing cases to the group she had encouraged the other CPNs to do likewise. However, Beth also identified the same problems as Alice does with the way this person was working within the group.</p> <p>In both Alice and Beth's accounts they did not understand the new member's rationale for discussing particular case (Clare was also part of the group and she briefly touched on this issue and had a similar perspective). There was a conflict of expectations about what rules were operating, but the group did not seem to have any way of addressing this,</p>	<p>Beth:</p> <p>...you kind of think</p> <p>I don't know why you're talking about this person</p> <p>I don't understand</p> <p>why</p> <p>this person has come and you know</p> <p>you've assessed them and this is what you've seen</p> <p>and now you're gonna see them again</p> <p>okay</p> <p>okay right</p> <p>and you know I'm</p> <p>trying to think of something productive</p>

it was unable to talk about itself.	to say and and really what I want to say is and?
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6.2.5.1.4 A Pocketful of Feelings

Susie experiences reassurance and emotional relief as a consequence of being able to express her feelings to her colleague and then in the supervision group. However she also finds the expression of negative emotion in the group frustrating. For Susie supervision makes some contribution to her emotion work, but is ultimately inadequate. In this way Susie’s story is slightly more negative than those told by the mental health nurses, who all had some good experience of supervision as supporting emotion work. However there were also accounts of having supervision which did not adequately support emotion work, and Susie’s story draws these.

The mental health nurses discussed various emotional responses to work. Sometimes these were around especially difficult situations such as the death of a client, but they also included more everyday issues such as finding personal resonance in a client’s story. For several of the mental health nurses, supervision did function as an important support for their emotion work.

Analysis	Data Extracts
In Alice’s story supervision was a place in which her emotional response to an irritating client could be expressed. This kind of negative emotional response is	Alice: ...there’s a patient that I’ve em recorded

<p>usually excluded from the work domain, but in supervision it was accepted and validated by her supervisor. The value of this opportunity for expression is suggested by Alice's use of the term "professional façade". This description draws attention to the active way in which she was managing her emotions when with her client. The discussion with her supervisor not only validated Alice's feeling of irritation, but also allowed this process of emotion management to be acknowledged.</p>	<p>a coupla times and he's-he's quite irritating and he's quite annoying em and so that's something that we've talked about and she's going "I understand that because I've listened to him and you=know I can see where you're coming from" so you=know again a bit of acknowledgement that that's okay to feel a bit irritated when you're seeing someone as long as that is not being em that's not coming out when I'm speaking to the patient but that's me talking about how I was feeling when you've got a professional façade on...</p>
<p>Faye highlighted the importance of having supervision as an opportunity for</p>	<p>Faye: I usually kinda walk away [from</p>

<p>emotional expression in assisting her to carry out nursing related emotion work. Her comment that supervision is like a “pocket” where she can store emotions is striking, and suggests that the expression of work related emotions should be regarded as a contextualised process rather than an ‘of the moment’ activity.</p>	<p>supervision] with either having just been able to off load or with some ideas in my head... ...I think [off-loading] is very important for being able to go home at the end of the day and not be carrying your caseload with you twenty-four seven... em it can be a very very emotive job being able to off-load that or to know that you’ve actually even in a month’s time got that opportunity to discuss something is really kinda nice it’s nice to know and reassuring to know that you’ve got somebody and some allocated time to be able to</p>
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	<p>to do that</p> <p>so it's some- it's almost like a pocket that you know that you can put it in</p> <p>and leave it there till you can get that opportunity</p>
<p>Faye's explanation of how supervision helped her when one of her clients died, reinforces the sense of emotional expression in supervision occurring over time. In Faye's narrative about this particularly difficult client she highlighted the fact that supervision is an on-going process. Discussing the client before and after their death meant Faye's supervisor was able to say "you tried everything".</p> <p>Faye's narrative suggests an important difference between supervision and <i>ad hoc</i> or informal support. The consistent discussion over time which supervision involves helped Faye when ultimately the case ended tragically.</p>	<p>Faye:</p> <p>...to have that supervision</p> <p>to have said discussed it before she died</p> <p>to have that kinda reassurance through supervision and then obviously post her dying</p> <p>em</p> <p>it was nice to have had that prior</p> <p>because you knew you'd done everything</p> <p>so when she died</p> <p>I could sit comfortably and say</p> <p>you know I did</p> <p>try everything</p> <p>and have that reassurance and have discussed that with somebody and you know I could go back to supervision and</p>

	<p>she</p> <p>she quite openly kinda said you know</p> <p>“you’ve gone down every route with her</p> <p>you tried everything you could do and</p> <p>she</p> <p>felt that support from you and</p> <p>you know she showed this by doing these things that you discussed in supervision before”</p> <p>and it does it helps you to kinda reflect...</p>
<p>Clare also drew attention to the way that supervision is an opportunity for emotional expression, and that the existence of this opportunity had helped her to manage her emotions out with supervision sessions. Like Alice, she described supervision as a place where emotions usually excluded from the work domain could be expressed, accepted and validated.</p>	<p>Clare:</p> <p>I suppose in some respects it made me emotionally stronger to do the job</p> <p>because</p> <p>for two reasons</p> <p>one was that you had an avenue</p> <p>because I-I trusted her one hundred per cent</p> <p>if there was something say upsetting me about somebody I was working with or</p> <p>you know make connections with home or that kinda thing if there’s something</p>

	<p>that</p> <p>somebody pushes your buttons</p> <p>I was able to discuss it at the time with her and if you got upset it was okay</p> <p>actually and she</p> <p>made that quite clear</p> <p>and so you had a sense of release</p> <p>for that</p> <p>but I also think the other thing was</p> <p>that you knew that you had that every month</p> <p>sometimes you carried thi- you were able to carry things more</p> <p>because you knew that you had that coming up</p> <p>and that there would be a release for it</p> <p>so I think I pro- it probably made you a bit stronger to be able to deal with some things</p> <p>that you found quite difficult</p>
<p>In a similar way to Faye's 'pocket', Dilys used the metaphor of "a big bag"</p>	<p>Dilys:</p>

<p>to explain how supervision acted as a way of storing feelings which she needed to express. However in Dilys' narrative supervision is not only about emotional release, but also about reflection. Her supervisor helped her to reflect on the way she was using supervision and so to examine what she was doing in her working life as a whole. She eventually changed jobs as a result of this reflection.</p>	<p>...I came into the supervision sessions with like a big bag of “I need to tell you all this and we’ve only got a certain amount of time and we need to get through all this” and then go out and thinking “okay I’ve cleared off my shoulders for another week [laugh] “and I’ll come and see her with another bag-full the next week” so it was very much reflecting “I’m taking lots and maybe that’s indicative of em there’s too much going on at the moment”...</p>
<p>The reflexive aspect of supervision described by Dilys contrasts with Olive’s comments from <i>The Moaning Shop</i>. She highlighted the importance of having the opportunity for emotional expression, but did not include a sense that this expression should be reflexive.</p>	<p>Olive: you’re just letting off steam which means you can go back then and get on with the job...</p>

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<p>What happens when there is no opportunity to empty the big bag? Contrasting her counselling and her nursing practice, Emma concluded that in her nursing role she had to adopt a more self-protective attitude toward emotional engagement with her clients.</p>	<p>Emma:</p> <p>...I can't be sitting in the counselling room with a client</p> <p>and [laugh] feeling or being demonstrating that I'm overwhelmed by what a client is saying</p> <p>but I suppose the knowledge that the support is there in the background as it were helps me contain my own feelings about it</p> <p>so that I can be with the client and work with them</p> <p>and my experience in nursing has been that that support in the background either isn't there in the same way or to the same extent or not at all</p>
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6.2.5.1.5 Summary of Susie

Susie has a central theme of the difference between formal and informal, work and personal life. The narratives discussed raise questions as to how these boundaries are negotiated in supervision, and how supervision may involve transgression of these boundaries. *Susie* also examines the experience of work-related emotions, and the role of supervision in supporting emotion work.

Watercooler Conversations makes it clear that the support of practice is multi-factorial, and includes contact with colleagues and access to expert advice, as well as planned supervision sessions. The importance of colleagues and *ad hoc* support comes up repeatedly in participants' accounts, and in *The Moaning Shop* we can see the personal expression which takes place in supervision as both necessary and problematic. The activity of 'moaning' in both the midwife and mental health nurse accounts suggests that this fulfils a need for emotional expression. However the mental health nurses identify this practice as inappropriate in supervision, thus distinguishing an informal, coffee-room discussion from a formal, supervision discussion.

What We Talk About and *The Moaning Shop* suggest that supervision allows the expression of emotions in a different way to other parts of the work sphere, and the mental health nurses express ideas of how this should and should not happen. Boundaries to the expression of emotions in supervision are identified along the lines of the public:private division and the formal:informal division. The conversation in supervision is therefore distinguished both from a private-domain interaction, and from an informal work-domain interaction.

The division between public and private being negotiated here demonstrates a tendency to treat the public:private dichotomy as real, and this does not allow for interaction between the two domains. So, for example, there is a strong sense that the supervisor is distinct from a therapist or friend, and that supervision shouldn't involve the discussion of personal issues but must remain in the work sphere.

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However, the negotiation over the emotional boundaries operating in supervision also reflects the concern that supervision should be an emotionally safe space.

One of the key ways in which supervision is described as different to an informal conversation with colleagues is through the reflexive approach used, and the outcome produced. Outcomes of supervision include the solving of a problem, exposure to new ideas, or the supervisee expressing feelings and undergoing an emotional change from feeling stressed/upset/anxious/angry to reflexive/considering/calm/open. This construction of supervision as creating a change in the supervisee raises the question of to what extent emotions are problematised, rather than simply acknowledged through supervision. However some of the participants' accounts do suggest that supervision can incorporate the acknowledgment and validation of feelings.

The *What We Talk About* narratives show that supervision operates according to the norms and expectations of the participants, even where these are not overtly stated. In Beth and Alice's accounts of the new member of their supervision group, unspoken rules of behaviour are made evident when a new member breaks them. The group is unable to openly deal with this, and instead the group members engage in resistive behaviour such as deliberately annexing time in the discussion to prevent the new member from dominating. Dilys' account of her student supervision group also describes a situation in which the group is unable to reflect on its own operations, creating an emotionally unsafe space.

In *A Pocketful of Feelings* supervision is described as part of the activity of emotion management. Faye, Dilys and Clare describe the way in which emotionally supportive supervision functions as an on-going process which carries on out with the supervision session. Being involved in the on-going supervision relationship, and knowing that there will be the opportunity to express and discuss their feelings in supervision sessions helps them to manage the day to day emotions of practice. This shows supervision as a contextualised process which is embedded in practice. Emma also describes the way in which supervision acts as a background to her practice,

supporting the emotion work she does when with clients. The importance of continuity in supervision suggests a key distinction between this and *ad hoc* support.

6.3 Key Narratives and Composite Stories – Summary

In this chapter the narratives told by the study participants have been analysed in light of the study research questions:

1. How do midwives and mental health nurses experience and understand supervision?
2. How can supervision narratives be understood within different professional contexts?

The findings presented in this chapter address the research questions in three key ways:

1. The participants' narratives show that midwives and mental health nurses experience supervision in a variety of ways.
2. The analysis of the narratives also shows that there are elements of shared experience and shared understandings of supervision.
3. The composite stories illustrate shared experiences and understandings of supervision within and between the professional groups.

In this thesis stories build upon stories in a process of fragmentation and configuration of data. The narratives and narrative fragments from the interviews are configured as key narratives, the key narratives are configured as composite stories, and finally the findings build towards the theoretical story of supervision constructed in this thesis.

The two professional groups in this study can be understood as each telling a 'professional' story of supervision: a midwifery story and a mental health nursing

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story. These two stories each emerge from a distinctive context, but also contain some shared elements. The story of supervision constructed in this thesis responds both to the unique features of each professional context, and to the shared elements in the professional stories of supervision. These shared elements can be understood from the perspective of two overarching themes which have emerged from the key narratives and composite stories. I have called these 'The Profession', and 'Emotions'. These themes are discussed in the next chapter with reference to the midwifery and mental health nursing stories of supervision which emerge from the data.

7 Findings Two: Themes

7.1 Introduction

This chapter discusses two major themes which have emerged through the comparison of the participants' narratives of supervision across two professional contexts:

Theme 1: The Profession

This theme describes the participants' accounts of the interaction between supervision and the experience of being a member of a profession. Supervision is connected to ideas of professional identity and status.

Theme 2: Emotions

This theme describes the participants' accounts of supervision as an emotional process located in the context of the emotional processes occurring within an organisation.

Figure 5. Two Themes

The theme of 'The Profession' is discussed in Section 7.2. This theme is explored in terms of autonomy, being a professional, and a sense of professional identity. The argument is made that supervision operates as a context in which professional identity is formed and enacted.

The theme of 'Emotions' is discussed in Section 7.3. This theme is explored through the construct of feeling rules which are present in the participants' narratives, and which draw on discourses of professional identity and status, the purpose of supervision, and the role of emotions in practice. The argument is made that supervision operates as an emotional ecology situated within the emotional ecology of the organisation, and may be governed by a distinctive set of feeling rules.

7.2 Supervision and the Profession

7.2.1 Supervision and the Profession – The Midwifery Story

The midwife narratives situated supervision in a largely mono-professional context. Supervisors and supervisees were all midwives, and supervision was understood as an integral part of being a professional midwife. For the NHS midwives in particular, the professional identity of ‘midwife’ was experienced as unproblematic, and the relationship between supervision and being a midwife was also described in unproblematic terms.

In the key narrative *We Are Autonomous*, the midwives explained that their role as autonomous practitioners created a need for statutory supervision. Being monitored in this way was “reassuring” (Kate), and protected their “accountability” (Rose) as professionals. ‘Autonomy’ is commonly associated with the ideal of the professional (Macdonald, 1995), and the midwives’ explanation of the relationship between autonomous practice and being supervised constructs supervision as a means of legitimising their professional status. This understanding of supervision reflects a widespread discourse in which supervision is seen as justifying the “special position” of midwifery as a profession (Winship, 1996: 41), and as contributing to a distinctive midwifery identity (Stapleton et al., 1998).

The midwives’ narratives present the concept of the autonomous midwife as a straightforward description of midwifery practice, however a comparison with the mental health nurse narratives suggests that, for the midwives, autonomy has a symbolic value. In this study, the practice of the NHS midwives appeared to have a similar level of autonomy to most of the mental health nurses. Both groups held caseloads and ran clinics, and both groups worked in teams. However the autonomy story was only told by the midwives, and seems to be associated with their sense of professional identity. It may be that the midwives’ group identity (Burke and Stets, 2009) as ‘autonomous’, influences their sense of individual role identity (Burke and

Stets, 2009), providing an interpretive framework which gives value to the quality of autonomy in the midwives' narratives of practice. In contrast the mental health nurses' narratives of practice did not employ the concept of autonomy, suggesting that this quality has less significance in the mental health nurses' construction of professional identity.

The findings of this study challenge the autonomy narrative in two ways: through the independent midwives' accounts of supervision, and through the accounts of how supervision interacts with practice. These challenges are discussed below.

7.2.1.1 Supervision and Autonomy in the Independent Midwives' Narratives

The NHS midwives experienced the relationship between supervision and being a professional as unproblematic. In contrast, the independent midwives' narratives show supervision as paradoxically both defending and threatening their professional identity and status.

The independent midwives had greater contact with the supervision system through more frequent meetings with their supervisors, contact with LSAMOs and supervisors in other areas, and referral for supervisory reviews. Their ability to practice autonomously was supported by their supervisors, who acted as a resource for clinical advice, and as a source of support. Molly described deliberately choosing a supervisor who has some standing within the NHS, in order to legitimise her practice in the eyes of NHS midwives. In this way supervision as a subjectifying power (Butler, 1997) constituted Lynn and Molly as midwives who worked independently of the NHS. By having supervision they could demonstrate their allegiance to a professional code of conduct, and for example, Molly could give clients her supervisor's contact details as a way of reassuring them that she had a degree of institutional backing.

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The independent midwives' participation in supervision supported their claim to a normalised practice (Foucault, 1977), even though this was outside the normalising structure of the NHS. At the same time it also subordinated them through the internalisation of the disciplinary power of supervision. There is a tendency for independent midwifery practitioners to be subject to punitive exercises of power by more conventional health services (Wagner, 1995, Demilew, 1996). Lynn and Molly both referred to this as a risk of independent practice. When compared to the NHS midwives, the independent midwives' accounts of supervision showed a greater awareness of the disciplinary power of supervision, and also described ways in which they were actively responding to this power through activities such as extensive note-taking and networking with statutory services.

In contrast, the NHS midwives' accounts tended to portray the power of supervision as being in theory rather than enacted. The midwives subscribed to the idea that the supervision system was capable of monitoring their practice, but none of the NHS midwives described instances where they had modified their practice in response to the requirements of supervision. Instead the NHS midwives' narratives describe being influenced by elements such as child protection procedures. For example Nina and Jo both described child protection work as stressful partly because it required a different way of working to the usual midwifery role.

Of all the participants in this study, the independent midwives were arguably the most truly autonomous as they practised independently of any organisation. It is striking, therefore, that these autonomous practitioners experienced the power of supervision most overtly. The independent midwives' relationship to the power of supervision was complex and paradoxical, reflecting Butler's (1997) argument that subjectifying power both subordinates and enables. In part they depended upon supervision in order to support their position as independent practitioners, but they also used supervision to achieve their own ends, to protect themselves against the supervision system. This resistance of the disciplinary power of supervision required consent to the structures of power. Collinson (1994) argues that this form of resistance, which involves an acceptance of the structures of power, makes workers more vulnerable to disciplinary practices. The independent midwives can therefore

be seen as in a relationship with the power of supervision in which they submitted to power in order to gain legitimacy and support for an autonomous way of working, and this submission both emancipated them and exposed them to the disciplinary power of supervision, causing them to internalise the norms of power. This picture of the independent midwives' position in relationship to the power of supervision problematises the argument that supervision straightforwardly legitimises autonomous professional status.

7.2.1.2 Supervision and the Capacity for Surveillance

The second way in which this study problematises the autonomy story is through the midwives' accounts of how supervision interacts with practice. The uncritical description of statutory supervision as 'necessary because midwives are autonomous' does not address the *mechanism* by which supervision ensures safe practice. The midwives argued that they were monitored through supervision, but the NHS midwives had little contact with the supervision system. The key narrative of *The Annual Meeting* shows that for the NHS midwives, supervision was generally restricted to a single meeting once a year. This study did not collect data on the duration of the annual meeting, but Mead and Kirby (2006) found that annual meetings could last for as little as three minutes, suggesting the midwife's exposure to supervision through the meeting can be minimal.

In this study the midwives described the annual meeting as focused on bureaucratic activities such as ensuring the midwife's 'Intention to Practise' form had been completed. Although the midwives described the meeting as also including time to talk about practice, this was framed in an informal way, as an 'extra' added to the bureaucratic function. Surveillance (Foucault, 1977) of practice through the annual meeting therefore only occurred in a restricted way, and the meeting did little to expose the midwives' practice to the disciplinary gaze (Foucault, 1977) of the LSA/NMC.

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In *She's There if I Need Her* the midwives described contact outside of the annual meeting as potential rather than an actual. The fact that the midwives experienced this unrealised potential for contact as being supportive, suggests that they had to some extent internalised the supervision system. Their understanding of the supervision system as supporting midwifery practice was translated into a sense of being supported by the possibility of supervision.

This may mean that the NHS midwives had also internalised the disciplinary gaze of the supervision system, but the accounts in this study provide no clear evidence of this. There was little contact with the supervision system outside of the annual meeting; among the NHS midwives, only Olive and Nina described contact with their supervisor outside of the annual meeting, and Nina described this contact as being out with her supervisor's official role. Olive had recently contacted her own supervisor after an incident where she felt bullied by labour ward staff, who wanted her to continue attending a client who had transferred into hospital when Olive had already been on duty for 24 hours. Olive was concerned that a less confident or experienced midwife would not have been able to resist the pressure to remain in attendance, and had contacted her supervisor for support in communicating with labour ward about this problem.

Olive's contact with her supervisor was arguably an organisational issue, and her account illustrates how the midwives' experience of supervision as members of a profession was entangled with their experience of supervision as employees of an organisation. For example, when Sarah made a clinical mistake in taking a blood sample, her supervisor was not contacted, but a member of Sarah's team (who was also a supervisor of midwives) gave advice to Sarah's team leader on how to deal with the situation. In this case the individuals monitoring Sarah's practice had both organisational and supervisory roles, and it is unclear as to whether there was any distinction made between these roles.

This entangling of the organisational and professional contexts occurs in both the NHS and independent midwives' narratives. For the NHS midwives, supervision was part of the context of practice, in which they were both employees and members

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of a profession. Although the independent midwives were not employed by an organisation, the NHS still formed part of the context of practice. They described feeling intensely scrutinised by the NHS, and their relationship with supervision was moulded by their experiences of this. For both the NHS and independent midwives, therefore, the experience of supervision as a professional structure was interconnected to their experience of the organisation.

Stories of contacting the on-call supervisor illustrate this entangling of supervision, the profession and the organisation. Not all of these stories were accounts of personal experience, some were hypothetical and so illustrate the midwives' understanding of supervision, rather than their practical experience. For example, the midwives described contacting the on-call supervisor for support with clinical matters, such as a home birth client who refuses to accept her midwife's advice that she should transfer into hospital. In this case the supervisor has a mediating role between client and midwife, and also functions as a witness to the situation. By witnessing the midwife's actions and decision making, the supervisor becomes a source of support for the midwife in the event that something goes wrong with the birth. In this instance the capacity for supervision to function as a form of surveillance is enacted, and is experienced positively by the midwives. The monitoring of practice by the supervisor protects the midwife's professional status, which may be threatened by her client's non-cooperation.

The midwives also described contacting the on-call supervisor about organisational issues such as when the local hospital asked Jo to do a home visit at 2am in order to give an injection. She considered this unreasonable, and the on-call supervisor supported her position. In this case supervision functioned as a means of mediating between different branches of the maternity service, rather than monitoring the midwife's practice. Jo also described labour ward staff contacting the on-call supervisor about staffing problems.

The use of the professional supervision system to deal with organisational matters shows how profession and organisation combine in the midwives' accounts as the context of supervision. If supervision is understood as a way to monitor practice, the

motivations and mechanisms of this surveillance are entrenched in both the professional and organisational context.

7.2.1.3 Summary

In this section, the NHS midwives' accounts of supervision as legitimising professional status and identity have been explored in light of the mental health nurse and independent midwife narratives of supervision. This comparison exposes the importance of the concept of autonomy in the NHS midwives' accounts, and this can be connected to the association of autonomy with professional status. The NHS midwives' narratives express professional identity as unproblematic. The relationship between supervision and autonomy is presented as a straightforward account of practice. The independent midwives' narratives problematise this connection, showing supervision as paradoxically supporting and threatening an autonomous form of practice.

The connection between supervision and autonomy is further problematised through the NHS midwives' accounts of minimal contact with the supervision system. These challenge the belief that supervision can function as a form of surveillance, since the midwives had little active exposure to supervision. However, the symbolic importance of supervision as legitimising professional identity and providing support may suggest an internalisation of the values of supervision. The midwives' interaction with the supervision system is further problematised through narratives describing the enactment of supervision in a context in which the profession and the organisation are entangled.

7.2.2 Supervision and the Profession – The Mental Health Nursing Story

In contrast to the midwife narratives, the mental health nurse narratives located supervision in a multi-disciplinary context. The mental health nurses did not make a conceptual association between the professional identity of nurses and supervision. However there was a practical association with professional identity and status as all of the nurses had experienced supervision with supervisors/supervisees from other disciplines. The mental health nurses' narratives suggest that this association between supervision and other disciplines could have both positive and negative effects on the nurses' experience of supervision, and their sense of professional identity.

Sometimes, as in Ian's description of his therapy supervision group, being in supervision with members of a higher status profession (psychiatrists or psychologists) could be anxiety provoking, triggering a sense of inferiority in the nurses (described in the narratives of *An In-Built Inferiority Complex*). At other times, as in Beth's description of her CAT supervision group, having supervision with higher status disciplines could provide the opportunity to challenge a sense of inferiority. Supervision could therefore both undermine and enhance a sense of professional status.

Having supervision with other disciplines, or within other disciplinary frameworks also influenced the mental health nurses' sense of professional identity, creating a blurred, or plural identity. In contrast to the straightforward sense of professional identity expressed in the midwife narratives, the mental health nurse narratives expressed an more ephemeral sense of identity, in which a nursing identity combined with allegiance to other disciplines. For example, in *My Default Setting* the nurses explained how non-nursing models of practice could become a guiding philosophy, influencing the enactment of the mental health nurse role. Supervision could also support an identity as therapist, for example as a requirement of accreditation with the British Association of Counselling and Psychotherapy. In this way supervision

strengthened an alternative, non-nursing professional identity. This operated externally as a requirement of certain forms of accreditation, and internally as influencing the way in which the nurses thought about their practice.

7.2.2.1 Being Professional

In the mental health nurse narratives there is a clear connection between supervision and practising as a therapist, but the connection to a professional *nursing* identity is less tangible. When considering this aspect of the narratives it may be helpful to distinguish the experience of being a professional from the experience of a specific professional identity. The nurses' narratives suggest that an increased sense of autonomy and status (qualities associated with being professional), was not necessarily associated with a stronger sense of identity as a mental health nurse.

The mental health nurse identity was blurred through the nurses' engagement with areas of work which have historically belonged to other disciplines. At times this could be a source of conflict between the disciplines: Clare described the nurses in her team feeling like "*junior psychologists*". Despite these conflicts the nurses described a strong sense of personal allegiance to the models used in various forms of therapy, and these were often contrasted with the less satisfactory medical model. The history of mental health nursing (see Chapter 2) shows that the discipline was initially defined by the medical profession, and then co-opted into the professional project of general nursing. The social closure (Witz, 1992) of mental health nursing has therefore been under the control of more powerful groups, most notably psychiatry (Nolan, 1993). Using Witz's (1992) model, the nurses' association with therapy and psychological roles can be understood as a colonisation of psychological and psychotherapeutic work. The nurses' colonisation of these roles pushes at the boundary between nursing and higher status professions, and also acts as a source of resistance to the demarcationary strategy (Witz, 1992) historically used by medicine to exercise control over nursing. In this study colonisation of therapy and

psychological roles enabled the nurses to select a model of care which they found more appealing, rather than the de facto model used by psychiatry.

To summarise, the experience of nursing identity expressed in the narratives is distinguished from the experience of being professional. The sense of commitment and satisfaction which the nurses described in relation to their therapy work seems to have incorporated a sense of being *more professional*. Therapy work was higher status, autonomous, and associated with disciplines who have a clearer remit of practice than that of mental health nursing, whose specialism is subject to debate (Stickley et al., 2009). At the same time, the nurses continued to be defined (and remunerated) according to their professional identity as mental health nurses. They were ultimately excluded from membership of the higher status or more rewarding professions.

7.2.2.2 Being a Mental Health Nurse

The nurses' narratives expressed an identification with non-nursing disciplines, but also included discussion of what it meant to be a mental health nurse. For some, plural disciplinary allegiances could reinforce a sense of nursing identity, while for others the lack of opportunity for role-modelling by nurses was troubling. Supervision operated as a setting within which this verification or blurring of identity occurred.

The story of the CPN supervision group told by Alice, Beth and Clare, illustrates the role which supervision played in the problem of identity verification (Burke and Stets, 2009) in a multi-disciplinary context. The CPNs were part of a new team in which the nurses were working with psychologists and taking on therapist roles. Clare described the conflict which this caused, and the negotiations over the relative status of the different disciplines. Clare told two stories to illustrate this conflict, concerning a client with a vomit phobia, and a client with an excrement phobia. In both of these stories Clare described the team psychologists as assuming these

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clients' problems were the remit of the nurses, because of the association with the body. For Clare, this symbolised a tendency for the nurses to be assigned lower status work.

For the CPNs, supervision functioned as a way for the nurses in the team to come together and talk about the unique qualities of nursing. The group was facilitated by Supervisor A, who was a psychotherapist (although Clare and Alice both told me they thought that Supervisor A had originally been a nurse). Supervisor A introduced the CPNs to the concept of mental health nursing as being about "*human responses*" (Alice). In this way the group verified a nursing identity through discussion of unique nursing qualities. Despite the fact that the group's supervisor did not identify him/herself as a nurse, s/he was able to facilitate the verification of a nursing identity.

In the literature there is little attention paid to the effect of the supervisor on the sense of professional identity constructed through supervision, although Arvidsson et al. (2001: 184) found that during group supervision with a nurse-supervisor, participants developed more "*nurse-orientated thinking*". The findings of this study suggest that the interplay between supervision and a nursing identity is a highly complex process, and a specifically nursing identity can be verified or undermined through participation in supervision.

7.2.2.3 The Confessional

The previous two sections have explored the nurses' experiences of supervision as enhancing a sense of being professional, and both blurring and enhancing a mental health nursing identity. In this section I explore this paradoxical effect on identity using the concept of supervision as a form of confessional (Foucault, 1976).

For the mental health nurses, the subjectifying power of supervision was the power of the confessional, in which the nurse exposed the inner world of his/her practice.

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Supervision meetings typically lasted for around an hour, at least once a month, and some supervision relationships were sustained over several years. The mental health nurses therefore had much more direct exposure to the subjectifying power of supervision than the midwives. This level of exposure may explain the power of supervision to constitute the nurses as therapists, thereby blurring their nursing identity.

In many instances supervision seemed to be experienced as an enabling power which supported the nurses and taught new skills such as therapeutic skills, decision making abilities, and emotion management skills. The key narratives of *A Pocketful of Feelings* show how supervision could promote practitioners' autonomy, enabling them to manage their feelings outside of the supervision session. As a 'confessional', supervision exposes the practitioner's inner management of emotions to the disciplinary gaze of the supervisor, but this process resembled Simons' (1996) mother and child relationship, rather than Foucault's (1976) confessee and judge. The practitioners felt nurtured by the experience of supervision, and being made subject to the process of supervision made them feel stronger and more confident outside of supervision.

The mental health nurse narratives also included some experiences of supervision as an oppressive power. The confessional nature of supervision puts the practitioner at risk of an uncomfortable degree of personal exposure, and Gina, Dilys and Faye all had experiences of supervision relationships which felt overly critical, or hierarchical, or emotionally unsafe. Buus et al. (2010) have also observed that in group supervision the requirement to 'confess' one's practice can lead to distressing professional and emotional exposure.

Subjectification produces resistance (Butler, 1997, Knights and Vurdubakis, 1994), and Gina, Dilys and Faye each described engaging in resistance towards uncomfortable supervision. Gina and her fellow group members were able to reform their group, excluding the troublesome member. Dilys and Faye's narratives show them as in a more powerless position. They both had supervision imposed upon them, and although this was an uncomfortable experience they could not refuse

outright to participate. Instead, they engaged in partial participation as a self-protective strategy. Dilys described concealing her true feelings in the student supervision group, and Faye described setting boundaries for her caseload supervision, keeping it focused on pragmatic issues. Each of these instances of resistance to supervision were about emotional safety, and resisting the exercise of power over the practitioner's emotions. This illustrates the importance of emotional processes in the operation of supervision (these are explored in Section 7.3).

Gina, Dilys and Faye's acts of resistance show that even where supervision makes the inner world of the practitioner visible, practitioners cannot be forced to fully participate in the process. The constitution of professional identity through supervision therefore depends upon the practitioner re-stating the discourses of professional identity, and may be resisted. In this study there were few examples of resistance towards the constitution of identity through supervision, although this was not always a comfortable experience. Nevertheless, despite a sense of pride in the nursing identity, other disciplinary identities were embraced.

7.2.3 Supervision and the Profession – Summary

The midwifery and mental health nursing stories of supervision show that in both professional contexts supervision incorporates a complex and sometimes contradictory nexus of factors: power and resistance to power; identity-verification and identity-destabilisation; and issues of status. Issues of identity and status are experienced differently within the different professional contexts. The midwifery supervision story is characterised by the strength of a single professional identity, while in the more ephemeral mental health nursing supervision story, a plurality of identities was experienced as both positive and troubling.

To summarise, the following key understandings have emerged from the theme of 'The Profession':

- The symbolic importance of autonomy as a characteristic of professional status.
- The entanglement of the organisational and professional contexts.
- The distinction between being professional and a specific professional identity.
- The operation of supervision as a form of confession in which the supervisee is exposed to discursive constitution as a practitioner within different disciplinary frameworks.

These understandings illuminate the interplay between supervision and the professional context, and this will be discussed further in Chapter 8.

7.3 Supervision and Emotions

In this section the findings are discussed in light of the theme of 'Emotions'. This theme has emerged from participants' descriptions of supervision as an emotional process which is situated in the emotional context of practice.

The composite stories and key narratives discussed in Chapter 6 illustrate a variety of emotional processes which are connected to supervision. These included positive stories of supervision as a resource which allowed practitioners to contain and manage the emotions elicited by work. There were negatively charged stories about supervision as an exercise in scapegoating, or supervision as emotionally unsafe. The narratives also show that supervision could be an emotionally negligible experience, perhaps offering an opportunity for informal talk about work problems, but with no deliberate aim. Supervision could also be a frustrating experience through which support was promised but not delivered.

This study aims to identify shared aspects of supervision experiences from individual narratives. Having recognised the importance of emotions in the supervision narratives, and building on a theoretical understanding of emotions as socially constructed, I then looked for the shared emotional norms expressed in the participants' accounts. In order to explore this question I turned to Hochschild's

(1983) construct of feeling rules as a means of examining the socio-cultural aspects of individual emotional experiences. The discussion is also informed by Bolton's (2005) typology of four different kinds of feeling rules. I was unable to identify any other examples of nursing or midwifery research which look at feeling rules in supervision.

In this section the discussion builds upon analysis presented in the previous chapter in order to identify the feeling rules being expressed through the narratives. The discussion of feeling rules in supervision draws primarily on narratives told by the mental health nurses. This reflects the fact that the mental health nurses said a lot more about emotional processes in supervision. In the midwife narratives the feeling rules describe how supervision fits into midwifery practice, providing an emotional context for the experience of statutory supervision.

7.3.1 Feeling Rules in the Key Narratives

Of the four composite stories presented in the previous chapter, *Susie* most fully illustrates the discussion of emotions and supervision. In the key narratives which make up *Susie*, I identified three feeling rules operating in the mental health nurses' accounts of emotional processes in supervision: 'staying professional', 'safety and reflexivity', and 'changing feelings'.

Feeling rules are also present in the key narratives from the other composite stories. In *Gillian*, the key narratives of *Being Stoical*, and *An In-Built Inferiority Complex* illustrate two feeling rules which form part of the emotion culture in which supervision occurs: a rule of stoicism and emotional self-control, and a rule of inferiority. In *Grace*, there is a feeling rule which might be called 'beneficial surveillance'.

Broadly, then, the feeling rules in the mental health nurse narratives describe emotional processes in supervision, and the interaction between emotion work and

supervision, as well as the emotional context within which supervision is done. In contrast, the feeling rules in the midwife narratives describe the emotional significance of supervision in the context of being a midwife. The feeling rules are each discussed in turn below.

7.3.1.1 Midwifery Supervision

7.3.1.1.1 The 'Beneficial Surveillance' Rule

A surprising finding from this study was the midwives' willingness to being subject to surveillance. This attitude suggests the beneficial surveillance feeling rule.

Midwifery supervision focuses more on monitoring and ensuring disciplinary control than the supervision experienced by the mental health nurses in this study. These aspects of supervision are problematised in the midwifery literature, but the midwives in this study expressed a degree of willing cooperation with the surveillance of their practice. So, for example, Sarah chose a supervisor who would be challenging and critical of her practice as well as supportive.

One of the ways in which the midwives spoke about supervision as beneficial, was as a way of ensuring the accountability of the individual to the organisation. Supervision was located in terms of the group need, and midwives seemed to accept that it was good for their profession as a whole that they as individual practitioners should be monitored. The beneficial surveillance rule therefore seems to express a strong institutional orientation (Gordon, 1989).

This group benefit of supervision was connected to midwives' professional status as autonomous practitioners. It is interesting that on this point none of the midwives made a comparison with other professions, such as medicine, who are also regarded as autonomous, and yet who do not engage in a system of statutory supervision. In this respect the beneficial surveillance feeling rule seems to be largely unchallenged,

in that the midwives did not express resentment or resistance over having their practice monitored. This might be further understood in the light of a widespread commitment in midwifery to the idea of statutory supervision, and to its importance as protection for the public (Henshaw et al., 2013).

The midwives' emotional concordance with the beneficial surveillance rule means that there is little sense of 'wrongness' around it, and the presence of the feeling rule in the midwives' accounts is subtle. The rule was highlighted more in Lynn and Molly's accounts, when they talked about the experience of being monitored as outsiders to the dominant system. In particular Lynn described feeling under surveillance from the statutory services, and this kind of surveillance was described as a more negative experience than surveillance through supervision.

Lynn and Molly's accounts of being referred for supervisory review suggest that practitioners in the statutory services experience a need to monitor practice, even where to do so oversteps the boundaries of their role. This reflects the experiences of other independent midwives described by Demilew (1996), who found that the supervisors of independent midwives seemed to have a need to control the midwife, resulting in heavy handed and punitive supervision. The beneficial surveillance feeling rule might help to explain this 'need to monitor'. The presence of this feeling rule in statutory services creates the strong sense that practiced must be monitored. Practice which seems to be less closely monitored therefore breaks the feeling rule, creating a sense of insecurity and 'wrongness'. In response to this there is a heavy-handed monitoring of practice through inappropriate use of the supervision system.

The beneficial surveillance rule shows that the subjectification (Butler 1997) of the practitioner has been largely successful. The midwives evinced little resistance towards being subject to the disciplinary power of statutory supervision, suggesting that the priorities of the state, the profession, and the institution have been internalised into an emotional state of needing to be watched. This suggests an underlying feeling of insecurity about practice which is hinted at in some of the NHS midwives' accounts, and is most evident in Lynn and Molly's accounts.

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As outsiders to the statutory system, Lynn and Molly experienced this sense of insecurity acutely. In light of the vulnerable position of independent midwives, they practised with a conscious awareness of the need to justify their clinical activities, and the ever-present possibility that their practice would be scrutinised by a hostile other. So, for example, Molly kept exceptionally detailed case notes. In this context supervision was a source of reassurance and security. Supervision allowed them to re-establish some control through their active participation in their own surveillance. In doing this they internalised the disciplinary gaze. Arguably they are the two participants in whom the disciplinary gaze (Foucault, 1977) was most successful, because they were most actively involved with surveillance of their practice through supervision. Nevertheless, their position as independent midwives remained a source of resistance to the normalisation of midwives as ‘practitioners who work within statutory services’.

A study by Cooper (2011) suggests a further possible understanding of the midwives’ willingness to be monitored through supervision. Cooper’s (2011: 137) low income participants worked on their emotions “to feel fine with less”, and avoid anxiety about material deprivation. Cooper (2011) argues that the feeling of resignation which this produced mitigated against the individuals concerned taking a critical approach to social injustice or inequalities.

Transferring this to midwives, it might be argued that by producing within themselves a feeling of ‘needing to be monitored’, the experience of being monitored becomes emotionally consonant and the practitioner can thereby avoid the kind of anxiety which, for example, the independent midwives experience. Cooper (2011: 144) references Hochschild’s (2003) argument that “*power doesn’t work around feeling, works through feelings, typically raising the expectations of the more powerful and lowering the expectations of the least powerful*”. Cooper (2011: 144) argues that the coping mechanisms she has identified not only show inequality but also “*as cultural logics they begin to drive inequality*”. The emotion work individuals do to make themselves feel all right about an unjust situation “*becomes a legitimizing force by providing an emotional rationale for an unequal situation*”, and

“systems of stratification make their way inside us, deep inside, shaping the way we feel, try to feel, and try not to feel” (Cooper 2011: 144-145).

In this study the beneficial surveillance rule is unique to the midwife accounts. Elsewhere, Clouder and Sellars (2004) have found a similar willingness to be monitored in occupational therapy students and physiotherapists. This rule may therefore be present in other disciplines. The fact that in this study it is present in the midwife accounts, and not the mental health nurse accounts, suggests that ‘monitoring of practice’ is an important way in which the midwives make sense of supervision, but this is not so important for mental health nurses. The findings of this study therefore illustrate an interaction between feeling rules and professional identity. In Section 7.2 I explored the ways in which the findings show the midwives’ sense of identity as explained and justified by supervision. In this section, the beneficial surveillance rule shows how discourses relating to professional identity construct practitioners’ emotional interaction with supervision.

7.3.1.2 The Emotional Context

This section discusses feeling rules which operate in the context in which supervision occurs. Two feeling rules emerge from the key narratives which describe aspects of the emotional context in which supervision occurs. The first rule, ‘inferiority’ was only evident in the mental health nurse accounts. The second rule, ‘stoicism’ was openly discussed by the mental health nurses, but could also be detected in some of the midwife accounts.

7.3.1.2.1 The ‘Inferiority’ Rule

The mental health nurses described feeling easily undermined in the presence of members of other disciplines, notably medicine and psychology. There seemed to be

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a rule which told nurses that they should feel inferior. This rule became evident through the conflict with other feelings of being skilled, experienced and not inferior.

For example, in the key narrative *An In-Built Inferiority Complex*, both Iain and Clare explained that when in supervision groups with practitioners from higher status disciplines they could feel anxious and insecure. They experienced these feelings as not fitting with their more usual concept of themselves as confident, skilled practitioners, and they both connected these feelings to a more general nursing culture of inferiority. To some extent this locates the source of the feelings with an external emotion culture. At the same time the feelings were obviously experienced as powerful, suggesting that although Iain and Clare both challenged the inferiority feeling rule it was also internalised.

The inferiority rule seems to be a 'professional' feeling rule (Bolton, 2005), which is assimilated as part of socialisation into a profession. This rule is latent, mental health nurses are not officially told to regard themselves as inferior. The rule might be connected to the historical development of mental health nursing as subordinate to psychiatry, and to an on-going insecurity of disciplinary identity and role in contemporary mental health nursing (Barker and Buchanan-Barker, 2011).

Examining this rule through the lens of Butler's (1997) perspective on subjectification, the mental health nurses can be seen as subjected to the power of a professional discourse which tells them that they are inferior. When they come into contact with certain other disciplines this discourse is translated into a feeling rule which produces a conflict of emotions. On the one hand they 'should' feel inferior, while on the other hand they do not consider themselves as inferior. The rule which tells them to feel inferior is the expression of a subjectifying discourse. It is closely connected to their subject-identity as mental health nurses. However, while the nurses embody the inferior subject position in relation to other professionals they also experience feelings of resentment and self-defence. The nurses question their subject position: Am I really inferior? Why do I have these feelings?

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Sometimes workplace experiences might offer the opportunity to resist the inferiority rule. For example, Beth explains that working with psychologists in her supervision group helped her to re-evaluate her position as a nurse practicing as a therapist, restructuring herself as *not* inferior.

In Section 7.2.2 the mental health nurse identity was characterised as ephemeral, and related to the nurses' identification with other, higher status disciplinary identities. The inferiority rule highlights some of the context within which such negotiations of identity occur. Section 7.2.2 showed that contact with other disciplinary identities could be experienced as positive, enhancing the nurses' sense of being professional. However, the nurses' narratives also described instances of conflict between the different mental health disciplines, and Brown et al. (2000) observe the tension and identity-threats which can accompany interdisciplinary working. For the mental health nurses in this study, supervision experiences could also challenge the inferiority rule. Working closely with members of higher status disciplines could cause nurses to rethink ideas about the superiority of psychologists or psychiatrists, and serve to validate the nurse's knowledge. This challenging of the Inferiority rule through supervision hints at the way in which the supervision interaction can be transgressive; involving the crossing of existing boundaries and the re-structuring of rules of interaction.

As discussed in Chapter 2, mental health nursing is increasingly allied to therapeutic and psychological models of practice (Hurley et al., 2006, Caie, 2011), and most of the mental health nurses in this study were supervised by members of these disciplines. In light of these trends, it is striking that in the supervision literature there is little discussion of the consequences of being supervised by a practitioner from a higher status discipline. Instead, in both the nursing and midwifery literatures, issues of status are discussed in terms of supervision by managers (cf. Kelly et al., 2001a, Teasdale et al., 2001, Cutcliffe and Hyrkäs, 2006, Shennan, 1996, Stapleton et al., 2000). In this thesis, my discussion of the inferiority rule engenders the argument that scholars must give more consideration to the consequences of multi-disciplinary supervision.

7.3.1.2.2 The 'Stoicism' Rule

7.3.1.2.2.1 Stoical Mental Health Nurses

The 'stoicism' feeling rule requires that practitioners accommodate difficult emotional experiences while maintaining a display of emotional control. The emotional experiences covered by this rule seem to involve more negative forms of emotion such as sadness or fear. The stoicism rule is directly articulated by some of the mental health nurses who discuss a 'macho' nursing culture which creates the expectation that nurses will cope. The existence of the rule is highlighted in cases where the participants were not stoical and had to engage in emotion work in order to conform to the rule (or create the appearance of conformity).

The mental health nurses discussed the stoicism rule from different perspectives. For example, Dilys described a particular, high pressure environment in which this rule flourished, and in which it was internal and self-protective. As a student nurse she and her colleagues wanted to seem stoical in order to justify their role as nurses.

This need to be self-protective through stoicism might be compared to Gonge and Buus' (2010) finding that those staff who worked under the most pressure were the least likely to participate in supervision, and to Buus et al.'s (2010) observations of how exposing supervision could be for practitioners. Kirkham (2007) observed that a high-pressure working environment created a culture of needing to be seen to cope, something she argued was a defence mechanism (if a maladaptive one). The stoicism rule has a similar effect, protecting practitioners by producing a display of coping, but ultimately making it difficult for them to work through emotions (Deery 2005).

As well as internal and protective, the stoicism rule may also be external, an example of the kind of organisationally structured restriction of acceptable emotions which is described by Gibson (1997). Gina discussed the stoicism rule as part of a culture where it is unacceptable to 'not cope'. As an 'organisational' feeling rule (Bolton,

2005), the stoicism rule helps to structure the organisation of care by creating practitioners who are able to cope with any emotional demand, and do not require support to manage their emotions. The stoicism rule can therefore be seen as both protecting the individual practitioner and disciplining the practitioner according to the requirements of the organisation.

Turning to Butler (1997) the stoicism rule can be understood as a means of subjectification, creating an emotionally controlled, self-sufficient subject as practitioner. As with the inferiority rule, however, there is evidence of a continuous challenge to the requirement to be stoical. This is best illustrated in the key narratives of *Watercooler Conversations*, and *The Moaning Shop*. Both midwives and mental health nurses talked about 'moaning', particularly in supervision, and also discussed the importance of *ad hoc* informal support. In this way it can be seen that the emotional experience of the practitioner, and the need for emotional expression, continuously fracture the process of reconstituting the practitioner-subject as stoical. Nevertheless the power of the stoicism rule can be seen in examples of practitioners excluding emotions from the work domain, and the way that participants feel uncomfortable about 'moaning'.

The stoicism rule shows the constitution of the practitioner according to the requirements of the organisation, but it may also be described as a professional feeling rule. Some of the participants connected stoicism specifically to a nursing culture, and to the value which is given to the wellbeing of nurses. In their study on team supervision, Hyrkäs et al. (2002) also identified a stoical culture in which personal emotionality was excluded and regarded as weakness. The supervisors in this study found that nurses attended supervision without having fulfilled basic personal needs such as having lunch (Hyrkäs et al., 2002). In this study supervision became an opportunity to encourage nurses to think more about the connection between their own needs and their ability to work effectively, thus challenging stoicism.

Debates on supervision in nursing do give value to the wellbeing of nurses (even if only as a means to a clinical end), however the accounts in this study suggest that

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even where there is some official acknowledgment of nurses' emotional fallibility, such as through supervision, this may be undermined by an emotion culture which castigates emotional neediness. Yegdich (1999a) has described how supervision in the USA moved from a focus on maintaining practitioners to improving outcomes. This downgrading of the significance of nurses' wellbeing is reflected in White et al.'s (1998: 191) comment that supervision research must show a causal link to patient outcomes because NHS executives are unlikely to invest in supervision on the grounds that "a happy nurse is a happy patient".

7.3.1.2.2 Stoical Midwives

Kirkham (2007) has identified a culture of coping and self-sacrifice in midwifery which exists alongside enormous emotional pressures. In this study, the stoicism feeling rule is most clearly articulated in the mental health nurse narratives, but its effects can also be traced in the midwives' accounts.

In the key narratives *She's There if I Need Her*, and *The Annual Meeting*, the midwives described a working culture in which support through supervision is offered but not realised. In contrast, *A Dream of Support* and *Individual Narratives of Supervision and Support* challenge the rule of stoicism. In these key narratives, midwives recounted how they had actively sought support for themselves, and considered how they might like to be supported with their practice. These narratives express a personal emotional need for support which contradicts an organisational/professional leaning towards stoicism.

In the midwifery literature, and in current midwifery supervision policy, support for midwives through supervision is promoted as an ideal (Stapleton et al., 1998, Nursing and Midwifery Council and Local Supervising Authorities, 2008). In practice however, Hunter (2009) has observed that statutory supervision does not provide any support for midwives. In this study informal sources of support were more important than statutory supervision, reflecting Hunter's (2009) findings.

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Collegial relations in midwifery can also be actively deleterious. Kirkham (Kirkham, 1999, Kirkham, 2007) has argued that there tends to be a lack of mutual support and a bullying culture among midwives. While this study uncovered evidence of bullying among the midwives, the midwives' accounts also identify colleagues as their main source of support; with support through supervision taking the form of an unofficial 'moaning session'.

When examined through the lens of the stoicism rule, support seems to sit uneasily in the midwives' accounts. Unlike the mental health nurses, who critiqued a culture of stoicism, and discussed the need for emotional support, the midwives' accounts express and describe a need for support in a less critical way. They did not seem to experience the same 'pinch' (Hochschild, 1983) around the stoicism rule as the mental health nurses.

Deery (2005), having unsuccessfully tried to implement clinical supervision with a group of midwives, concluded that two factors inhibited participation in supportive supervision: First, the midwives lacked awareness about the emotional impact of their work; and second, the midwives lacked basic resources such as time. These findings are very much reflected in this study. The midwives described being under intense pressure at work, so that activities such as regular meetings for reflection on practice could not be accommodated. The midwives also showed less consciousness (compared to the mental health nurses) about the emotional processes of their work, despite the fact that when prompted in interview, they described emotional aspects of their work such as child protection and dealing with death.

This study shows the stoicism rule as being present among both the mental health nurses and the midwives. However while the mental health nurses challenged the rule, the midwives did not. The contrast which this thesis provides between the two disciplines serves to illuminate the strength of the stoicism rule in midwifery culture (and this is supported by the literature). Dilys' story of the student supervision group illustrates possible consequences of conducting supervision in a stoical culture, and this thesis highlights the fact that implementation of an emotionally supportive

supervision practice in midwifery would constitute a transgression of the stoicism rule, inhibiting this kind of practice.

7.3.1.2.3 Social Feeling Rules in Informal Support

The inferiority rule and the stoicism rule described in the previous two sections can be identified as professional and organisational feeling rules. However the emotional context of practice was also characterised by the use of informal means of support, which seems to have been governed by ‘social feeling rules’ (Bolton, 2005). Informal supportive interactions might occur at work, but narratives of these interactions refer to elements more associated with the emotional gift exchange of private-life (Hochschild, 1983). For example, in Faye’s team “*you could cry*”, Kate described her team as providing mutual support for one another through nights out and sharing cake and coffee, while in her story of the student supervision group, Dilys described how the stoicism rule was subverted during informal conversations in the coffee shop. These conversations are described in terms of more intense, spontaneous emotions, and seem to have been experienced as more personally authentic than the supervision group conversations. In this way the accounts of informal support suggest the ‘mixing and matching’ of feeling rules which Bolton (2005) describes, with practitioners able to select a different set of feeling rules for informal interactions. As Bolton (2005) argues, the organisational/professional feeling rules are not total, and practitioners are able to move between different sets of feeling rules and create spaces within the work environment in which organisational feeling rules are ignored or subverted.

The importance of informal support is also highlighted in a study by Teasdale et al. (2001) in which the authors found that nurses used informal support networks alongside formal supervision, and that when critical incidents produced intense emotional reactions in nurses, they often sought immediate, informal support from colleagues, rather than waiting to see a clinical supervisor. This emphasises the need

to understand supervision as occurring in a context. The contrast between the stoicism and inferiority rules, and the more informal interactions described in this study highlights the complexity of the emotional context in which supervision occurs, showing the practitioner as responding to various, and sometimes conflicting feeling rules. This study therefore supports an understanding of the practitioner as engaging with supervision from a position of emotional complexity in which s/he is subject to powerful emotional norms, but is also able to challenge these.

7.3.1.2.4 An Organisational Emotional Ecology

The metaphor of an ‘emotional ecology’ (Frost et al., 2000), provides a way of picturing the complex emotional context in which supervision occurs. The ecology enables a bringing together of the various feeling rules identified, showing the interplay between these rules and the practitioner in conjunction with other factors such as the power of the organisation.

Frost et al. (2000) argue that organisational ecologies promote or inhibit certain kinds of emotional interactions. In the key narrative *Despondency, Fear and Blame*, both mental health nurses and midwives described an emotional ecology which was dominated by the threat of anxiety. This recalls Menzies’ (1960: 100) observation of “*unmanageable anxiety*” in the health service of the 1950s, and similar, later observations by Evans (2006) and Kirkham (1999). Considering the organisation described in the narratives as an anxious emotional ecology enables an understanding of how the feeling rules identified in the participants’ narratives form part of an anxious context.

For example, the stoicism rule requires the putting up of emotional barriers in order to exhibit emotional control. In an anxious emotional ecology, this may be self-protective in that it safeguards practitioners’ status as ‘being able to cope’, and distances practitioners from overwhelming emotions. However it also poses a risk to practitioners, who must disavow feelings of distress, creating the possibility of

emotional estrangement from the work-self (Hochschild, 1983). Furthermore, it requires a delicate balancing between the ideal of the emotionally warm and compassionate practitioner, and that of the emotionally controlled practitioner. This raises an interesting question as to how the practitioner who has an institutional emotional orientation (Gordon, 1989) is able to reconcile these opposing demands and maintain a sense of authenticity at work.

Having pictured the feeling rules as operating within an anxious emotional ecology, the next section goes on to consider how supervision may function within the organisational emotional ecology.

7.3.1.3 Emotionally Supportive Supervision: A Different Emotional Ecology

The mental health nurse narratives describe both an anxious organisational ecology, and the experience of emotionally supportive clinical supervision. This section explores how supervision can be constructed as an emotionally supportive practice within the context of an anxious organisational ecology. The feeling rules operating in emotionally supportive supervision are identified, and the interaction between these and the emotional ecology of the organisation is discussed.

7.3.1.3.1 A Separate Emotional Ecology

Emotional support through supervision entailed a negotiation of boundaries and rules. So, for example, the mental health nurses found that supervision could challenge the inferiority rule, re-working traditional interdisciplinary relationships. Emotionally supportive supervision also challenges the stoicism rule, in that it gives value to the nurse's emotional experience, and acknowledges his/her need for support. The practitioner's emotional processes may be refigured from a weakness

to be suppressed, to a therapeutic tool to be used consciously and critically (Hawkins and Shohet, 2012).

The emotional ecology of supervision may therefore be actively constructed as different to the organisational ecology. This activity of construction can be seen in the mental health nurses' interest in determining how clinical supervision should operate, what rules should be followed and what boundaries should be observed. This was despite the fact that their supervision practices did not generally involve an overt discussion of ground-rules with the other participants. Rules and boundaries seemed to be implicit, and yet when the participants thought more deeply about this, it was evident that the rules and boundaries of supervision were not the same as in the external, organisational ecology.

7.3.1.3.2 The 'Staying Professional' Rule

When elucidating the characteristics of supervision, the mental health nurses argued that it was important that supervision should not be about 'moaning' or 'chatting', it should not be about the practitioner's personal problems, and it should have some kind of outcome for practice. I suggest that in these characteristics there is an overall commitment towards 'staying professional': meaning that the supervision should accommodate 'professional' feelings not 'personal' feelings. This is a subtle distinction, and might be compared to the stoicism feeling rule in that it is based on the exclusion of certain feelings from the work domain. However, where the stoicism rule may be a defensive response to an emotionally threatening environment or a means of constructing 'docile' (Foucault, 1977) practitioners, the staying professional rule seems to construct a situation in which emotional expression is both enabled and contained.

The staying professional rule seems to be motivated by an institutional orientation, as it values emotional expression in the service of professional norms over spontaneous emotional expression (Gordon, 1989). This supports an understanding of supervision

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as a process of subjectification into the position of professional practitioner. So Faye explained that while personal feelings are significant, their discussion in supervision has to be kept within professional boundaries, while for Clare the supervision interaction required a clear awareness of role, and the boundary between professional and personal, private-life roles.

I suggest that the staying professional rule is a response to the transgressive quality of supervision. Emotionally supportive supervision forms a different emotional ecology to the wider work-place ecology. Emotional expression of a kind which is excluded from the wider ecology is permitted in the supervision ecology. Existing boundaries are blurred, and the practitioner must determine how to distinguish, for example, having counselling from having supervision.

This distinction between therapy and supervision has been extensively discussed by Yegdich (1999b). In papers by Jones (1998) and Chambers and Long (1995b), the personal feelings of the supervisee (such as relationships with family, fear of death) inform, or are informed by supervision. In contrast, Yegdich (1999b: 1267) argues that “*it is the professional self that is refined in supervision, not the personal self*”, and “*supervisees need to feel a freedom from being ‘therapized’*” (Yegdich, 1999b: 1273).

Analysing the concept of an emotionally supportive interaction, Yegdich (1999b: 1269) notes that ‘support’ aims to “*bolster the person’s level of functioning, rather than to focus on change*”. However an analysis of three case studies drawn from the supervision literature, shows ‘supportive supervision’ being used to explore the supervisee’s personal world and self-knowledge (Yegdich, 1998, Yegdich, 1999b, Yegdich, 2000). Yegdich (1999b) argues that these archaeological techniques are in fact contra-indicated in supportive work. By placing the supervisor in the position of analyst, and guiding the discussion away from the supervisee’s area of expertise (clinical practice), this kind of supervision disempowers the supervisee (Yegdich, 1999b). The supervisee is placed in an emotionally vulnerable position, requiring him/her to discuss issues which should be dealt with through normal personal and social resources (Yegdich, 1999b). In this model, resistance to supervision becomes

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a psychological problem belonging to the supervisee, rather than a problem of the supervision (Yegdich, 1999b). Yegdich (1998) also argues that when supervision strays away from the nurse-patient relationship towards an inquiry into the nurse's feelings the patient is lost from the discussion. Attention is no longer on the focus of nursing work, and this kind of supervision may become a way for nurses to actually avoid patients (Yegdich, 1999b).

These are the kinds of issues which seem to lie behind the staying professional rule, and the identification of the rule in the nurses' narratives suggests that Yegdich's (Yegdich, 1998, Yegdich, 1999b, Yegdich, 2000) argument resonates with the practical experience of nurses. However the study findings also suggest that when in supervision the nurses do not engage with these issues directly. The nurses are aware of the distinction between a therapeutic interaction and a supervisory interaction, and give thought to it, but this is not discussed in supervision.

The construction of supervision is in fact being addressed by the organisation in which the participants worked. Current training days on clinical supervision draw on a transactional analysis model (Berne, 1975), in which the supervisory relationship is understood as aiming for an adult to adult interaction, with supervisor and supervisee avoiding parent/child roles.

The staying professional rule responds to the emotionally transgressive quality of supervision, but it may also reflect how nurses' wellbeing is valued. Does 'staying professional', reveal an underlying discomfort with (as Emma comments) "*bringing all of me into my work*"? Does it mean that nurses continue to problematise emotions as being somehow unprofessional? Hawkins and Shohet (2012) address the presence of 'difficult' and 'spontaneous' emotions in supervision. They regard this as inevitable, and recommend that "The role of supervision is to slow down the reactivity and create the space to reflect on and explore the strong feelings" (Hawkins and Shohet, 2012: 149). Hawkins and Shohet (2012) frame the function of supervision as enabling the work of the practitioner, but also incorporate the idea that supervision responds to the personal emotions triggered by work. Staying professional therefore perhaps helps practitioners to construct a bridge between

stoicism, and the 'restorative' style of supervision described by Proctor (2001) and Hawkins and Shohet (2012), while also maintaining the 'freedom from being therapized' described by Yegdich (Yegdich, 1999b)

7.3.1.3.3 The 'Safety and Reflexivity' Rule

The 'safety and reflexivity' rule is connected to an ideal of what should happen in supervision, that it should be an emotionally safe space in which the supervisee engages in reflection on practice. The idea of supervision as a reflexive activity is widespread (Sloan, 2006, Deery and Corby, 1996). This is seen as part of the desirable emotional ecology of supervision. For example, Alice described how her group supervisor's uncritical and reassuring manner created a sense of emotional safety for the CPNs.

Trust, and feeling safe also emerge as issues in the supervision literature. For example, in studies by White and Winstanley (2009), and Hyrkäs et al. (2002), the authors found that nurses were inhibited from participating in supervision by feelings of mistrust and suspicion about the confidentiality of supervision. In this study, Dilys recounted an experience of having a supervision confidence broken, which has made her reluctant to ever again have supervision within the NHS.

The problematising of the role of managers in supervision (cf. Burden and Jones, 1999, Yegdich, 1999a) may be examined in the light of the safety and reflexivity rule. There is a common assumption that supervision with a manager will inhibit supportive supervision because of the hierarchical relationship and potential confusion of roles (Teasdale et al., 2001). However, in this study, Clare's story of supervision with her manager suggests that having a manager as supervisor can be experienced as safe and reflexive.

Hawkins and Shohet (2012) argue that a problematic power dynamic may be enacted in supervision for a number of reasons, not only because of workplace hierarchy, but

also cultural and gender differences. In this study an issue of status is expressed through the inferiority rule in that so many of the supervision experiences described by the mental health nurses were with non-nursing supervisors from higher status disciplines. However, unlike the externally imposed inferiority rule, there is a sense that the safety and reflexivity rule is more under the control of the practitioner. This was the rule which nurses imposed on supervision, and supervision which failed to elicit these feelings was deemed unsatisfactory. For example in Gina's supervision group one member interfered with the other members' ability to feel safe and able to express themselves freely, resulting in the formation of a new group.

Gina's experience of group supervision is, unfortunately, not uncommon. Cleary and Freeman (2005) observe that group supervision can be an emotionally unsafe experience for practitioners. The personal exposure which group supervision entails, creates the risk that supervisees end up feeling anxious or vulnerable (Buus et al., 2010). Buus et al. (2010) showed what the consequences can be when the safety and reflexivity rule is not followed. The process used in the supervision group, in which one supervisee was 'interviewed' by the supervisor could leave the supervisee feeling "*professionally stripped in front of the group and maybe overwhelmed by an unanticipated emotional response*" (Buus et al., 2010: 658). In a midwifery clinical supervision group, Deery (2005: 171) found that the midwives were unprepared to cope with difficult relationship dynamics and behaved as "*ladylike saboteurs*", avoiding emotional confrontation while manipulatively undermining one another.

In some cases participants' narratives suggested that the safety and reflexivity rule developed as a consequence of having a good supervision experience which gave the nurse certain emotional expectations of supervision. Practitioners were sensitised to emotionally unsafe supervision, enabling them to avoid or limit such interactions. The safety and reflexivity rule was therefore empowering. As noted above, the research literature seems to mainly address disempowerment in supervision in terms of the conflation of supervision and management, there is less attention given to how practitioners can be empowered to maintain their own emotional safety. Yegdich (1999b) does address the issue of emotionally unsafe supervision as perpetrated by the supervisor, but does not consider how the supervisee might protect themselves

from this. In contrast, this study shows how practitioners can protect themselves from emotionally unsafe supervision when they have a sense of what an emotionally safe ecology feels like. The instances of resistance discussed in Section 7.2.2.3 illustrate how even where practitioners are unable to refuse participation or reform the supervision ecology, they are still able to resist participation in emotionally unsafe supervision. The safety and reflexivity rule suggests a motivation for such acts of resistance.

7.3.1.3.4 The ‘Managing Feelings’ Rule

7.3.1.3.4.1 Managing the Emotions of Mental Health Nurses

In the *What We Talk About* narratives, the mental health nurses considered how supervision operates in terms of the nuanced distinctions made between appropriate and inappropriate self-expression in supervision. One of the ways in which this distinction was made was through the idea of an outcome. The participants argued that supervision should have some kind of effect on the supervisee’s feelings, perhaps by solving a problem, reflecting on a difficult interaction, gaining a new perspective or re-motivating the supervisee, or validating the supervisee’s emotions. This is emotion management which is about feelings not display. Where the nurse ‘gains a new perspective’ and feels “*refreshed*” (Faye) by supervision, she is not engaging in surface acting (Hochschild, 1983) to display the correct feelings, but is changing her inner feelings. There is no reason to think that this was experienced as an inauthentic process.

In one example, Alice described her feelings of irritation with a client being validated by her supervisor, and the surface acting which these feelings required acknowledged. In this instance supervision did not changed feelings on a deep level, but Alice’s superficially ‘wrong’ feeling of irritation was reconciled with the expectation that a nurse will view her client with compassion. In the presence of her

client, Alice engaged in surface acting to conceal her current feelings, but experienced this as deeply authentic (Ashforth and Tomiuk, 2000) because it concurred with her allegiance to a professional code. Her surface acting concealed a lack of compassion in the moment, but was ultimately motivated by compassion. Supervision functioned to acknowledge this need for surface acting without questioning Alice's commitment to her nursing role, indeed, in this story Alice's surface acting becomes an expression of her deep commitment to being a nurse.

In another example of the way in which supervision can function as a space for emotion management, Gina argued that supervision could facilitate the management of feelings by allowing for an emotionally cooled-down discussion of clinical issues, (recalling Hawkins and Shohet's (2012) recommendation that the supervisor 'slow down reactivity' to promote reflexivity). The role of the supervisor may be particularly important here. Gina described supervision as ideally being a less emotionally intense interaction, but Hyrkäs et al. (2002) found that emotions which had been suppressed in the workplace could emerge in supervision sessions. The supervisors in Hyrkäs et al.'s (2002) study had a crucial role in setting boundaries around emotional expression, perhaps constructing an emotional ecology in which a cooled-down, reflexive interaction could occur.

The managing feelings rule connects to an institutionally oriented (Gordon, 1989) emotion management which is done with the aim of conforming to professional norms. This may include working on feelings in supervision, or constructing supervision as an ecology which fosters the management of feelings. In the supervision literature the management of feelings underpins ideas about supervision. Proctor (2010) argues that White and Winstanley's (2010) findings suggest that the educational and normative activities of supervision depend upon the restorative – a function which implies changing feelings. A model of supportive supervision formulated by Chambers and Long (1995a) constructs supervision as a process in which the supervisee's feelings are managed by exploring his/her unconscious thoughts and emotions. Yegdich's (1999b) critique of Chambers and Long suggests how emotion management may threaten as well as support the supervisee. Chambers and Long's (1995) journey into the supervisee's unconscious may represent an

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expression of control over the nurse's emotions. This is not done for commercial reasons, but can be compared to the kind of emotional control which Hochschild (1983) described as being exerted over employees. In this study the mental health nurse narratives create a largely positive picture of the managing feelings rule, but the literature problematises this, highlighting how supervision can become a way of controlling the supervisee's emotions.

7.3.1.3.4.2 Managing the Emotions of Midwives

Among the midwives there was less discussion about supervision as having a particular emotional ecology or a particular emotional outcome for the supervisee, but there were references to the midwives finding the emotional process of supervision supportive. In most cases this sense of support was expressed in a general way, but Sarah described supervision as giving her a feeling of self-confidence.

The references to using the annual meeting with the supervisor as a 'moaning session' suggest that there is a process of emotional expression occurring in the meeting, even though this is not regarded as important. Olive described this more clearly, commenting that she appreciated being able to use supervision to "*just let off steam*".

7.3.1.3.5 Managing Feelings – A Professional and Social Rule

The comparison of the managing feelings rule in the mental health nurse and midwife narratives shows how the operation of a feeling rule is influenced by the professional context. In the mental health nurse narratives 'managing feelings' is a professional rule, motivated by an institutional orientation, and requiring formal, reflexive emotion work in supervision. In the midwife accounts 'managing feelings'

has an informal framing which suggests a social feeling rule. From outside of this study there is evidence that ‘managing feelings’ is present in the midwifery discipline as a professional rule. The LSA/NMC (2008: 9) regard one of the functions of supervision as being to support the midwife, and list some of the qualities of a supervisor as being “*visionary and inspiring... sympathetic and encouraging*”. This suggests that statutory supervision is constructed as an activity which works on midwives’ feelings, making them feel supported, inspired, and encouraged.

The differences in operation of a managing feelings rule in the two disciplines shows how the different meanings attached to supervision within each discipline, and different professional discourses, create different interpretations of the ethos that ‘supervision should make me feel supported’. Therefore, even where a feeling rule is introduced into the practice of supervision, the professional context will influence how the rule is interpreted.

7.4 Themes – Summary

This chapter has explored two themes which emerged from the findings: ‘The Profession’ and ‘Emotions’. These themes describe two major aspects of the participants’ accounts of supervision, which are understood within the different disciplinary contexts of mental health nursing and midwifery.

The chapter began by exploring the complex interaction between supervision and the professional context. The participants’ narratives describe different experiences of professional identity as singular and straightforward, and as plural and ephemeral. Supervision operates as a context in which disciplinary identities are formed and enacted, and participants could experience this as unproblematic or as troubling.

The chapter continued with an exploration of the emotional aspect of the participants’ experiences of supervision. This is analysed through the construct of

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feeling rules, which show the operation of discourses of practice in supervision. Supervision as an emotional process is situated within the emotional processes occurring in the organisation. The metaphor of the emotional ecology is used to describe how the practitioner interacts with these discourses and emotional frameworks, and to picture how supervision may operate as a distinctive emotional context within the emotional context of the organisation.

In exploring both of these themes supervision has been understood as an exercise of power. The practitioner's experience of emotional processes and being a professional have been framed in terms of the operation of supervision as a form of subjectification.

In conclusion, the understanding of supervision which has emerged from the findings discussed in Chapters 6 and 7 has three dimensions: power, emotions and the professional context. The discussion of the findings suggests that supervision involves an interplay of these three dimensions, and this is discussed in the next chapter.

8 Discussion: An Emotional and Professional Activity

8.1 Introduction

This chapter brings together the findings of this thesis and discusses them in light of the gap in knowledge and unanswered questions about supervision in nursing and midwifery. In Section 8.1 the key arguments of the chapter are introduced and located with reference to both the gap in knowledge, and major themes present in the supervision literature. Section 8.2 gives a background for the discussion, which is provided by the understanding of supervision through the exploration of two comparable but contrasting disciplinary contexts.

Next there is an exploration of the understanding of three dimensions of supervision practices and concepts, which have emerged in this thesis. Section 8.3 discusses supervision as a means of subjectification. Section 8.4 explores supervision as located in the context of a professional identity. Section 8.5 considers supervision as an emotional ecology constructed within an organisational emotional ecology. The chapter concludes with a discussion of how this thesis has constructed a picture of supervision as both a practice and a concept.

In this introductory section I discuss how the findings presented in this thesis address the gaps in knowledge about supervision in nursing and midwifery identified in the literature. I then review the key arguments made in this chapter. Finally I discuss the picture of supervision constructed in this thesis in the light of the major themes present in the supervision literature.

8.1.1 Addressing the Gap in Knowledge

The aim of this study has been to address the gap in our understanding of supervision in the context of nursing and midwifery knowledge. This thesis has identified the following areas as containing unanswered questions about supervision:

1. What happens in practice.
2. How practitioners experience supervision.
3. How personal, professional and organisational contexts influence practitioners' experiences of supervision.
4. Supervision as having both negative and positive outcomes.
5. Supervision as an umbrella term, which covers a variety of practices.
6. Supervision as a form of power.

The study has addressed the need for knowledge about supervision practices by exploring practitioners' experiences and understandings of supervision as communicated through sense-making narratives. This has constructed an understanding of supervision practices from the perspective of the practitioner. By situating the analysis of supervision in richly detailed accounts, the study has challenged the treatment of supervision as solely an abstract concept, which can be understood as independent of any specific context or practice. A narrative analysis has attended to the details of context contained within the participants' accounts, and this has constructed a picture of supervision experiences in which the influence of contextual factors can be understood. The conjunction of two disciplinary groups within the study has enhanced the understanding of supervision as a practice in context, and illuminated the interaction between supervision practices and professional discourses. Finally the theoretical approaches used to interpret the study findings have highlighted the operation of supervision as the exercise of power, and explored the interplay between power, emotions and the professional context. This interplay is discussed in more depth in this chapter.

8.1.2 Three Dimensions of Supervision

Chapters 6 and 7 have presented the narratives about supervision in two professional contexts. The analysis of these narratives has given rise to an understanding of supervision from the perspective of three key dimensions: ‘subjectification’, ‘being part of a profession’, and ‘emotions’. These three dimensions offer different, but inter-related perspectives on supervision, and the interaction between practices, concepts and context. The findings of this study show that the practice of supervision is dependent upon professional and organisational context, and that how practitioners experience and understand supervision will therefore vary according to how, why, where and by whom it is done. However, understanding supervision in terms of the dimensions of power, emotions and the professional context, provides a way of thinking about the discourses and contextual factors that influence the construction of specific supervision practices. These dimensions can be used to understand supervision practices in different contexts, and highlight factors that may influence why and how supervision is done.

Thinking about supervision in terms of the three dimensions offered here, provides a different approach to that of previous research studies in which supervision is explored in terms of specific models or features of practice. In Chapter 3 I observed that the majority of supervision research is not situated in an understanding provided by social theories. For example, Hyrkäs et al. (1999: 179) discuss the use of theory in the field in terms of a “theory of clinical supervision” rather than the use of social theories to understand the phenomenon of supervision. An aim of this thesis has been to situate the inquiry into supervision experiences within an understanding of the theoretical perspectives of emotional labour and emotions in the workplace (cf. Hochschild, 1983, Bolton, 2005), sociological theories of the professions (cf. Friedson, 2001, Larson, 1977, Witz, 1992), and subjectification (cf. Butler, 1997, Foucault, 1976,1977). Situating the thesis within these theoretical understandings has provided a broader perspective of the context-specific picture of supervision created by the participants’ narratives. The three dimensions of supervision that

emerged here have allowed me to make a connection between the experiences and understandings of individual practitioners, discourses of practice, and the organisational context. These dimensions of supervision are discussed in more depth in Sections 8.3-8.5.

8.1.3 Themes in the Literature

In the review of the supervision literature in this thesis five themes were identified:

1. The concept of supervision: clinical supervision and statutory midwifery supervision.
2. Supervision as a 'good thing'
3. Supervision as surveillance, and resistance to supervision
4. Reflection
5. Professional identity.

In this section I shall review how the development of this study has been informed by these themes.

8.1.3.1 The concept of supervision

The literature review presented in Chapter 3 has problematised the concept of supervision, and this thesis has taken a critical approach to the concept of supervision, challenging the idea of a singular concept by situating the exploration of supervision within two disciplinary contexts. The location of the supervision concept in two comparable but contrasting contexts has illustrated the influence of professional discourses on the experience and understanding of supervision, showing that supervision as a concept is more usefully understood when located and described within specific, context-dependent practices.

8.1.3.2 A 'Good Thing'

The 'good thing' discourse in the supervision literature sensitised me to the lack of critical awareness about supervision. This led me to develop an approach in the study in which no assumption was made about inherent benefits or problems of supervision. This critical approach to the concept of supervision also challenged the assumptions within the 'good thing' discourse by connecting supervision to specific practices and contexts. The findings of this thesis pose two challenges to the idea that supervision can only be described as beneficial: First, supervision practices varied significantly between disciplinary and organisational contexts. Second, some practitioners perceived supervision as having harmful or troubling effects, for example, as an oppressive power or an emotionally unsafe activity.

8.1.3.3 Professional identity

In the literature, supervision is connected to professional identity and the development of the practitioner as a professional. This study has set out to explore the connection between supervision and the professional context. The structure of the study allowed the comparison of supervision experiences in two disciplinary contexts. This comparison has highlighted the interaction between practitioners' experiences of supervision, their understandings about supervision, and disciplinary discourses about supervision, about what it means to be professional, and about what it means to be a mental health nurse or midwife. This thesis puts forward the argument that the professional context forms a major influence on supervision practices, and this is discussed in more depth in Section 8.4.

8.1.3.4 Surveillance, Resistance and Reflection

In the literature, critical discussions of supervision have highlighted the operation of supervision as a form of surveillance. Reflection, which is widely regarded as the main mechanism of supervision, has also been situated within this analysis of supervision, with the process of reflective supervision likened to Foucault's (1976) theory of the confessional (Gilbert, 2001). These critical discussions of supervision as a form of power cast new light on the references made in research studies to resistance of supervision by practitioners. This study has responded to these critical themes in the literature by taking Butler's (1997) reading of subjectification as a theoretical lens through which supervision is examined as an operation of power. This is discussed in more depth in Section 8.3.

8.1.4 Introduction – Summary

In this section I have discussed how this study has addressed the gap in knowledge identified in Chapter 3, and how the study has responded to the five major themes in the supervision literature. The three dimensions of power, emotions and the professional context have been introduced, and these have been discussed as connecting context-specific practices to theoretical perspectives that help to explain how and why supervision is constructed and experienced in different ways. The arguments introduced in this section are discussed in more depth below beginning with the picture of supervision which has been created through the analysis of two disciplinary contexts, then the analysis of supervision as a form of power, followed by the interaction between supervision and the professional context, and finally supervision as an emotional ecology situated within an organisational emotional ecology.

8.2 Two Professional Contexts

In this section I shall review the two professional contexts which have provided the background to this study, and discuss the implications of comparing and contrasting experiences and understandings of supervision in these two disciplines. Section 8.2.2 discusses the argument which this thesis makes about conceptualisation of supervision. Section 8.2.3 discusses the argument which this thesis makes about experiences of supervision.

8.2.1 Comparing and Contrasting Mental Health Nursing and Midwifery

Mental health nurses and midwives work in different clinical areas, but the history of these disciplines reviewed in Chapter 2, displays some shared traits. These include the gendering of mental health nursing and midwifery as associated with feminine values, and as mainly employing women. Furthermore, both disciplines have gone through a process of professionalisation which has involved the use of registration to justify professional status. For both disciplines professionalisation has required the negotiation of relationships with medicine and general nursing. Both disciplines have been subject to the demarcationary strategy (Witz, 1992) of medicine, by which medical dominance of mental health and maternity care has been strengthened through the construction of mental health nursing and midwifery as subordinate disciplines. At the same time, mental health nursing and midwifery have been closely associated with the professional project (Larson, 1977) of general nursing, and this has threatened to compromise the distinctiveness of these disciplines. The relationship with general nursing means that mental health nursing and midwifery share some aspects of their knowledge base, for example, the disciplines draw on some of the same supervision literature.

In light of these shared traits, this thesis has taken the perspective that the disciplines of mental health nursing and midwifery are engaged in different clinical work, with unique professional structures and histories, but are also similarly situated in relation to issues around professional status and the construction of professional identity. This has provided the basis for a comparison of practitioners' experiences of the distinctive supervision practices that have developed in each discipline. This comparison has highlighted the interaction between supervision and the disciplinary context, and has entailed an approach to the concept of supervision as a sensitising concept (Blumer, 1969/1998).

8.2.2 The Concept of Supervision

I take the position that the term 'supervision' is not definitive, but guides an understanding of supervision-practices-in-context by suggesting directions for inquiry (Blumer, 1969/1998). This approach to conceptualisation moves inquiry into supervision away from concerns that the ambiguity of the concept inhibits research or implementation of supervision (Cleary et al., 2010, Rice et al., 2007). Some scholars suggest that we must seek definition if the field of supervision research is to move forward (Hyrkäs et al., 1999). In contrast, Shanley and Stevenson (2006) argue that the meaning of supervision must be understood in terms of local practices. This thesis follows Shanley and Stevenson's (2006) argument, and rather than seeking a 'defined', abstract concept, Blumer's (1969/1998) view of the sensitising concept is used to enhance understanding of specific contexts and practices.

In this thesis, supervision is regarded as an 'umbrella term' covering a cluster of related concepts including clinical and statutory supervision. These sub-concepts also incorporate numerous related concepts, for example 'clinical supervision' is itself described as an umbrella term (Butterworth, 1992a, Fowler, 1996). Understanding supervision as a sensitising concept suggests a way for scholars to approach this complex cluster of concepts, making the argument that the specificity

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of supervision concepts and terms depends upon their being tested against the phenomena which they describe (Blumer, 1969/1998).

The concept of supervision can be understood as part of the mechanism by which norms of practice are maintained (Berger and Luckmann, 1966). The concept therefore references discourses about, for example, what it means to be a mental health nurse or a midwife. This thesis has consequently taken the position that the norms and expectations that are incorporated in the concept of supervision, influence how supervision is practised. Context is therefore understood as both influencing the understanding of supervision through the development of context-specific practices, and also as influencing the understanding of supervision through participation in the discourses which construct the context. This view of the relationship between context and concept suggests how supervision as a sensitising concept may be situated with regard to specific practices and understandings.

The concept of supervision is used differently in the two professional contexts explored in this thesis and can be understood as describing two ways in which supervision can operate. In the midwife narratives, statutory supervision is a primarily professional activity, it is framed by the idea of the profession, and the practice of statutory supervision draws on discourses about what it means to be a professional. In the mental health nurse narratives, clinical supervision is a primarily relational activity, it is characterised by an emotional and reflective interaction, a focus on client relationships and the practitioner's experience, and draws on discourses about the practitioner's use of emotions and self in relationship with clients.

Conceptualisations of supervision-as-professional and supervision-as-emotional are also overlapping. In the participants' narratives, statutory supervision had an emotional, reflective function in that it allowed for an informal 'chat', while clinical supervision had a professional function in that it legitimised identification with other disciplines, and constructed practitioners as therapists. The literature also shows that other concepts of supervision are present in the disciplines, for example, there are instances of clinical supervision being practised in midwifery, and here the

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conceptualisation of supervision draws upon the nursing literature on clinical supervision (Deery and Corby, 1996). The understandings of supervision present in the disciplines of mental health nursing and midwifery are therefore not discrete, but participate in a network of conceptualisations of supervision.

Comparing practitioners' understandings of supervision in different disciplinary contexts has led this thesis to challenge tropes about supervision, and make two contributions to conceptualisation. First, understandings of supervision are situated in the context of specific practices and professional discourses. This shows that there are different ways for practices called 'supervision' to operate. Second, the constructedness of supervision concepts in use in each discipline is displayed. This shows that the operation of supervision practices is influenced by the meanings attached to supervision, and to a professional identity.

This thesis therefore offers a response to Buus and Gonge's (2009: 251) argument:

“[clinical supervision has been] defined and redefined by scholars and clinicians to fulfil several professional and educational aims, which has further added to the congested meaning of the term.”

For Buus and Gonge (2009) – and others – the existence of multiple conceptualisations of clinical supervision formed in the context of different discourses of practice is problematic. They suggest that this inhibits the establishment of a 'field' of clinical supervision scholarship. I make an alternative argument, that a field of scholarship has formed around 'supervision' and related terms, and that the usefulness of these concepts should not be tested against a notion of abstract clarity, but rather against the phenomena which they are intended to describe (Blumer, 1969/1998), and that they should be understood as constructed in relation to practices, and political, theoretical and institutional discourses.

8.2.3 Experiences of Supervision

The narratives presented in this thesis show the complexity of the participants' experiences of supervision and the influence of context on how supervision was understood and practised.

In this thesis experience has been conceptualised as located in the subjective, inner world of the person, where it is shaped by internalised, socially constructed meanings (Berger and Luckmann, 1966, Stoller, 2009). Experience is therefore always interpreted, and cannot be accessed as an 'objective' phenomenon. In this study experience was accessed through the collection of narratives. Narrative has been conceptualised as a form of discourse through which people make sense of their experiences, and communicate the meanings of their experiences (Ricoeur, 1983/1984, Bruner, 1987, Gee, 2005, Mishler, 1999). The accounts of experience produced in this thesis do not represent an objective reality, but are interpretive, and co-constructed (Mishler, 1986, Ricoeur, 1983/1984), offering a perspective on the meaning-making processes within which the participants practise and understand supervision.

This study set out to situate practitioners' experiences of supervision in the context of the profession. However the findings presented in this thesis show that the participants experienced the professional and organisational contexts as entangled, and the participants experienced supervision both as members of a profession, and as employees of an organisation.

The importance of understanding the context of supervision experiences is highlighted in White and Winstanley's (White and Winstanley, 2009, White and Winstanley, 2010) study of a largely ineffectual implementation of supervision in Queensland. White and Winstanley (2010) identify a single, unique case within the trial which showed better outcome scores than the other study sites. This case, in a single clinical setting, was distinguished by a dedicated supervisor, support from management, and a high degree of participation in supervision by clinical staff

(White and Winstanley, 2010). In contrast, White and Winstanley (2009) found evidence that in other study sites the implementation of supervision was impeded by hostility and lack of resources. White and Winstanley (2010) did not set out to produce a contextually detailed account, but their study does suggest that context was significant in determining how supervision was practised. This supports the argument that practitioners' experiences must be understood as contextually produced.

In some studies, aspects of the context are described which influenced the experience of supervision such as stressful working conditions (Arvidsson et al., 2001), or competing work priorities (Buus et al., 2011), but there is often a lack of discussion about the interaction between the context and how supervision was experienced. While there are a number of existing studies in which supervision is explored as the inner, subjective experience of the practitioner (cf. Williams, 1996, Sloan, 2006, Shennan, 1996, Marrow et al., 2002), there is little attention paid to how the inner experience is formed through interaction with the discursive context.

In more detailed discussions of context, Cleary and Freeman (2005), and Kirkham (1999), identify the existence of a coping culture which prevents practitioners from accessing support through supervision. A stoical, coping culture was also identified in this study. However this culture is not always overtly described in the interviews. The mental health nurses recognised and discussed a 'macho' culture in which practitioners are expected to cope, but this aspect of working culture was expressed less overtly in the midwives' narratives. This aspect of the context may therefore not be immediately apparent, and yet it influences how practitioners experience supervision, for example whether they are able to ask for support, or whether having supervision is experienced as failure to cope. In this study the richness of data, and the depth of analysis allowed these latent aspects of participants' accounts to emerge.

Sloan's (2006) study also shows the importance of context. Sloan (2006) set out to examine the relationship between supervision practices and the organisational context, finding that an organisational discourse on supervision as risk management, combined with supervisors who were also managers, led to supervision which was

dominated by a managerial agenda, with practice being discussed in practical rather than relational terms.

These discussions demonstrate the importance of understanding nuances of context which may be latent, but which have a significant effect on how supervision is experienced. However there is minimal existing theoretically informed discussion about the mechanisms by which context influences the experience of supervision. In this thesis the findings have produced an understanding of supervision as articulated through three dimensions: power, emotions and the professional context. Exploring supervision experiences from the perspective of these three dimensions has contributed to a theoretically informed understanding of some of the contextual processes which influence practitioners' experiences of supervision.

8.2.4 Two Professional Contexts – Summary

In this section I have discussed the background from which the three dimensions of supervision emerged. This thesis presents an inquiry into practitioners' understandings and experiences of supervision as situated in the context of being part of a profession. Exploring supervision in two professional contexts has illuminated how professional discourses influences the way in which practitioners understand and experience supervision. This has enabled me to challenge existing tropes about supervision.

One of the ways in which this thesis challenges tropes about supervision is by problematising the process of conceptualisation. I argue that supervision is difficult to conceptualise not because there is some inherent flaw in the field, but because conceptualisation is, in itself, a difficult activity. The social science literature contains a multitude of examples of hotly debated concepts. I have therefore approached the conceptualisation of supervision by asking what function this activity performs. Scholars rely on shared understandings contained in the concept in order to discuss and research 'supervision'. At the same time, existing research, and the

findings of this study, show that ‘supervision’ describes a variety of context dependant practices. In this thesis, therefore, ‘supervision’ has been approached as a sensitising concept which informs the understanding of supervision as praxis. This approach entails a degree of conceptual scepticism, avoiding the reification of supervision as a concept. The abstraction of the concept is tested against its use in practice, contributing to a phronetic (Flyvbjerg, 2001) understanding of supervision.

This thesis set out to produce phronetic knowledge about supervision, and an important component of this is the analysis of practitioners’ experiences of supervision. The narratives of experience collected through this study have allowed me to test conceptual and theoretical perspectives on supervision against the practical wisdom (Flyvbjerg, 2001) possessed by mental health nurses and midwives who participate in supervision practices. The narratives of experience have produced three ways of looking at supervision, and in the following sections I shall discuss these three dimensions of supervision.

8.3 Supervision and Power

In the supervision literature, power is discussed from two main perspectives: the association between supervision and management (cf. Sloan, 2006, Shennan, 1996, Allison and Kirkham, 1996, Kelly et al., 2001b), and the phenomenon of resistance to involvement in supervision (cf. Deery, 2005, White and Winstanley, 2009, Demilew, 1996, Hyrkäs et al., 2002). Both midwifery and nursing scholars argue that when supervision is conflated with management, this introduces an undesirable power imbalance between supervisee and supervisor (Sloan, 2006, Yegdich, 1999a, Shennan, 1996). I suggest that, in the literature, the problem of power tends to be framed in terms of eliminating managerial power from supervision.

Resistance is less widely problematised in the literature, and is often framed as a practical issue to be solved by better working practices and education about supervision. For example, Cottrell (2002) argues that resistance to supervision may

be reduced through improved relationships between the various parties involved. Cottrell's (2002) relational perspective constructs a more complex picture than that of power as a managerial problem, (for example, arguing that supervisees may be seen as exercising a subversive power through supervision). However, like other scholars, Cottrell's (2002) solution to the problem of resistance seems to be to remove power, something which Foucault (1980) has argued is impossible. Stevenson and Jackson (2000) also offer an understanding of power which moves beyond the role of management, arguing that the clinical supervision relationship is inherently hierarchical. Again, however, the authors' response to the problem of power seems to be to eliminate power.

Turning to Foucault's (1976) argument, that power is an inherent part of social relationships, I take the position that power is an inevitable component of the supervision relationship. Rather than regarding power as something to be eliminated from supervision, this thesis has employed the theoretical lens of subjectification (Butler, 1997) in order to explore the operation and consequences of power .

8.3.1 Subjectification

Butler's (1997) theory of subjectification describes the paradox of a controlling power which creates the conditions under which resistance and autonomy can develop. The narratives presented in this thesis describe the experience of supervision as similarly paradoxical. Supervision controls, and it enhances autonomy; it blurs and it legitimises professional identity; it makes practice visible, and it allows the details of practice to remain unseen.

This thesis constructs an understanding of supervision as a process of subjectification in which the practitioner is constituted according to professional and/or organisational norms (these norms are understood as entangled but not necessarily concordant). I argue that the subjectification of the practitioner in this way should be considered a necessary and desirable process. It is necessary for the practitioner to

be constituted as a professional mental health nurse or midwife in order for him/her to be able to function as a mental health nurse or midwife. It is also desirable that the practitioner's behaviour should be normalised so that s/he practises ethically, and in conformity to quality standards. If we understand subjectification as a process in which the subject position must be constantly restated (Butler, 1997), then supervision offers a means by which this continuous restatement can occur

Understanding supervision as subjectification builds on the work of Gilbert (2001), Cotton (2001), Rolfe and Gardner (2006) and Clouder and Sellars (2004), who analyse reflection and supervision in terms of Foucault's (1977) concept of surveillance. Clouder and Sellars (2004) argue that the surveillance of healthcare practitioners is inevitable, in that everyday practice is evaluated by patients and colleagues. They also argue that surveillance is desirable, in that practitioners have a responsibility to be accountable for their practice. However, Clouder and Sellars (2004) challenge Gilbert (2001) and Cotton's (2001) arguments, that when practitioners reflect on their practice they are constituted as self-disciplining. Gilbert (2001) and Cotton (2001) employ the Foucauldian concept of the confessional as a form of surveillance in which the subject becomes their own observer (Foucault, 1976). Gilbert (2001) argues that supervision functions as a form of confessional, making practice visible and subject to normalisation.

Clouder and Sellars (2004) agree with Gilbert (2001) and Cotton (2001) that supervision is a form of surveillance. However, they argue that the idea that individuals reveal the 'truth' about themselves through reflection on practice is problematic because there is no objective truth to be revealed, and individuals are able to resist self-exposure by choosing how to present themselves. Clouder and Sellars' (2004) argument addresses the possibility of resistance to surveillance through the confessional, but makes the subject independent of disciplinary discourses. Butler (1997) emphasises the dependence which the subject has on power. This challenges Clouder and Sellars' (2004) idea of the resistive, impression-manipulating practitioner, instead suggesting that where supervision operates as a form of subjectification, the practitioner will experience a passionate attachment

(Butler, 1997) to the disciplinary power expressed through supervision, motivating him/her to participate in good faith.

The narratives presented in this thesis show that supervision can influence practitioners to different degrees. The interaction between supervisee and supervisor may be limited, making practice visible in a superficial way. For example, the annual meeting of midwives and their supervisors makes the midwife's functioning as a midwife visible to the supervisory authority through the Intention to Practise form. In this example surveillance takes a concrete form. Arguably, however, significant aspects of practice in both mental health nursing and midwifery are less easily observed. This is particularly the case for the ethical and emotional aspects of practice, which may require considerable inner resources, but the struggles and effort involved in these practices are not readily visible to others.

Where supervision requires the supervisee to construct a detailed account of his/her practice, I argue that these inner aspects of practice are made visible in the context of disciplinary discourses. In contrast, Rolfe and Gardner (2006: 597) argue that when the inner workings of practice are made visible through reflection, this does *not* function as a confessional in which the practitioner's self is normalised, because "*the focus of reflection is cognitive knowledge about practice rather than spiritual knowledge about self*". Rolfe and Gardner (2006) therefore argue that reflection does not involve 'confession' because the focus is on the *process* of reflection not the content.

This thesis offers a challenge to Rolfe and Gardner's (2006) position. First, following Butler's (1997) argument, the subjectifying power of reflective supervision is seen as constituting the subject not the self. The supervisee's self is larger than their subject position as a healthcare practitioner. Therefore, even though supervision does not focus on the spiritual self of the practitioner, it can still operate as a subjectifying power which constitutes the practitioner. Second, the narratives presented in this thesis show that reflective supervision is not necessarily a cognitive process, but can involve working on the supervisee's emotions, influencing the

supervisee on a deep level. This emotional aspect of supervision is discussed in Section 8.5.

8.3.2 Supervision and Power – Summary

In this section the operation of power in supervision has been explored through the theoretical lens of subjectification. I have made the argument that where supervision involves making practice visible through reflection, it can constitute the practitioner according to normalising discourses. However this process of subjectification cannot be assumed to be total. Subjectification is understood as producing resistance, and as fostering autonomy (Butler, 1997). Two consequences can therefore be projected for supervision as subjectification: the practitioner resists subjectification into the position of an ethical and caring professional; the practitioner becomes able to operate autonomously according to the norms of good practice – in Flyvberg’s (2001) terms, they become an ‘expert’ who has thoroughly internalised the methods of practice and is able to apply these in a context-specific and value-framed way.

The understanding of supervision as a form of subjectification discussed in this section informs the understandings constructed of supervision in the professional context, and emotions and supervision. These are discussed below.

8.4 Supervision and the Professional Context

In the literature supervision is connected to professional identity and professional development. This study has responded to this connection by framing the exploration of supervision within two professional contexts. The findings presented in this thesis support three main arguments about the interaction of supervision and the professional context. First, the professional context influences how practitioners

understand supervision. Second, the study findings challenge the connection made between supervision, autonomy and the legitimisation of professional status in midwifery. Third, the findings construct a complex picture of the interaction between professional context and supervision, suggesting lines of inquiry for future research. These three arguments are discussed in this section.

8.4.1 A Professionally Framed Understanding of Supervision

As discussed in Section 8.2.2, the professional context influences how practitioners conceptualise supervision, and consequently engenders different understandings and expectations of what supervision is for and how it works. Supervision can be understood in terms of the interaction of supervisee and supervisor, the relationships between individual practitioners. However, these interactions occur in the context of larger discourses about supervision: about support, and about what it means to be a mental health nurse or a midwife. The microcosm of the supervision session is situated within the larger structures of the profession. While highlighting the importance of the professional context, this study has also found that from the perspective of the practitioners, the experience of being part of a profession can be entangled with the experience of being part of an organisation.

8.4.2 Autonomy

The findings presented in this thesis show that midwives connected supervision, professional identity and autonomy. Stapleton et al. (1998) and Henshaw et al. (2013) have observed that this discourse connecting statutory supervision to professional identity is widespread in the midwifery discipline, and supervision is seen as legitimising the professional status of midwives.

Berger and Luckmann (1966: 110) describe ‘legitimation’ as a process through which already institutionalised meanings are made “*objectively available and subjectively plausible*” for the individual. The process of legitimation ‘explains’ and ‘justifies’ pre-existing institutional meanings (Berger and Luckmann, 1966). Applying this to the example of statutory supervision of midwives, we can see that statutory supervision and the professional status of midwifery are involved in a dialogue of explanation and justification: midwives are professional because they are supervised and midwives must be supervised because they are autonomous professionals. Supervision therefore functions as a way in which the institutionalised meanings of the midwifery discipline (professionalism, autonomy) are legitimised for individual midwives. Berger and Luckmann (1966) argue that over time these institutional meanings can become disconnected from concrete experience and so require legitimisation. The discrepancy between midwifery practice, and the symbolic importance of supervision as legitimising the autonomy discourse, can be understood as part of this process of institutionalisation and legitimisation.

The findings of this thesis challenge and problematise the connection between professional identity, supervision and autonomy. The discussion of subjectification in Section 8.3 suggests a mechanism by which supervision could promote autonomous practice through an enabling subjectification (Simons, 1996) of the practitioner. However, I argue that the NHS midwives had too little contact with the supervision system to accomplish this degree of subjectification. The assumption that statutory supervision supports autonomous practice is also challenged by the independent midwives’ narratives, in which supervision is experienced as both supporting and undermining autonomy.

8.4.3 Professional Identity

The narratives presented in this thesis show that supervision can be an opportunity for the enactment of professional identity. As discussed above, statutory supervision

provides a setting for the enactment of ‘we are autonomous’, and although this thesis problematises the connection between identity and supervision, the participants experienced this connection as straightforward. In clinical supervision the connection to professional identity was more complex, and involved multiple disciplinary allegiances.

Little attention has been paid to how supervision can interact with professional identity. Despite the widespread discourse around professional identity and statutory supervision I have not been able to identify any research which explores how midwifery identity is constructed through supervision. In the nursing literature there are studies of multi-disciplinary supervision practices, but there is little discussion of how supervision interacts with the disciplinary context. For example, in Hyrkäs et al.’s (2002: 394) study of multi-disciplinary team supervision the authors report that supervision “*strengthened professional identity*”, however the effect of having different disciplines in the supervision group is not discussed. Brown et al. (2000) have found that multi-disciplinary working challenges the boundaries between the professions, blurring traditional roles, and this can be experienced as positive or troubling. In this study there was a similarly varied response to multi-disciplinary clinical supervision.

The picture constructed of the connection between clinical supervision and professional identity is complex. The narratives include examples of supervision enhancing a sense of nursing identity, and examples of supervision enhancing alternative disciplinary identities. Clinical supervision constituted practitioners into different subject positions as ‘therapists’ or ‘nurses’. This could be a means for practitioners to resist power. For example, constitution as therapists functioned as a means of resistance towards the powerful medical model, while constitution as mental health nurses functioned as a means of resistance against colonisation by clinical psychology.

As a further complicating factor, I have also argued that supervision was related to a general sense of ‘being professional’. This resonates with Hyrkäs et al.’s (2002)

description of supervision as strengthening a sense of general professional identity, (not a specific disciplinary identity).

This understanding of supervision as situated within a complex relationship with the professional context, contributes to current debates by highlighting the significance of supervision as a professional activity, and the potential for supervision to influence professional identity in various ways. This study draws attention to the lack of research into the interaction between supervision and professional identity, particularly in the context of multi-disciplinary working. The findings presented in this study suggest possible avenues for future inquiry into the different ways in which supervision can influence a sense of being professional and a sense of disciplinary identity.

8.4.4 Supervision and the Professional Context – Summary

This section has reviewed the three major arguments which this thesis has put forward about the interaction between supervision and the professional context. The professional context is understood as influencing the conceptualisation of supervision, and supervision is understood as influencing the construction of professional identity. This thesis also problematises the association made between statutory supervision, autonomy and the professional status of midwives.

8.5 Supervision and Emotions

The third dimension of supervision which has emerged in this thesis is that of emotions. The field of supervision research in nursing and midwifery has a well-established tradition of connecting *clinical* supervision to the emotional wellbeing of practitioners, particularly in terms of burnout, stress, and job satisfaction (cf. Butterworth et al., 1999, Hyrkäs, 2005, Bégat and Severinsson, 2006, Deery and Corby, 1996). There is also evidence that practitioners themselves understand supervision as providing emotional support. For example, Buus et al. (2011) found that mental health nurses articulated the benefits of supervision as clinical and emotional, rather than learning or development. In contrast, *statutory* supervision is more loosely connected to practitioners' emotions through the idea of supervision as supporting the midwife (Halkswork et al., 2000, Hughes and Richards, 2002, Kirkham, 1999). However, although supervision is situated with reference to emotions I have been unable to identify any research in which theoretical approaches to emotions and emotion work have been applied to supervision.

In this thesis, the activity of supervision is conceptualised as part of the emotional interactions of the workplace, and also as a potential source of support for practitioners' emotional work. The exploration of emotions and supervision has been framed by the theory of emotional labour (Hochschild, 1983). This provides a theoretical basis for recognising the emotional component of healthcare as work (Smith, 2011). In Chapter 7, the construct of feeling rules was used to explore shared aspects of the emotional context, and the feeling rules expressed in the participants' narratives were discussed as showing the operation of professional and organisational discourses.

This thesis has also used the metaphor of 'emotional ecology' (Frost et al., 2000) to describe how the practitioner's experience of supervision is located within an emotional context of supervision, which is situated within the emotional context of the organisation. Each of these emotional contexts is governed by feeling rules, and subject to a variety of influences. Situating the practitioner's experience of

supervision within the context of an emotional ecology helps to illustrate how the practitioner is located within, interacts with, and moves between, systems of emotional discourses.

In this section supervision is discussed as an emotional ecology located within the emotional ecology of the organisation.

8.5.1 Emotional Ecology in an Organisational Context

Understanding supervision in terms of emotions, and specifically the emotional processes which occur within work, draws attention to the location of supervision within a network of emotional interactions which are governed by feeling rules. Applying the construct of feeling rules to the understanding of supervision helps to connect the unique, relational interaction of the supervision session, to wider conventions and discourses. This provides a way of thinking about supervision within different contexts. This study shows that supervision is located within the emotional ecology of the organisation, and responds to the feeling rules in operation within the organisation. However this study also suggests that supervision can be constructed as separate from the organisation, and participants can select a different set of feeling rules for the practice of supervision. Thinking about supervision practices therefore requires an understanding of the practitioner as situated within multiple emotional contexts.

8.5.2 Supervision as a Distinctive Emotional Ecology

The second understanding of supervision which has been produced in this thesis is that of supervision as an emotional process which may operate as a distinctive emotional ecology, employing different feeling rules to those operating in the organisational ecology.

The findings suggest that for supervision to operate in this way requires time and effort. The annual meeting of midwives and their supervisors seemed to employ professional/organisational feeling rules (for the filling in of forms), and professional/social feeling rules (for the chat) (Bolton, 2005). Understandably these brief and infrequent meetings provided little opportunity to construct a supervision interaction which employed distinctive feeling rules to achieve an emotionally supportive discussion of practice. The mental health nurses' discussions of emotionally supportive supervision show the complexity of this process of construction, and the difficult negotiations which are required in order to determine what is appropriate for discussion in supervision and how supervision discussions should be structured.

Where supervision is successfully constructed as a distinctive emotional ecology, the consequences of this will inevitably depend upon the feeling rules in operation within this ecology. Where feeling rules disempower the supervisee, or result in an overly invasive interaction, supervision may have adverse consequences, making the supervisee feel exposed or undermined. In this study, examples of supervision as a distinctive emotional ecology were generally positive. Where a positive emotional ecology is constructed the supervisee is likely to be more actively involved in the selection of feeling rules, and in this respect the supervision interaction may bear greater resemblance to the more egalitarian, fluid negotiations of the emotional gift exchange (Bolton, 2005, Hochschild, 1983), rather than conforming to more hierarchical, inflexible organisational/professional feeling rules.

The discussion of feeling rules in the previous chapter shows practitioners as using organisational, professional and social feeling rules. This supports Bolton's (2005) argument that individuals are, to some extent able to move between sets of feeling rules, and suggests a mechanism by which the emotional ecology of the organisation may be challenged within supervision. The feeling rules of 'inferiority' and 'stoicism' illustrate the power of the profession and organisation to constitute the practitioner in certain ways. However the presence of informal support interactions governed by social feeling rules shows that the practitioners are able to select feeling rules which challenge the feeling rules of the organisation. This reflects Butler's

(1997) argument that the person is bigger than the subject. The stoicism rule constitutes the practitioner as emotionally controlled, but the practitioner continues to have access to social feeling rules which allow for more emotionally expressive interactions that resist the stoicism rule.

Healthcare understandably requires emotional work from practitioners. It would be undesirable for practitioners to display indifference, lose their temper, or break down in tears, when interacting with clients. However this controlled emotional work is done in a highly emotional context in which practitioners deal with life, death and suffering. The concern with burnout in nurses and midwives, and the literature on emotional labour, highlight the consequences of this emotional work, showing that the carers also require care (cf. Smith, 2011). Where supervision is constructed as a distinctive emotional ecology this may be a way of delivering such care. In this kind of supervision, the practitioner can discuss his/her emotional work through an interaction which allows a different emotional expression than the emotional ecology of clinical practice. The emotional ecology of clinical practice should be focused on the needs of the client, but the emotional ecology of supervision can be focused on the needs of the practitioner, and in this way can become a place for the practitioner to be supported and nurtured.

8.5.3 Subjectification Within a Distinctive Emotional Ecology

This thesis brings together the two constructs of supervision as ‘subjectification into the position of professional’, and as ‘a distinctive emotional ecology’. The interaction of these two functions of supervision can be seen in the accounts of emotionally supportive supervision produced in this study, and the theoretical perspectives discussed in this chapter suggest ways of thinking about the consequences of these two functions of supervision.

Where supervision involves an in-depth and reflexive response to the supervisee’s emotion work, the subjectifying power of supervision is enhanced. In reflexive

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supervision, the inner world of practice is made visible, and an important component of this world, the practitioner's emotion work, is also exposed to the subjectifying power of supervision. If supervision is understood as a professional/organisational activity in which the supervisee is constituted according to professional/organisational norms, then the practitioner's emotional processes are also constituted in this way.

It seems likely that this will have the advantage of encouraging practitioners to emotionally orientate themselves towards the institutional, enhancing the practitioner's allegiance to professional/organisational norms. Emotions are a major motivation for behaviour (Turner and Stets, 2005), and supervision which promotes an institutional orientation will thus constitute practitioners who are motivated on a deep level to practice in accordance with professional/organisational norms. This is of obvious benefit to those who depend upon the practitioner for committed and compassionate care. Failings in health care such as those in Mid-Staffordshire (Francis, 2013) show that compassion in the health service cannot be taken for granted, but must be actively created.

Frost et al. (2000) have argued that an emotional ecology can foster compassionate behaviour. The emotional ecology of supervision is open to being constructed in this way, and can therefore become a means of constituting compassionate, caring practitioners. However this study also shows that the emotional ecology of supervision occurs in the context of an organisational ecology, and that separating these is not straightforward. The emotional context of the organisation can cross over into supervision, and the construction of supervision as emotionally distinctive requires resources and effort.

This has particular implications for the role of managers in supervision. In both mental health nursing and midwifery there is a widespread phenomenon of managers taking on the role of supervisor. It seems likely that where the same person occupies the role of manager and the role of supervisor, it will become more difficult for the participants in supervision to select a different set of feeling rules to govern interaction. This is also likely to be the case in team supervision, where relationships

have been formed within the organisational emotional ecology. Where such relationships already exist, and particularly where the relationships are hierarchical, it may be very difficult to construct supervision as a distinctive emotional context. The subjectifying power of the manager may colonise the subjectifying power of the supervisor, meaning that supervision as subjectification becomes controlling rather than nurturing.

Constituting practitioners who find personal satisfaction in compassionate care is of benefit to those who require care. When the caring work of practitioners is motivated in such a deep way, the emotion work required as part of this becomes connected to a sense of emotional authenticity. The activities of deep and surface acting required in everyday practice become authentic emotional expressions (Ashforth and Tomiuk, 2000), arguably protecting the practitioner from the kind of emotional estrangement from self which is described by Hochschild (1983).

An institutional orientation (Gordon, 1989) is therefore of benefit to the practitioner in that their work becomes a source of emotional meaning and authenticity, increasing job satisfaction. However, Sloan (2007) shows that promoting an institutional orientation is also likely to have negative consequences for the practitioner as emotion management performed as part of work becomes more personally significant, imposing a greater emotional strain on the practitioner. This means that if healthcare practitioners are to be actively constituted as caring, and having a sense of personal authenticity in their emotion work, then they also require support in order to develop emotion management skills and maintain the effort required for such work. An advantage of supervision as a practice is that it can accomplish both these tasks, constituting and supporting the practitioner.

8.6 Conclusion: The Possibilities of Supervision as an Emotional and Professional Activity

Early on in the development of the field, Butterworth and Faugier (1992: 230) set out a positional framework for supervision in nursing which included the argument that supervision “*requires time and energy and is not an incidental event*”. In this way, the argument that supervision practices have to be deliberately constructed was introduced into the field at an early stage. However in some respects the field seems to have moved away from an approach to supervision as a construction towards an assumption that supervision has similar features in different contexts. In contrast, this thesis has put forward the argument that the concept of supervision has to be understood in the context of specific practices, and assumptions cannot be made about the process or outcomes of supervision since these depend upon how, where, why and who does supervision.

The narratives of the practitioners who took part in this study show that supervision can be experienced in a variety of ways. Supervision could be experienced as unimportant, ineffectual, unsafe, or controlling. However it could also be experienced as supportive, developmental, and validating. I therefore make the argument that it is possible (but not inevitable) that supervision can operate as a beneficial activity. In this study the main benefit of supervision has been identified as the support of caring work.

As described in Chapter 2, compassionate care is a cornerstone of current healthcare policy, and failings in the health service have shown that compassionate care is not a naturally occurring phenomenon. Smith (2011: 185) argues that “*the importance of defining care as work cannot be underestimated if this most essential ingredient of what nurses do is to be recognized and valued*”. This thesis has made the argument that supervision can offer a way in which emotional work is recognised and supported, and that supervision can operate as a distinctive emotional ecology in which the practitioner’s emotion work is reflexively discussed and supported. It is

argued that this provides the opportunity for the practitioner to be constituted as compassionate.

In conclusion, this thesis makes the argument that supervision can be a way in which practice is normalised according to quality and ethical standards, and it can also be a way in which practitioners are supported in maintaining a personal, emotional commitment to their caring work. Supervision can therefore have highly desirable consequences for the practitioner whose capacity to perform emotion work is maintained, and who is likely to have a more meaningful experience of work. Supervision can also have desirable consequences for those who depend upon the capacity of the practitioner to perform in a caring, ethical way. However this thesis also considers the potential for supervision to have negative consequences. Subjectification through supervision cannot be assumed to be effective or total: the practitioner can resist the subjectifying power of supervision. Constituting the practitioner as having a deep, personal emotional commitment to his/her work also puts him/her at risk of suffering greater emotional strain as a consequence of emotion management. Supervision is therefore understood as an activity with both positive and negative personal and professional consequences for the practitioner.

In this chapter, supervision has been discussed in terms of the three dimensions of power, emotions and the professional context. The understanding of supervision created from these three key perspectives has been informed by sociological theories of subjectification, emotional labour, and professional identity. These perspectives help to explain the processes and mechanisms which contribute to the participants' experiences of supervision. This has constructed a theoretical understanding of supervision which has emerged from a contextually situated, practical understanding of supervision as it is experienced and understood by mental health nurses and midwives. The theoretical understanding of supervision constructed in this thesis helps to explain how and why supervision may operate in certain ways, and illuminates ways of understanding specific supervision practices.

9 Conclusion

9.1 Introduction

This chapter provides an overview of the thesis, and reviews the conclusions which have been produced by this study, and the limitations of the study. I discuss the contribution which the findings make to the field of supervision research, and supervision practice and policies, and possible directions for future research into supervision in mental health nursing and midwifery.

9.2 The Contribution to Knowledge

This thesis makes the following key contributions to knowledge about supervision:

- The study has addressed the need for knowledge about the interaction between the experience of supervision, and the context in which supervision occurs, through an exploration of practitioners' experiences and understandings of supervision as communicated through sense-making narratives.
- The location of the supervision concept in two comparable but contrasting contexts has illustrated the influence of professional discourses on the experience and understanding of supervision, showing that supervision as a concept is more usefully understood when located and described within specific, context-dependent practices. This thesis has therefore constructed an understanding of supervision as a sensitising concept whose abstract, universal features are tested against the practices which they describe.

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- By exploring supervision in two different contexts this thesis highlights the different ways in which supervision practices can be constructed, and the need to understand supervision in terms of specific features of context, aims and practice.
- This thesis has constructed a theoretical understanding of supervision as comprising three dimensions: power, emotions and the professional context. The understanding of supervision in terms of these three dimensions supports an explanatory account of how and why supervision may operate in certain ways, and illuminates ways of understanding supervision practices in different contexts.
- This thesis argues that supervision can be constructed as a means of constituting practitioners as compassionate, and supporting practitioners' emotion work. The argument is made that to constitute healthcare practitioners as compassionate, and as having a sense of personal authenticity in their emotion work, means that practitioners also require support in order to develop emotion management skills and maintain the effort required for such work.
- This thesis also makes a methodological contribution to knowledge through the creation of a method of narrative analysis which draws together the work of narrative theorists (cf. Ricoeur, 1983/1984, Bruner, 1987, Gee, 2005). The method frames data analysis in terms of a dynamic process of fragmentation and configuration in which the separate elements of the data are analysed in the context of their location within the 'whole' of the narrative. The method incorporates an approach to oral narrative data as performative with the presentation of findings as a narrative way of knowing.

9.3 Limitations

The argument constructed in this thesis is limited by the nature of the data collected and the theoretical approach taken. The constitution and processes of supervision have been explored through the experiences of the participants, and these have been compared in two different professional contexts. Mason (2002) argues that qualitative research is particularly suited to constructing these kinds of arguments which explain process and context. Qualitative research is less suited to proving cause and effect based on a limited number of variables (Mason, 2002), and this study does not identify these kinds of processes. However narratives have an explanatory function (Bruner, 1991), and so in this thesis it has been possible to approach questions of causality in a different way, by asking how and why certain processes are occurring.

The generalisability of the findings from this study is also limited by the methodology. As a qualitative research study, the aim of the methodology is to create in-depth, contextualised knowledge, not a representative analysis. The findings cannot be applied unproblematically to other contexts, but can be used to sensitise researchers to ways of understanding the phenomenon of supervision in different contexts.

The knowledge produced in this study is understood in light of the process of production in which participants and researcher have engaged in the interpretation of experience. A detailed explanation of the circumstances of production allows the reader to take a critical perspective on the knowledge produced through this study. A key aspect of this approach to knowledge production is the conceptualisation of narrative as co-constructed between participants and research (and subsequently researcher and reader). The meanings produced through the interviews are not held to represent an objective reality, however the process of knowledge production is understood as part of the social construction of reality, and so the co-constructed meanings of the interview narratives present a reality which is subjective, but which influences participants' understandings and actions.

This study focuses on the practitioner's experience of supervision. For the most part this has been from the perspective of the supervisee, although some of the mental health nurses who took part in the study also had experience as supervisors. The focus on the experience of the practitioner has meant that the supervision relationship has been understood through only one side of the relationship. It is argued that this is an important perspective on the supervision relationship because it is the practitioner who takes the effects of the supervision relationship back into practice, but this is a limitation on the study's scope to understand the processes of the relationship. The focus on the practitioner also limits the understanding created of the system of statutory midwifery supervision. This large and complex system has a broad range of functions including advocacy for clients, practice development and audit roles for supervisors of midwives. This study's focus on the midwife's experience has meant that these aspects of the supervision system are not addressed.

The ethical requirements of the study also entail limitations. Context was an important factor in this study, but details of the geographical and organisational context have had to be concealed in order to protect the anonymity of participants. However the main focus of the study was on the practitioner's perspective, and so context has been understood in this way.

This study has acknowledged the gendered nature of the two professions, but has not addressed the interaction of gender with supervision. The predominantly female study sample did not support an inquiry into gender and supervision, and issues of gender did not emerge in the findings.

9.4 Implications for Practice

The findings presented in this thesis suggest that supervision needs to be considered as a practice rather than a concept, and that the practice of supervision must be understood as a normative process occurring through power relationships.

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For practitioners and organisations the findings of this study highlights some of the risks and benefits of supervision, and the necessity of considering what a particular supervision practice is intended to achieve and how this can happen. Attention must be paid to the context in which supervision will occur, and how this is likely to affect the practice of supervision. The idea of supervision is deceptively simple, at its most fundamental it is a relationship with a focus on work. However the findings of this study suggest that the practice of supervision is influenced by a wide range of factors.

Understanding supervision as an exercise of power draws attention to the possibilities of supervision as having a beneficial impact on the practitioner and on practice, however it also draws attention to the possibility of harm to the practitioner who is made vulnerable through supervision, and to the possibility of resistance to participation in supervision.

The concept of supervision as an emotional ecology, which may be constructed as distinct from the organisational emotional ecology, suggests a mechanism by which supervision may achieve certain aims such as encouraging candid reflection on practice, providing support, developing emotion management skills, and normalising practice.

Some of the mental health nurses in this study reported that their organisation was keen for all practitioners to identify a named supervisor. It was felt that this was a rather superficial approach which did not require any evidence as to the existence of a supervision practice (or the quality of practice). The arguments constructed in this thesis challenge the position of 'all our staff have named supervisors which means they are having supervision'. This thesis shows that supervision is complex and has both risks and benefits, and its implementation in practice requires careful consideration.

9.5 Implications for Research in the Field of Supervision

This thesis has produced an understanding of supervision as a constructed and contextualised process. Analysing the participants' accounts of their supervision experiences as narratives has preserved the complexity of the supervision experience as composed of numerous interacting factors. This suggests a number of areas which would benefit from further research, and also forms the basis for an argument that research methodologies must take account of the complex, context-specific nature of supervision practices.

9.5.1 Areas for Research

The findings of this study suggest a number of questions about supervision, and the theoretical argument constructed in this thesis could be used either to examine existing supervision practices, or as the basis for a research-led development of supervision practices.

The understanding of supervision as a form of subjectification engenders questions about how this occurs, and what influences the success of such a process. The concept of supervision as a distinct emotional ecology within an organisational emotional ecology can be applied to understand different forms of supervision practices in different contexts, and raises the question of how certain kinds of emotional ecology could be constructed in supervision, for example an ecology of compassion.

This thesis also suggests profession-specific questions. In midwifery, the findings of this study suggest that more research is needed to analyse the aims of statutory supervision, and the processes by which these might be achieved. The contrasting pictures of statutory supervision created in this study also suggest that research might

attend to ways in which the statutory supervision system might be developed and what practitioner needs this might address.

In mental health nursing, the findings of this study raise questions about the relationship between multi-disciplinary supervision and the role of the mental health nurse. The majority of experiences recounted in this study involved supervision with a supervisor or other supervisees from a non-nursing background, and future research could investigate both multi-disciplinary supervision, and solely nursing supervision.

Finally, future research might consider the interaction between gender, and gendered institutions, and the experience, understanding and practice of supervision.

9.5.2 Methodology

This thesis has highlighted the complex, context-dependent nature of supervision, and so has made the argument that research methods must be able to accommodate this. Future research might therefore employ methods which gather rich data in order to construct a detailed picture of supervision practices. The analysis of supervision as an exercise of power and as having both positive and negative outcomes, suggests that inquiry into supervision must include a critical questioning, asking why supervision is being done, whose purposes are being served through supervision, and what potential for harm there is in supervision.

This thesis has also made the argument that research into supervision can be usefully informed by the use of social theories offering explanatory frameworks for the processes being investigated. Future research might further explore the theoretical perspectives employed in this thesis, or select alternative theories to frame the understanding of supervision.

9.6 Implications for Policy

In Chapter 2 I described the ‘compassionate care’ agenda which is current in healthcare policy. I began this thesis with an ethical argument that those who care also need to be cared for, and government publications such as *Compassion in Practice* (Chief Nursing Officer, 2012) and the *Scottish Government Quality Strategy* (The Scottish Government, 2010), have also put forward the argument that healthcare practitioners require care and support in order to be maintained in their roles. This thesis puts forward an argument about how supervision could contribute to the compassionate care agenda in two ways. First, supervision may constitute practitioners as compassionate, encouraging an emotional commitment to the ethic of compassionate care. Second, supervision may support practitioners to carry out emotion work enabling them to maintain a compassionate practice. Importantly this thesis shows that supervision does not necessarily achieve these goals, but must be deliberately constructed in order to support these processes.

In the recent *Quality Assurance Framework* from the NMC (2013), the supervision of midwives is connected to the management of risk, and to the on-going professional education of midwives, reflecting the discourse that the supervision of midwives is a way to protect the public from poor quality care. The findings of this thesis contest this belief, questioning to what extent supervision impacts on the practice of midwives, however this thesis also suggests that statutory supervision might be developed in order to have more impact upon midwives’ practice.

9.7 Summary

This study was carried out with the aim of exploring mental health nurses and midwives' understandings and experiences of supervision. This thesis has shown that the experience of supervision is complex and integrally connected to the context in which it occurs. The thesis has challenged the reification of supervision, instead focusing on supervision as context-dependent practices. The investigation of supervision in different professional contexts highlighted shared and contrasting elements of the participants' experiences, and drew attention to the impact of context. The thesis has formulated a theoretical understanding of supervision which considers the processes and mechanisms operating when practitioners engage in supervision.

This thesis began with the ethical premise that practitioners who give care to others must themselves be cared for. I have asked whether supervision might offer a way of caring for the wellbeing of practitioners. The rich variety of experiences recounted by the study participants suggest that supervision *may* offer such care, when it is constructed and enacted in certain ways. At the same time, supervision can also be a harmful or negligible experience.

The narratives told in this study show that where supervision was a positive, enabling experience, it could have a profound influence on how practitioners sustained their engagement with practice. However for several of those interviewed in this study, most notably the midwives, supervision did not offer meaningful care. I therefore end this thesis with two quotations from the interviews, which express why practitioners need care, and how supervision might help.

Kate:

...there's times when you don't sleep
you know you can go through some very bad
very difficult cases
um women whose babies
who aren't going to get their babies home
women who you've looked after who lose their babies um
and just sometimes it can be really *really* hard

Faye:

...to know that you've actually even in a month's time
got that opportunity to discuss something is really kinda nice
it's nice to know
and reassuring to know that you've got somebody and some
allocated time to be able to
to do that
...it's almost like a pocket that you know that you can put it
in
and leave it there till you can get that opportunity

10 References

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Appendices

Appendix 1: Table 1. Empirical Research Papers Reviewed

Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Arvidsson B, Löfgren, H & Fridlund B.	Psychiatric nurses' conceptions of how group supervision in nursing care influences their professional competence	2000	Phenomenography, Semi-structured interviews, narrative analysis.	Clinical supervision had positive effects on job satisfaction; improved knowledge and competence; feeling more confident in therapeutic relationships; being convinced about the value of supervision; a greater sense of nursing fellowship.	Sweden
Arvidsson B, Löfgren, H & Fridlund B.	Psychiatric nurses' conceptions of how a group supervision programme in nursing care influences their professional competence: a 4-year follow-up study	2001	Phenomenography, Semi-structured interviews, narrative analysis.	Effects of supervision observed by Arvidsson et al. (2001) were sustained 4 years after the intervention.	Sweden
Ayer S, Knight S, Joyce L & Nightingale V	Practice-led education and development project: developing styles in clinical supervision	1997	Action research. Case studies, questionnaires and interviews.	Clinical supervision improves clinical leadership.	UK
Béat I, Berggren I, Ellefsen, B & Severinsson E	Australian nurse supervisors' styles and their perceptions of ethical dilemmas within health care	2003	Questionnaire, descriptive statistics.	Supervision was most frequently based on discussion of a specific case or decision making. Reflection was the most common theory used.	Australia
Béat I & Severinsson E	Reflection on how clinical nursing supervision enhances nurses experiences of well-being related to their psychosocial work environment	2006	A hermeneutic synthesis of three published studies.	Clinical supervision enhances nurses' psychosocial wellbeing in the workplace and improves their understanding of the nursing role.	Norway Japan Sweden

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Berg A & Hallberg IR	Effects of systematic clinical supervision on psychiatric nurses' sense of coherence, creativity, work-related strain, job satisfaction and view of the effects from clinical supervision: a pre-post test design	1999	Pre and post test questionnaire, descriptive statistics.	A one year clinical supervision intervention reduced workplace conflict, reduced work-stress, improved nurses' sense of creativity and coherence, but had no effect on the organisational climate. Nurses became more convinced of the worth of supervision. From the same study as Berg & Hallberg (2000)	Sweden
Berg A & Hallberg IR	The meaning and significance of clinical group supervision and supervised individually planned nursing care as narrated by nurses on a general team psychiatric ward	2000	Interviews, latent content analysis.	A combination of clinical supervision and individual care planning gave a more robust foundation to care and illuminated the complexity of care.	Sweden
Bowles N & Young C	An evaluative study of clinical supervision based on Proctor's three function interactive model	1999	Questionnaire, statistical analysis	Clinical supervision benefits nurses in all three areas of Proctor's model. Positive effects are associated with greater experience in supervision and shorter length of service. Supervision changes nursing practice.	UK
Butterworth T, Carson J, White E, Jeacock J, Clements A & Bishop V	<i>It is good to talk.</i> An evaluation study in England and Scotland.	1997	Experiment, multi-site, mixed methods: questionnaires, interviews.	Clinical supervision involved discussion of casework, management issues, professional development, education, personal issues, and was confidence building. The most valued outcomes were reflecting on and learning from practice and discussing organisational issues.	UK

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Buus N, Angel S, Traynor M & Gonge H	Psychiatric Hospital Nursing Staff's Experiences of Participating in Group-Based Clinical Supervision: An Interview Study	2010	Semi-structured Interviews, interpretive analysis.	Clinical supervision provided learning opportunity, peer support, and enhanced professional identity. Effects were short term and limited by organisational problems. Supervision was a means of control, and caused anxiety by making nurses feel exposed during sessions.	Denmark
Caldwell K	Care for the Carers in Exeter	1996	Audit, secondary data analysis	A programme employing a variety of measures including social and therapeutic interventions, improved the wellbeing of midwives. Care was assessed as 'excellent' in an independent survey.	UK
Cleary M & Freeman A	The cultural realities of clinical supervision in an acute inpatient mental health setting	2005	Ethnography	Although mental health nurses seem to accept clinical supervision there is a culture of passive resistance to engaging in supervision practice. This may be connected to beliefs about the nature and value of supervision.	Australia
Cutcliffe JR & Hyrkäs K	Multidisciplinary attitudinal positions regarding clinical supervision: a cross-sectional study	2006	Questionnaire, descriptive statistics	Clinical supervision should be separate from managerial supervision, and must be confidential. Attitudes to supervision are similar across different disciplines.	USA
Deery, R	An action-research study exploring midwives' support needs and the affect of group clinical supervision	2005	Action Research, interviews and focus groups.	Organisational change and workloads impeded the establishment of clinical supervision. Midwives and their managers showed a lack of awareness of the emotion management involved in clinical work.	UK

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Deery, R	The tyranny of time: tensions between relational and clock time in community-based midwifery	2008	Action Research, interviews and focus groups.	Midwives' conceptualisation of time impeded their ability to engage with clinical supervision.	UK
Demilew J	Independent midwives' views of supervision	1996	Semi-structured interviews, thematic content analysis	Many midwives had negative views of supervision, and had experienced supervision as punitive.	UK
Duerden, J	Auditing supervision: an example of one audit and general issues concerning audit.	1996	Audit, structured interviews, statistical analysis	There was a wide variation in supervisee:supervisor ratios in different parts of the country. Almost all supervisors were holding annual review meetings, which lasted from 3-12 minutes and longer. Public safety was seen as the most important outcome of supervision.	UK
Edwards D, Burnard P, Hannigan B, Adams J, Fothergill A & Coyle D.	Factors influencing the effectiveness of clinical supervision	2005	Questionnaire, statistics.	Clinical supervision sessions should happen away from the workplace, last for more than an hour and take place at least once a month. Supervisees should choose their supervisors.	UK
Edwards D, Burnard P, Hannigan B, Cooper L, Adams J, Juggessur T, Fothergil A & Coyle D.	Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses	2006	Questionnaires, statistics	More effective supervision was associated with lower levels of burnout, particularly emotional exhaustion and depersonalisation.	UK
Gonge H & Buus N	Individual and Workplace Factors that Influence Psychiatric Nursing Staff's Participation in Clinical Supervision: A Survey Study and Prospective Longitudinal Registration	2010	Questionnaire, descriptive statistics.	There was a wide variation in how nurses participated in clinical supervision, and a large number did not participate in supervision. Participation in supervision was related to organisational factors.	Denmark

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Gonge H & Buus N	Model for investigating the benefits of clinical supervision in psychiatric nursing: A survey study	2011	Questionnaire, descriptive statistics.	An association was identified between participation in clinical supervision and more effective supervision.	Denmark
Farkas-Cameron MM	Clinical supervision in psychiatric nursing. A self-actualizing process.	1995	Interviews	Clinical supervision fostered personal-professional development, improved skills, and allowed a therapeutic discussion of emotions connected to practice.	USA
Halksworth G, Bale B & James C	Evaluation of supervision of midwives. Wales	2000	Questionnaire, case study, interviews	Supervisor:supervisee ratios were too big. Supervision practice was becoming more supportive.	UK
Hancox K, Lynch L, Happell B & Biondo S	An evaluation of an educational program for clinical supervision	2004	Questionnaire, statistical and content analyses.	An educational programme in clinical supervision reduced nurses' misunderstandings of supervision and increased confidence in practicing supervision. Participants also regarded supervision more positively.	Australia
Holst G, Edberg AK, Hallberg I	Nurses' narrations and reflections about caring for patients with severe dementia as revealed in systematic clinical supervision sessions	1999	Narratives, Phenomenological-Hermeneutic Analysis.	Nurses used supervision sessions to reflect on their interactions with patients, and construct new stories about patients explaining why patients behaved in certain ways.	Sweden
Hughes A & Richards J	Accessing midwifery supervision	2002	Qualitative questionnaires	A study day on the role of the supervisor led midwives to have increased contact with their supervisors outwith the annual review. Midwives subsequently found supervision more effective.	UK

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Hyrkäs K,	Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in finland	2005	Questionnaire, statistics.	Clinical supervision was associated with reduced burnout and stress, and increased job satisfaction.	Finland
Hyrkäs K & Paunonen-Ilmonen M	The effects of clinical supervision on the quality of care: examining the results of team supervision	2001	Group interviews, phenomenography.	Team supervision was associated with improved quality of care, but nurses had varying conceptualisations of knowledge and quality.	Finland
Hyrkäs K, Appelqvist-Schmidlechner K & Paunonen-Ilmonen M	Expert supervisors' views of clinical supervision: a study of factors promoting and inhibiting the achievements of multiprofessional team supervision	2002	Semi-structured interviews	Team supervision was influenced by a combination of factors including the skill and confidence of the supervisor, team relationships, logistics of supervision provision and commitment to supervision. Team supervision improved working relationships, facilitated multi-disciplinary working and strengthened professional identity.	Finland
Hyrkäs K, Appelqvist-Schmidlechner K & Oksa L.	Validating an instrument for clinical supervision using an expert panel	2003	Mixed methods	Validation of the MCSS for use in Finland. Some items on the scale were identified as culture-specific.	Finland
Hyrkäs K & Lehti K	Continuous quality improvement through team supervision supported by continuous self-monitoring of work and systematic patient feedback	2003	Questionnaires, statistical process control and control charts.	Over the course of a three year intervention the quality of care was improved through a system of self-monitoring by nurses and patient feedback combined with team supervision.	Finland

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Hyrkäs K, Appelquist-Schmidlechner K, & Kivimäki K	First-line managers' views of the long-term effects of clinical supervision: how does clinical supervision support and develop leadership in health care?	2005	Empathy based stories.	Managers receiving clinical supervision reported a positive long-term impact on leadership, communication and coping skills, improved self-awareness and a better understanding of work.	Finland
Hyrkäs K, Appelquist-Schmidlechner K & Haataga R	Efficacy of clinical supervision: influence on job satisfaction, burnout and quality of care	2006	Questionnaire survey, statistics.	Supervision was more effective for some nurses than others, and these differences were statistically significant. Clinical speciality, work contract, experience and knowledge of supervision were associated with efficacy of supervision. Evaluations of supervision were predictors for burnout, job satisfaction and care quality.	Finland
Jones, A	'Out of the sighs' —an existentialphenomenological method of clinical supervision: the contribution to palliative care	1998	Case study	During the supervision interaction, interpersonal issues from clinical practice are manifested alongside the supervisee and supervisor's own existential struggles.	UK
Kelly B, Long A & McKenna H	A survey of community mental health nurses' perceptions of clinical supervision in Northern Ireland	2001	Questionnaire, statistics	There was widespread support for and implementation of, clinical supervision, but there was little education in supervision, and the model in use was management-led despite a general belief that supervisors should not be managers.	UK
Kirkham, M	The culture of midwifery in the National Health Service in England	1999	Interviews, grounded theory analysis	There is a 'service and sacrifice' culture in midwifery which, together with widespread feelings of guilt and blame deprives midwives of support.	UK

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Koivu A, Saarinen PI & Hyrkas K	Does clinical supervision promote medical–surgical nurses’ well-being at work? A quasi-experimental 4-year follow-up study	2012	Questionnaire survey, statistics	Effective clinical supervision was associated with improved wellbeing of medical-surgical nurses.	Finland
Malin NA	Evaluating clinical supervision in community homes and teams serving adults with learning disabilities	2000	Observation and semi-structured interviews		UK
Marrow CE, Hollyoake K, Harmer D & Kenrick C	Clinical supervision using video-conferencing technology: a reflective account	2002	Reflective accounts.	Nurses experienced clinical supervision as supportive, developing working relationships, improved reflective skills and enhanced understanding about practice.	UK
Mead M & Kirby J	Evaluation of time spent by Supervisors of Midwives on supervisory activities	2006	Audit: questionnaire and activity diary, statistics	Supervisors of midwives’ estimates of time spent on supervisory duties varied enormously. A third of supervisors dealt with a major event during the audit week, requiring increased time devoted to supervisory activity.	UK
Rice F, Cullan P, McKenna H, Kelly B, Keeney S & Richey R.	Clinical supervision for mental health nurses in Northern Ireland: formulating best practice guidelines	2007	Survey	Health service directors believed that clinical supervision would support and develop mental health nurses, but found clinical supervision difficult to implement in the absence of clear guidelines.	UK
Scanlon C & Weir WS	Learning from practice? Mental health nurses’ perceptions and experiences of clinical supervision	1997	Semi-structured interviews, constant comparative analysis.	Mental health nurses evaluated supervision positively, but provision was constrained by confusion between clinical supervision and management and by a lack of education in supervision.	UK

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Severinsson EI & Hallberg I	Systematic clinical supervision, working milieu and influence over duties: the psychiatric nurse's viewpoint – a pilot study.	1996	Questionnaire, statistics	Clinical supervision enhances nurses' sensitivity towards their patients. Other forms of work support and nurses' autonomy had no influence on clinical supervision.	Sweden
Severinsson EI & Borgenhammar EV	Expert views on clinical supervision: a study based on interviews	1997	Interviews, grounded theory.	The clinical supervision relationship guides the practitioner from novice to expert. Implementation of clinical supervision has both positive and negative consequences.	Sweden
Severinsson E, Haruna M & Friberg F	Midwives' group supervision and the influence of their continuity of care model – a pilot study	2012	Observation, focus group, thematic analysis.	Group supervision increased midwives' professional competence.	Norway
Shennan C	Midwives' perceptions of the role of supervisor of midwives	1996	Interviews, thematic content analysis.	Midwives experienced their supervisors as generally unsupportive.	UK
Sloan G	Good characteristics of a clinical supervisor: a community mental health nurse perspective	1999	Questionnaire and focus group, thematic content analysis.	A good supervisor is able to form a supportive relationship, is knowledgeable, committed to supervision, has good listening skills and is a role model. In practice supervisors were allocated not chosen.	UK
Sloan G	Clinical Supervision in Mental Health Nursing	2006	Case study, interviews, journals, documents and recorded supervision sessions.	Supervisors were also line managers and supervision tended to follow a managerial agenda, with a controlling approach from the supervisor and a risk management, problem solving focus. Clinical supervision included little discussion about the therapeutic relationship, but could include discussion of supervisee's personal problems.	UK

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Sloan G & Watson H	Illuminative evaluation: evaluating clinical supervision on its performance rather than the applause	2001	Case study, interviews, journals, documents and recorded supervision sessions.	Clinical supervision included interventions identified using Heron's framework as catalytic, prescriptive, informative, supportive and degenerative. Informative interventions focused on organisational matters.	UK
Stapleton H, Duerden J & Kirkham M	Evaluation of the impact of the supervision of midwives on professional practice and the quality of care.	1998	Ethnography, fieldnotes, interviews, focus groups, audit tool	Midwives were uninformed about supervision. Supervision was a source of professional identity. Supervision was seen as primarily about protecting the public, but also about supporting midwives.	UK
Stevenson C & Jackson B	Egalitarian consultation meetings: an alternative to received wisdom about clinical supervision in psychiatric nursing practice	2000	Audiovisual recordings, hermeneutic grounded theory.	Nurses participating in egalitarian consultation meetings felt free of hierarchy and narrated their practice from the position of expert. The egalitarian ethos conflicted with dominant organisational culture.	UK
Teasdale K, Brocklehurst N & Thom N	Clinical supervision and support for nurses: an evaluation study	2001	Survey, mixed methods.	Clinical supervision had more positive effects on junior nurses. There was no apparent association with reduced burnout. Nurses used both informal support and clinical supervision.	UK
Wallbank, S	Effectiveness of individual clinical supervision for midwives and doctors in stress reduction: findings from a pilot study.	2010	Quasi-experimental, questionnaires, statistics.	Midwives and doctors who received clinical supervision showed reduced stress levels, increased compassion and reduced burnout and compassion fatigue.	UK

Appendix 1: Table 1. Empirical Research Papers Reviewed

Author	Name of Study	Year	Methods	Key Findings	Country of Origin
Walsh K, Nicholson J, Keough C, Pridham R, Kramer M & Jeffrey J	Development of a group model of clinical supervision to meet the needs of a community mental health nursing team	2003	Questionnaire, statistics	A model of clinical supervision was developed based on Proctor's three functions of supervision. The group was positively evaluated particularly in the areas of critical evaluation, understanding issues and improving practice.	Australia
White E & Roche M	A selective review of mental health nursing in New South Wales, Australia, in relation to clinical supervision	2006	Questionnaire survey, statistics	Mental health nurses in New South Wales were generally not practicing clinical supervision .	Australia
White E & Winstanley J	Cost and resource implications of clinical supervision in nursing: an Australian perspective	2006	Secondary analysis of data, financial modelling	The cost of giving one-to-one clinical supervision to a nurse was 1% of annual salary.	Australia
White E & Winstanley J	Clinical supervision: outsider reports of a research-driven implementation programme in Queensland, Australia	2010	Semi-structured interviews	Senior managers supported clinical supervision, but the implementation of supervision in the services was impeded by junior managers' sceptical attitudes.	Australia
White E & Winstanley J	Implementation of Clinical Supervision: educational preparation and subsequent diary accounts of the practicalities involved, from an Australian mental health nursing innovation	2009	Diaries	Managerial and administrative support was crucial in facilitating the implementation of clinical supervision.	Australia

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Author	Name of Study	Year	Methods	Key Findings	Country of Origin
White E & Winstanley J	Clinical supervision for nurses working in mental health settings in Queensland, Australia: a randomised controlled trial in progress and emergent challenges.	2009	Randomised controlled trial, questionnaires, statistics.	Understandings of clinical supervision were divided between high expectations and scepticism. Nurses most in need of clinical supervision were least likely to receive it. Organisational culture change was required to support the implementaion of clinical supervision.	Australia
White E, Butterworth T, Bishop B, Carson J, Jeacock J & Clements A	Clinical supervision: insider reports of a private world	1998	Interviews, content analysis.	Participants had no experience of clinical supervision prior to involvement with the research project. Clinical supervision was associated with other activities such as preceptorship, peer support and therapy.	UK
Williams, EMJ	Clinicians' Views of Supervision	1996	Semi-structured interviews, thematic content analysis.	Midwives were uninformed about statutory supervision, but saw it as an important way of ensuring safe practice.	UK

Guidelines for Interviews

These guidelines will be used flexibly. The questions are intended as a guide and to stimulate discussion. Where discussion flows freely questions may not be used.

Starter Question:

When I use the term supervision, what comes to mind?

For you, what is the purpose of supervision?

What sort of things do you get out of supervision?

Ideally what would support you with practice – what do you need?

Can you tell me about your most recent experience of supervision?

What makes you feel supported with your practice?

Is there anything which makes you feel unsupported with your practice?

Probes

What does that mean to you?

How did that affect you?

How did you feel about that?

Can you tell me more about that?

Supervision Probes

Who is your supervisor?

How was your supervisor chosen?

How are your sessions arranged?

When/where/how often/how long are supervision sessions?

How do you decide what to discuss?

Who does the talking?

Who asks the questions?

What sort of things are discussed?

**University of Edinburgh,
School of Health in Social Science
RESEARCH ETHICS COMMITTEE
Self-Audit Checklist for Level 1 Ethics Review**

The audit is to be conducted by investigators:

- **For funded research:** the Principal Investigator.
- **For other research conducted by members of academic staff:** the academic staff member.
- **Postdoctoral research fellows:** the research fellow in collaboration with the mentor or proposed mentor.
- **Postgraduate research students (PhD and Masters by Research):** the student in collaboration with the supervisor(s).
- **Taught Masters dissertation students and Undergraduate dissertation/project students:** the student in collaboration with the dissertation/project supervisor

Note: all members of staff and students should conduct the self-audit level of ethics review of their proposed research as part of the proposal process.

• **1. IRAS or LOCAL AUTHORITY/SOCIAL WORK ethical review**

Does the project require IRAS review or other external review including by bodies abroad? NO

2. Protection of research subject confidentiality

Are there any issues of CONFIDENTIALITY which are not ADEQUATELY HANDLED by normal tenets of academic confidentiality? NO

These include well-established sets of undertakings that may be agreed more or less explicitly with collaborating individuals/organisations, for example, regarding:

- (a) Non-attribution of individual responses;
- (b) Individuals and organisations anonymised in publications and presentation;
- (c) Specific agreement with respondents regarding feedback to collaborators and publication.

3. Data protection and consent

Are there any issues of DATA HANDLING and CONSENT which are not ADEQUATELY DEALT WITH and compliant with established procedures? NO

These include well-established sets of undertakings, for example regarding:

- (a) Compliance with the University of Edinburgh's Data Protection procedures (see www.recordsmanagement.ed.ac.uk);
- (b) Respondents giving consent regarding the collection of personal data;
- (c) No special issues arising about confidentiality/informed consent;
- (d) application for Caldicott Guardian approval.

4. Moral issues and Researcher/Institutional Conflicts of Interest

Are there any SPECIAL MORAL ISSUES/CONFLICTS OF INTEREST? NO

- (a) An example of conflict of interest would be a financial or non-financial benefit for him/herself or for a relative of friend.
- (b) Particular moral issues or concerns could arise, for example where the purposes of research are concealed, where respondents are unable to provide informed consent, or where research findings would impinge negatively/differentially upon the interests of participants.

Appendix 3: University of Edinburgh School of Health in Social Science Self-Audit Checklist for Level 1 Ethics Review

5. Potential physical or psychological harm, discomfort or stress

Is there a SIGNIFICANT FORSEEABLE POTENTIAL FOR PSYCHOLOGICAL HARM OR STRESS for participants?	NO
Is there a SIGNIFICANT FORSEEABLE POTENTIAL FOR PHYSICAL HARM OR DISCOMFORT?	NO
(c) Is there a SIGNIFICANT FORSEEABLE RISK TO THE RESEARCHER?	NO

6. Bringing the University into disrepute

Is there any aspect of the proposed research which might bring the University into disrepute?
NO

7. Vulnerable participants

Are any of the participants or interviewees in the research vulnerable, e.g. children and young people, people who are in custody or care, such as students at school, self help groups, residents of nursing home? NO

8. Duty to disseminate research findings

Are there issues which will prevent all participants and relevant stakeholders having access to a clear, understandable and accurate summary of the research findings? NO

Overall assessment

If all the answers are NO, the self-audit has been conducted and confirms the ABSENCE OF REASONABLY FORESEEABLE ETHICAL RISKS.

All students (undergraduate, Masters and Doctoral) lodge completed self-audit forms electronically with their supervisor and/or the Subject Area Research Ethics Co-ordinator as advised in information provided by the subject area. The subject area considers the information provided and either confirm ethical approval or refer the request back to the student.

Postdoctoral research fellows lodge completed self-audit forms electronically with their mentor and/or the Subject Area Research Ethics Co-ordinator as advised in information provided by the subject area. The subject area will consider the information provided and either confirms ethical approval or refers the request back to the postdoctoral researcher.

Academic staff (excluding postdoctoral research fellows) lodge completed self-audit forms electronically with the Subject Area Research Ethics Co-ordinator as advised in information provided by the subject area. The subject area will consider the information provided and log the information or confirm ethical approval or refer the request back to the staff member as appropriate.

If one or more answers to the self-audit is YES, level 2 assessment is required. See the School Research Ethics Policy and Procedures for full details. <http://www.ed.ac.uk/schools-departments/health/research/policyandprocedures>

Narratives of Supervision

This study is to be carried out as part of the requirements for a PhD. Research design, data collection, analysis and write up will all be conducted by Jessica MacLaren under the supervision of Deborah Ritchie and Dr Rosie Stenhouse. The study will use qualitative data collection methods, employing narrative methodology to analyse data collected through unstructured interviews, and from documents (NMC guidelines and [REDACTED] supervision policies). The focus of this study is on midwives' and community mental health nurses' experiences and understandings of supervision in the context of wider professional discourses of supervision. The study will not collect patient information.

Contact Details

Researcher:

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01382 308508

Study Topic and Aim

The topic of this study is supervision

In the nursing literature the concept of supervision is widely problematised (cf. Cutcliffe et al. 2001; Cutcliffe & Lowe 2005; Hyrkäs et al. 1999; Lyth 2000; Yegdich 1998; Yegdich 1999a; Yegdich 1999b; Yegdich 2000). A conceptualisation of supervision has therefore been developed for the purposes of this study: Supervision is conceptualised as a formal system of support for professional practice in which the basic units are a supervisee and supervisor. [Here the terms supervisee and supervisor do not necessarily imply a hierarchical relationship.] Supervision is understood as a socially constructed concept which is used to signify a variety of meanings and practices, and whose meaning depends on the context of use.

The aim of the study is to explore how supervision is experienced in two contexts: midwifery and mental health nursing. The exploration of this topic will take account of two themes: 1. Other forms of support for the professional role. 2. Wider professional discourses of supervision.

Research Questions

1. How do midwives and mental health nurses experience and understand supervision?
2. How can supervision narratives be understood within different professional contexts?

Background

In the UK, the Nursing and Midwifery Council requires all midwives to have supervision as a condition of practice, and has recommended that nurses engage in supervision as an important part of their career-long development of practice (NMC 2008a; NMC 2008b). There is also an international literature on clinical supervision and nursing (cf Buus & Gonge 2009; Hyrkäs et al. 1999).

Nursing Literature

To date several studies have been conducted on the effects of clinical supervision (cf. Arvidsson et al. 2000 & 2001; White et al. 1998; White & Winstanley 2010), and there is evidence to suggest that clinical supervision has a beneficial effect on aspects of nursing practice such as competence, ethical decision making, leadership, burnout and the nurse-patient relationship (cf. Bégat & Severinsson 2006; Bégat et al. 2003; Bowles & Yound 1999; Edwards et al. 2006; Hyrkäs et al 2002; Marrow et al. 2002; Sloan 2004).

There are few research studies which provide in-depth investigation of how clinical supervision is conducted in practice or how the context in which clinical supervision takes place affects the practice of nursing (Hyrkäs 2006). However those studies which do investigate these issues suggest that in practice clinical supervision is of poor quality, often

conducted with little understanding of the theoretical background or aims of supervision (cf. Proctor 2009; White & Winstanley 2009). There is also some limited evidence suggesting that the experience of clinical supervision is affected by aspects of context such as the training of supervisors and supervisees, organisational policies, work environment and workload and the attitudes of the multi-disciplinary team towards supervision (cf. Cleary & Freeman 2005; Edwards et al. 2005; Johns 2003; Hyrkäs et al. 2006; Marrow et al. 2002; Sloan 2004; White & Winstanley 2009 & 2010).

Midwifery Literature

In the main, supervision in the midwifery literature occurs as *statutory* supervision (cf. Dimond 2004; O'Connor 2001, 2002; Kirby 2002), and there are only a small number of studies which explore the use of *clinical* supervision in midwifery (cf. Deery 2005; Lyberg & Severinsson 2010; Skoberne 2003; Wallbank 2010). However, there is evidence that functions commonly associated with *clinical* supervision – such as support, development, empowerment or reflection – have begun to be incorporated into the concept of statutory supervision (cf. NMC 2008b; Yearly 2003).

Sampling

The sampling strategy will be purposive. The aim is to recruit participants who are likely to be “acute observers and... well informed” (Blumer 1969/1998: 37). Participants will therefore have at least 1 year’s post-qualification experience, and have a variety of experiences to draw upon. The sample will consist of 8-10 midwives and 8-10 mental health nurses.

Participants will be recruited through [REDACTED], the researcher will make initial contact with the relevant service managers to negotiate contact with potential participants.

Inclusion Criteria:

Qualified midwives and mental health nurses who have at least 1 year’s post-qualification experience, and who are working in community-based settings within [REDACTED].

Exclusion Criteria:

Midwives and mental health nurses who are not predominantly community based.
Mental health nurses who do not have an allocated supervisor (there is no requirement as to the type of supervision, or frequency of supervision meetings).
Newly qualified (<1 year post-registration) midwives of mental health nurses.

Data Collection Methods

Interviews

There will be a single, unstructured interview with each participant. The aim of the interview will be to collect a narrative of supervision and support experiences. Interview location will, in part, depend on practical considerations such as available spaces. The aim will be to

conduct interviews in a neutral location away from busy working environments, and participants will be involved in choosing a location for their interview.

Documentary Analysis

Narrative methodology will be used to analyse the NMC's (2008a; 2008b) guidance on supervision for midwives and nurses, and the [REDACTED] supervision policies for midwives and mental health nurses. The aim of the documentary analysis will be to place individual narratives collected through interview in the context of wider discourses around supervision.

Ethical Issues

Impact on participants

Participants will be asked to devote 60-90 minutes to attending an interview. This may be an issue for busy professionals, and the researcher will be as flexible as possible when arranging interviews in order to minimise disruption to participants' schedules. Any travel costs incurred will be reimbursed by the researcher from a research fund awarded by the University of Edinburgh. As a thank you gift for donating their time participants will be offered a £20 gift voucher. This will be from a research fund awarded by the University of Edinburgh.

Participants will be asked about the psycho-social impact of their work and how they cope with this, and it is possible they may find this upsetting. As part of the recruitment process it will be explained that participation is voluntary and they can choose not to discuss an issue. Participants will have the option of terminating participation at any time. This will be made clear at the beginning of each contact, and if they become visibly upset. The researcher is a qualified mental health nurse and able to respond sensitively and professionally in such a situation.

It is hoped that participants will find being involved in the study a rewarding experience as it will offer participants an opportunity to reflect on, and discuss, their experiences.

Consent

Participation will be on the basis of voluntary and informed consent. All potential participants will be given detailed information about the aims, nature and conduct of the study before deciding whether to participate. All participants will have the opportunity to ask questions about the study at any point before or during the study. The researcher will seek informed, full, and freely given consent before the study begins. Participants will be asked to read and sign a consent form. Consent to participate may be withdrawn at any point during the study. All participants will be given the name and address of an independent person who may be contacted with any complaints or concerns about the study.

Sensitivity

The researcher will maintain an awareness of the potentially sensitive nature of participants' discussion of practice related problems, their emotional impact, and ways of coping with this. The researcher will aim to avoid causing distress to research participants and to support participants in the event that they experience distress as a result of the research. An advantage of the unstructured format of the interviews will be that participants are able to

Appendix 4: Research Design Reviewed by NHS Ethics Service

exercise control over the topics discussed and so avoid topics which they may find distressing and overdisclosure.

Confidentiality

The focus of this study is on the experiences of midwives and mental health nurses, and no details of individual patient cases will be collected. Participants will be asked to anonymise any references to individual patients.

Data from each individual participant will be kept confidential and will not be shared with others participating in the study. Confidential information will only be disclosed to a third party if there is risk of serious harm or where there is a legal requirement for the researcher to disclose the information. Participants will be informed of the limits of confidentiality.

Management of Research Data

Data collected during this study will be managed in accordance with the University of Edinburgh research records management and data protection policy.

Data in electronic format (e.g. Word documents) will be stored on the University of Edinburgh's secure computer network, password protected, and accessible only by the researcher. 'Hard copy' data (e.g. data on digital voice recorders, USB sticks, printed documents, handwritten documents) will be stored in a locked cupboard in the School of Health at the University of Edinburgh. The cupboard is only accessible by the researcher and is located in a keypad-entry office.

Anonymised data will be held for five years after collection and then the possibilities for archiving will be reviewed.

Dissemination of Findings

The findings of the study will be written up as part of the requirements for the PhD. The researcher will also publish findings from the study in academic and professional journals, and present findings at conferences. The researcher will give all participants a summary of the study findings, and will be available to present the findings to interested parties within [REDACTED] and for other knowledge transfer activities within the NHS.

Study Sponsor

Lead sponsor:

(Academic)

University of Edinburgh

Gemma Watson

[REDACTED]

Appendix 4: Research Design Reviewed by NHS Ethics Service

[REDACTED]
[REDACTED]
Tel: [REDACTED] 242 9461
Fax: [REDACTED] 242 9447
Email: [gemma.watson@\[REDACTED\]](mailto:gemma.watson@[REDACTED])

*Co-sponsor
(NHS organisation)*

[REDACTED]
Karen Maitland

[REDACTED]
[REDACTED]
Tel: [REDACTED] 242 3328
Fax: [REDACTED] 242 3343
Email: [Karen.maitland@\[REDACTED\]](mailto:Karen.maitland@[REDACTED])

The University of Edinburgh and [REDACTED] have established a joint research and development office (ACCORD) to facilitate clinical research. Co-sponsorship responsibilities are outlined in a framework agreement.

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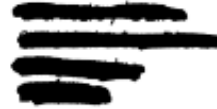
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[REDACTED] Research Ethics Service



Name: Jessica MacLaren
Address: School of Health
in Social Science,
University of Edinburgh
Edinburgh

Date: 07/03/2011
Your Ref:
Our Ref: NR/1103AB1
Enquiries to: Alex Bailey
Direct Line: [REDACTED] 465 5679
Email: alex.bailey@[REDACTED]

Rectangular Snip

Dear Jessica,

Full title of project: Midwives' and community mental health nurses' experiences and understandings of supervision in the context of wider professional discourses of supervision

You have sought advice from the [REDACTED] Research Ethics Service on the above project. This has been considered by the Scientific Officer and you are advised that, based on the submitted documentation (1Narratives of Supervision Research Design.doc and Narratives of Supervision Research Design.doc), it does not need NHS ethical review under the terms of the Governance Arrangements for Research Ethics Committees in the UK. The advice is based on the following:

- *The project is an opinion survey seeking the views of NHS staff on service delivery.*

If this project is being conducted within [REDACTED] you should inform the relevant local Quality Improvement Team(s).

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements. However, if you, your sponsor/funder or any NHS organisation feels that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further. Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

You should retain a copy of this letter with your project file as evidence that you have sought advice from the [REDACTED] Research Ethics Service.

Yours sincerely,

Alex Bailey
Scientific Officer

[REDACTED] Research Ethics Service

Research Ethics Service

DIFFERENTIATING AUDIT, SERVICE EVALUATION AND RESEARCH

November 2006

The "Ad Hoc Advisory Group on the Operation of NHS Research Ethics Committees" recommended NRES should develop guidelines to aid researchers and committees in deciding what is appropriate or inappropriate for submission to RECs, and NRES (with the Health Departments and with advice from REC members) has prepared the guidelines in the form of the attached table.

RESEARCH	CLINICAL AUDIT	SERVICE EVALUATION
The attempt to derive generalisable new knowledge including studies that aim to generate hypotheses as well as studies that aim to test them.	Designed and conducted to produce information to inform delivery of best care.	Designed and conducted solely to define or judge current care.
Quantitative research – designed to test a hypothesis. Qualitative research – identifies/explores themes following established methodology.	Designed to answer the question: “Does this service reach a predetermined standard?”	Designed to answer the question: “What standard does this service achieve?”
Addresses clearly defined questions, aims and objectives.	Measures against a standard.	Measures current service without reference to a standard.
Quantitative research -may involve evaluating or comparing interventions, particularly new ones. Qualitative research – usually involves studying how interventions and relationships are experienced.	Involves an intervention in use ONLY. (The choice of treatment is that of the clinician and patient according to guidance, professional standards and/or patient preference.)	Involves an intervention in use ONLY. (The choice of treatment is that of the clinician and patient according to guidance, professional standards and/or patient preference.)
Usually involves collecting data that are additional to those for routine care but may include data collected routinely. May involve treatments, samples or investigations additional to routine care.	Usually involves analysis of existing data but may include administration of simple interview or questionnaire.	Usually involves analysis of existing data but may include administration of simple interview or questionnaire.
Quantitative research - study design may involve allocating patients to intervention groups. Qualitative research uses a clearly defined sampling framework underpinned by conceptual or theoretical justifications.	No allocation to intervention groups: the health care professional and patient have chosen intervention before clinical audit.	No allocation to intervention groups: the health care professional and patient have chosen intervention before service evaluation.
May involve randomisation	No randomisation	No randomisation
ALTHOUGH ANY OF THESE THREE MAY RAISE ETHICAL ISSUES, UNDER CURRENT GUIDANCE:-		
RESEARCH REQUIRES R.E.C. REVIEW	AUDIT DOES NOT REQUIRE R.E.C. REVIEW	SERVICE EVALUATION DOES NOT REQUIRE R.E.C. REVIEW



Narratives of Supervision Information Sheet

What is this Research Study About?

This study will explore how supervision is experienced in two different professional contexts: Midwifery and Mental Health Nursing. The study will focus on the individual experiences of Midwives and Mental Health Nurses, looking both at experiences of supervision and also other forms of support with professional practice.

Why is the Study Being Carried Out?

This study will form part of the requirements for a PhD degree. The aim of the study is to create a deeper understanding of how supervision operates in practice, and in relation to other forms of support which Midwives and Mental Health Nurses may use to help them with their work.

Who Will Conduct the Research?

The research will be conducted by Jessica MacLaren. Jessica is a PhD student at the School of Health in the University of Edinburgh. Jessica is a registered mental health nurse and has worked in a variety of settings including community services and primary care.

The research will be supervised by Deborah Ritchie, Senior Lecturer at the School of Health, University of Edinburgh and Dr Rosie Stenhouse, Lecturer, University of Abertay Dundee.

What Will the Study Involve?

1. Giving consent - Jessica will meet with you to discuss what the study will involve and if you would like to take part.
2. Interview - Jessica will meet with you for a single interview. The interview will be loosely structured, and will focus on your experiences and ideas about supervision and support.
3. Findings - Jessica will send you a summary of the study findings and be available to discuss them with you.

How Can I Get Involved?

If you would like to discuss taking part in this study please contact Jessica MacLaren.

Tel. 07913 383 331 / J.M.MacLaren@sms.ed.ac.uk

Confidentiality

The interview will be recorded. The recording will be listened to and transcribed by Jessica. The audio-recording will be stored in a locked cupboard in a secure-access office at The School of Health, University of Edinburgh. All audio-recordings will be destroyed at the end of the study.

Interview transcriptions will be anonymised so that no individuals may be identified. All data connected to the study will be managed in accordance with the University of Edinburgh Data Management Guidelines.

Independent Contact

If you have concerns about this study and would like to speak to an independent person not involved with the study please contact:

Marion Smith
Postgraduate Convener
School of Health in Social Science
University of Edinburgh
0131 651 3969
Marion.Smith@ed.ac.uk



Narratives of Supervision Consent Form

I have spoken to Jessica MacLaren about the study

This meeting took place on(date)

	Tick One Box	
	Yes	No
We have looked at the information sheet	<input type="checkbox"/>	<input type="checkbox"/>
I have had a chance to look at the information sheet and ask questions	<input type="checkbox"/>	<input type="checkbox"/>
I know enough about the research now to make a decision on taking part	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I can chose to take part or not	<input type="checkbox"/>	<input type="checkbox"/>
I understand that if I don't want to take part I don't have to give a reason	<input type="checkbox"/>	<input type="checkbox"/>
I understand that if I do take part our interviews will be recorded	<input type="checkbox"/>	<input type="checkbox"/>
I understand that if I do take part, I can withdraw at any time without giving a reason	<input type="checkbox"/>	<input type="checkbox"/>
I understand that if I do not want to take part this will not affect my position at work.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in the study	<input type="checkbox"/>	<input type="checkbox"/>

Signed.....Date.....

Name (in block letters).....

Researcher.....Date.....



Desperately Seeking Volunteers! Supervision Research Study

I am looking for midwives who would be willing to discuss experiences of supervision and support with practice in a research interview.

The aim of this study is to create a deeper understanding of how supervision and support are experienced in practice. I believe that it is important that midwives' stories are heard - particularly in a situation where pressures on the health service may make finding time to reflect on practice more difficult.

If you are interested in helping with this study, but cannot spare the time during working hours, would you be willing to donate an hour of your time outside of work?

Thanks to research funding from the University of Edinburgh I am able to offer you a £20 gift token as a thank-present for giving up your free time.

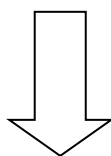
If you are interested in helping with the study please get in touch:

Jessica MacLaren

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More Information About the Study



What is this Research Study About?

This study will explore how supervision is experienced in two different professional contexts: Midwifery and Mental Health Nursing. The

study will focus on the individual experiences of Midwives and Mental Health Nurses, looking both at experiences of supervision and also other forms of support with professional practice.

Why is the Study Being Carried Out?

This study will form part of the requirements for a PhD degree. The aim of the study is to create a deeper understanding of how supervision operates in practice, and in relation to other forms of support which Midwives and Mental Health Nurses may use to help them with their work.

Who Will Conduct the Research?

The research will be conducted by Jessica MacLaren. Jessica is a PhD student at the School of Health in the University of Edinburgh. Jessica is a registered mental health nurse and has worked in a variety of settings including community services and primary care.

The research will be supervised by Deborah Ritchie, Senior Lecturer at the School of Health, University of Edinburgh and Dr Rosie Stenhouse, Lecturer, University of Abertay Dundee.

What Will the Study Involve?

1. *Giving consent* - Jessica will discuss with you what the study will involve and if you would like to take part.
2. *Interview* - Jessica will meet with you for a single interview. The interview will be loosely structured, and will focus on your experiences and ideas about supervision and support.
3. *Findings* - Jessica will send you a summary of the study findings and be available to discuss them with you.

The Participants, Their Areas of Practice and Types of Supervision

Table 2

<i>Mental Health Nurses</i>	<i>Area of Practice</i>	<i>Supervision Practice</i>
Alice	Primary Care Mental Health (Includes specialist CBT Practice)	→ CPN Group Supervision – 1 ½ hours once a month → CBT 1:1 Supervision – an hour every 4-6 weeks
Beth	Primary Care Mental Health Private CAT Practice	→ CPN Group Supervision – 1 ½ hours once a month → CAT Group Supervision once a week
Clare	Primary Care Mental Health (Includes specialist CAT Practice)	→ CPN Group Supervision – 1 ½ hours once a month → CAT Group Supervision every 2 weeks
Dilys	Mental Health Crisis (Team Leader) In the past has practiced as a Counsellor out with the NHS.	→ 1:1 Supervision (privately employed supervisor) 1 ½ hours once a month.
Emma	Substance Misuse Private Counselling Practice	→ No nursing supervision at time of interview → In counselling role: 2 Supervision Groups –every 2 weeks, and once a month + 1:1 supervision once a month (to meet supervision hours required for Counselling registration)
Faye	Severe and Enduring Mental Health	→ 1:1 clinical supervision once a month → 1:1 caseload supervision every 6-8 weeks → Peer team supervision once a month → 1:1 managerial supervision, occasionally
Gina	Mental Health Crisis (Team Leader)	→ No supervision at time of interview → Past experience of CBT supervision, group CPN supervision and nurse prescribing supervision.
Iain	Severe and Enduring Mental Health (Includes specialist therapy practice)	→ 1:1 supervision every 4-6 weeks → Supervisor of specialist therapy group supervision

Appendix 9: Tables 2 and 3. Participants, Areas of Practice and Types of Supervision

Table 3

<i>Midwives</i>	<i>Area of Practice</i>	<i>Supervision Practice</i>
Jo	NHS Community Midwifery	→ Supervisor of Midwives – annual meeting → On-Call Supervisor of Midwives – as needed
Kate	NHS Community Midwifery	→ Supervisor of Midwives – annual meeting → On-Call Supervisor of Midwives – as needed → Annual meeting with Team Leader for appraisal, support and to plan professional development.
Lynn	Independent Midwifery	→ Supervisor of Midwives – annual meeting + meetings during the year for support + contact by phone for advice (has contact with Supervisor of Midwives roughly once every 2 months.) → On-Call Supervisor of Midwives – as needed
Molly	Independent Midwifery	→ Supervisor of Midwives – annual meeting + meetings for reflection and support 2-3 times a year + contact by phone for support and advice → On-Call Supervisor of Midwives – as needed
Nina	NHS Community Midwifery	→ Supervisor of Midwives – annual meeting + personal support with work issue including accompanying Nina to meetings. → On-Call Supervisor of Midwives – as needed
Olive	NHS Community Midwifery (Team Leader)	→ Supervisor of Midwives – annual meeting (has also had contact out with annual meeting for support) → 1:1 meeting with clinical manager every 6 weeks to discuss team and for support. → 1:1 meetings with midwives in her team every 6-8 weeks to discuss caseload and provide support → On-Call Supervisor of Midwives – as needed
Rose	NHS Community Midwifery	→ Supervisor of Midwives – annual meeting → On-Call Supervisor of Midwives – as needed
Sarah	NHS Community Midwifery	→ Supervisor of Midwives – annual meeting → On-Call Supervisor of Midwives – as needed

Fracturing and Configuring: Storying an Interview

Jessica MacLaren

Abstract

This paper looks at the process of constructing stories from interview data. As part of my doctoral research I am using narrative inquiry to understand nurses and midwives' experiences of supervision (a supportive practice in which practitioners are encouraged to reflect on their clinical work). I regard narrative as offering a way of knowing that is richly contextualised and allows access to the everyday interpretation of experience. My perspective on narrative is particularly guided by the work of Ricoeur, and I seek to understand narrative in terms of both structure and performance, and both individual experience and social discourses.

In this paper I'm going to use one story in particular in order to explore how I have produced a topic-centred narrative from oral interview data. I discuss how production of this story began with the delineation of the features of narrative using Gee's socio-linguistic approach; looking and listening for these features within the interview in order to make a prosodic transcription which reflects speaking rhythms more closely than a prose transcript. The narrative sections were then reconfigured to form topic-centred stories. The wholeness of narrative is uniquely meaningful, and I will discuss the implications of this process by which the wholeness of the interview is fractured and a new wholeness is formed. The meaning of narrative is also in the fluid connection between author and audience, and I consider what happens to meaning as the role of the researcher moves from audience to author and so begins a new mimetic cycle by re-plotting the fragments of narrative.

Keywords:

Storying interviews, poetic transcription, meaning-making.

1. Fracturing and Configuring

As a PhD student I approached the analysis of my data as a complete novice. I was working on the transcripts of sixteen interviews which I had conducted with mental health nurses and midwives to explore their experiences of supervision as a supportive practice. The interviews were designed to encourage storytelling, and had produced some rich data, but as I now tried to unpick the complex web of accounts which formed each interview, the problem which emerged for me was how to capture the nuances of meaning which formed through

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the juxtapositions and layers of narrative. Trying to understand better what analysis means, I came across a dictionary definition of ‘analysis’ as ‘to separate a whole into its parts’.¹ For me this clarified my difficulty with analysis, and I found it difficult to reconcile the fracturing action of analysis with the synthesising action of narrative.

I encountered a solution to this problem of fracturing and configuring in the form of ‘storying’ – reworking the data into a new narrative form². ‘Storying’ means that narratives become not only a kind of data, but also a way of producing knowledge.³ This accords well with a concept of narrative as discourse, and of discourse as “language in use”⁴ or language as practice⁵. Furthermore, Bruner and Ricoeur both argue that narrative produces a special kind of knowing which is distinguished by subjectivity, contextualisation, and the organisation of events into a whole.⁶ Bruner contrasts this with the more traditionally scientific way of knowing, which he calls the ‘paradigmatic’, and which is concerned with the division of things into constituent parts and the creation of generalised types and categories. Polkinghorne comments that most qualitative analyses, (including analyses of narrative data) create *paradigmatic* knowledge which “functions to generate general knowledge from a set of particular instances”.⁷ In contrast, an analysis which works towards the production of a story by emplotting elements creates *narrative* knowledge which is anchored in the specific characteristics of the case and formulates an understanding of how and why something happened⁸.

As an approach, storying was particularly appealing to me because I aimed to move away from abstract conceptualisation of supervision toward an understanding of supervision in practice. Mishler argues that narrative is praxis – the interaction between our position as ‘active agents making and transforming the world’ and as subjects responding to the world.⁹ This captures the circular role of narrative which we see in Ricoeur’s cycle of mimesis where narrative emerges as an interpretation of our experience of the world (which Ricoeur argues is already meaningful), is communicated to an audience who actively interpret it, and then becomes part of the world to which we respond and from which we make new narratives.¹⁰ Storying embraces this role of narrative as making the world, and also draws attention to the active role of the researcher as interpretive audience of the participant’s narrative.

Storying, then, is an epistemological project which produces narrative knowledge through the synthesising of data into a new whole. The primary action by which this is achieved is emplotment. Famously, Aristotle placed emplotment as the configuration of events at the heart of narrative, and Ricoeur expanded on this to include time so that emplotment is the configuration of events and time.¹¹ This configuration is the process which creates narrative structure (or plot), it is the bringing together of parts to form a whole, and it is this which underpins the unique meaning-making action of narrative.¹² Structure, and the creation of structure, is therefore of fundamental importance in narrative, and the action of storying is the creation of a narrative structure. This does not, however, exist in

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isolation. Narrative is communication, it exists in the movement of understanding from author to audience, and it is practice, it is a social performance.¹³ Meaning-making in narrative is the interplay of structure and performance, and so I wanted to find a way of storying which would pay attention to how the interview narratives were structured and performed, and would make explicit my contribution to the story structure since by creating a new structure I would be creating new meaning.¹⁴ In this I found the socio-linguistic work of Gee of particular help because he looks at how meaning in narrative is created through both structure and performance.¹⁵ Using Gee's approach meant that I paid close attention to the details of my participants' speech, which, as I shall discuss, has some disadvantages in that it tends to think about the storyteller in isolation. I also drew on the work of McCormack and Mishler in order to produce an account of each interview as a case incorporating emplotted stories based on the interview narratives.¹⁶ I shall demonstrate some of this process using the story of 'A High Risk Client' which is taken from an interview conducted with Faye, a community mental health nurse.

2. Storying: "A High Risk Client"

The first step in the storying of an interview is transcription. The concept of a transcript as a replica of speech has been problematized.¹⁷ And Mishler argues that we must resist 'the tendency to reify transcripts'.¹⁸ Instead, the complexity of speech¹⁹ means that transcription involves the selection of those parts of speech which are methodologically relevant, transcription is a stage of analysis and "a transcript is a theoretical entity".²⁰

Gee's method of transcription produces a prosodic representation of speech in which the transcript is structured according to performative features. An advantage of this prosodic representation is, as Richardson has argued in a different context, prosodic/poetic writing draws attention to the constructedness of a text and the reader becomes more aware that what is recorded on the page is a representation not a replica of speech.²¹

Gee divides speech into idea units.²² Within an idea unit there is a single pitch glide where the tone goes up or down. The pitch glide indicates which part of the sentence the speaker intends as new or important information. Idea units are then grouped into lines (similar to clauses or sentences). A line contains a central topic or idea. For example, Faye says:

*you=know it's very difficult to make changes
and to recognise the small changes that you do make so*

The emphasised words indicate the pitch glides. There are three idea units in this line indicated by the dotted underlines. Together they form a line whose central topic is 'making changes'.

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Gee then identifies larger chunks of speech: stanzas and parts.²³ *Stanzas* are formed of groups of lines which are about one topic and contain one perspective. *Parts* consist of chains of topically connected stanzas. These divisions show how a narrative has been constructed, how topics have been linked together and themes developed – how the parts of the narrative combine to form the whole.

I have too much data to engage in such an in-depth structural analysis, so I remained at the level of idea units and lines, and also used pauses to identify lines as well as pitch glides. Gee & Grosjean connected pauses to narrative structure.²⁴ They found that pauses tend to operate hierarchically so that lines are divided by small pauses, stanzas are divided by longer pauses and so on. In my transcripts I have used pauses in a simple way to identify the ends of lines. Using pauses to identify lines rather than identifying idea units then combining them into lines makes for a less rigorously produced transcript, but is much quicker and so has made it possible for me to transcribe a substantial amount of data in this way. Several times Gee makes the argument that his divisions reflect how we hear speech. We intuitively pick up on the information of lines and idea units and I argue that this supports the validity of my simplified version of Gee's method.

It is because Gee's method makes explicit the aspects of narrative which we intuitively understand which makes it such a useful way of exploring a spoken narrative. I found that when I paid such close attention to the interview stories the structure and style of the participants' narrations were highly intricate. This was particularly evident when I experimented with summarising the narratives in my own words; the results were a pale imitation of the richness of the original narrative. For example, the first few lines of the High Risk Client contain a surprising amount of information:

Faye:

*a previous client of mine was
particularly high risk of
suicide but also accidental death
due to kind of self-harming behaviours*

em

and she was particularly difficult to manage...

We learn facts of the story (the client, risk, behaviour, death), but we also learn that Faye distinguishes two kinds of death. Both are caused by the client herself, but one is intended and the other accidental. A further distinction is made between self-harm and suicide. This conveys some understanding about the teller of the story and her expertise in this area which leads her to distinguish death by suicide from death by self-harm.

The first four lines also provide an explanation for the sixth line: the client was difficult to manage. From the perspective of the audience the information that the client was difficult to manage makes sense to us because we have already

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learned how risky the client was. I noticed that my interviewees often told stories in this way; beginning with information which could be used to explain ‘why or ‘how’ before giving the ‘what’ information. This allows the audience to feel that they are discovering something for themselves rather than being directly *told* what to think.

Unlike Gee I have chosen not to ‘clean-up’ the text and have included repetitions, false starts and non-lexical expressions. This is partly an attempt to preserve some of the richness of speech in the written form. Gee does argue that these features of speech performance are meaningful, indicating events such as a change in focus, or the formulation of a new idea.²⁵ For example, later in the ‘High Risk Client’, the hesitations and non-lexical expressions seem to frame an emotionally difficult part of the story:

she ←————— Hesitation
she was so high risk
and I just kept trying all these different avenues
and it was really refreshing to go to clinical supervision
and sometimes I would come away with new ideas or
just the fact that I was doing things right
and the things that I was doing
em ←————— Hesitation
you=know ←————— Non-Lexical Expression
- - -
I was always putting a lot of work into
so it was very reassuring
that client specifically actually died later em
- - -
due to the risks
so... ←————— Non-Lexical Expression

Visually, in the transcript, the hesitations and non-lexical expressions isolate the four lines in which Faye talks of the client’s death. The first two lines of this small section (marked with a dotted line) repeat what Faye has already said several times in the course of talking about this client: that she worked hard at trying to help her client, and supervision was a source of reassurance and support. The next two lines convey the entirely new information that this person died. Referring back to my observations about the use of a *how/why* followed by a *what* narrative structure it is noticeable that here the structure is weaker, Faye’s hard work doesn’t explain the client’s death, the explanation is further back in the repetition that the client was high risk. I suggest that this contributes to the slight sense of shock when Faye says that the client died, the information arrives unexpectedly, the preceding narrative doesn’t build up to it.

Having produced transcribed data which reflected structural and performative features of Faye’s speech I then fragmented the interview, identifying chunks of discourse which were concerned with the high risk client. There were

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four of these in total, and they appeared at different stages in the interview. I identified the beginnings and ends of the chunks of discourse using pauses and changes in intonation. Most of the chunks have a narrative structure with features such as a beginning, middle and end, and diachronicity. Having identified the chunks of discourse I emplotted them into a story. I chose to use the order of telling in the interview as the temporal structure of the story, as this reflected the way Faye built up a picture of the high risk client over the course of the interview. This created a topic centred story. I repeated this with other parts of the interview until, in Faye's interview I had identified six topic centred stories. I then created a picture of the interview which I adapted from a study by McCormack, who uses nested boxes to represent storied interview data (see figure 1).²⁶

In order to create this picture I had to impose a new structure on the interviews. I continued with the order of telling, so the beginning of the top story came first in the interview, the beginning of the second from top came second and so on. This belies the complexity of the interview. As with a 'High Risk Client', story sections come from different parts of the interview. In configuring the stories I have imposed a new unity on the interview. Because I am primarily interested in content I chose to create this unity around topic, and it is interesting to note that this way of using topic may reflect a cultural bias toward a particular kind of storytelling – Michaels found that among her American research participants topic-centred storytelling was associated with white, middle-class participants, and topic-associating storytelling was associated with black, working-class participants.²⁷

The Story and Beyond

Storying an interview has involved a dynamic interplay between the parts and the whole. Beginning with interviews in which discourse was configured in narrative form I fractured this configuration and re-formed the discourses into a new narrative structure. I then used the topic-centred stories to make a new configuration of the interview, and this was used as the foundation of a cross-case comparison.

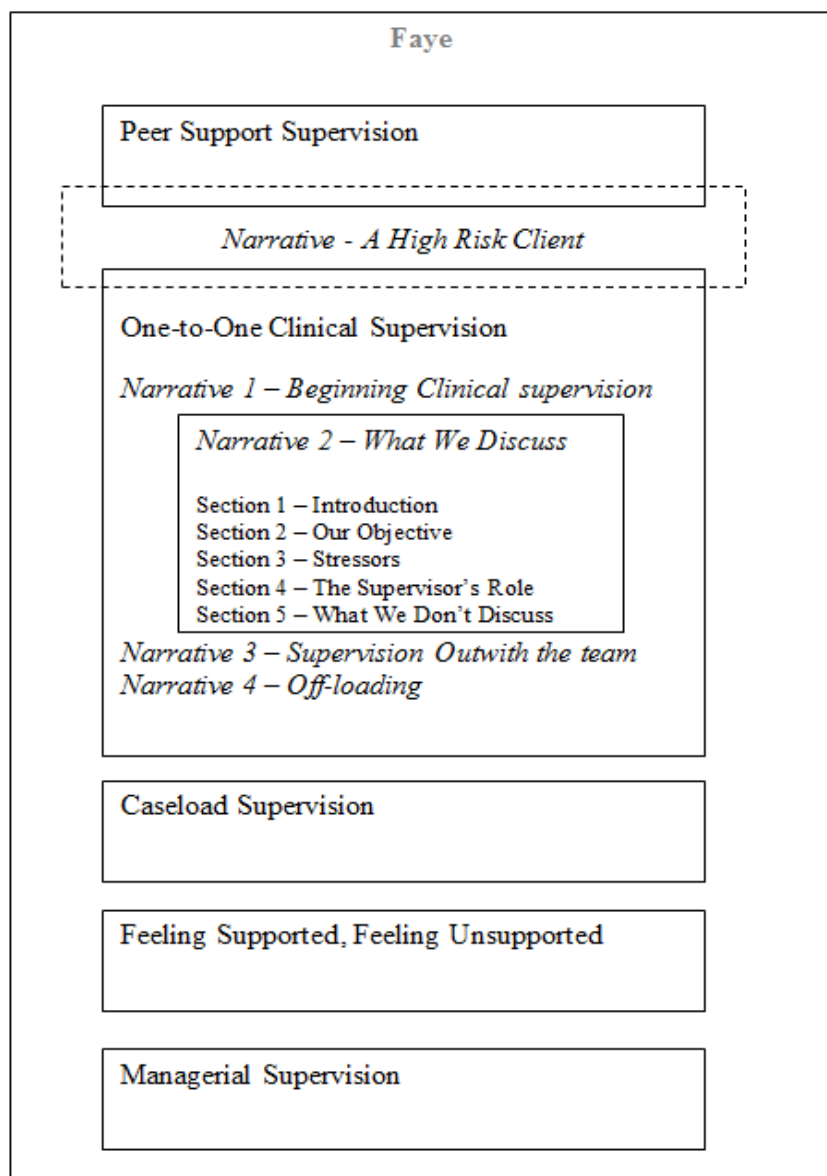
As I noted above, a disadvantage to my approach has been that the social role of the narratives have been largely ignored, and I have tended to focus on narrative 'primarily as a tool for individual meaning-making'.²⁸ This creates a danger that rhetorical functions of narrative are forgotten. For example, the four sections of 'A High Risk Client' are told for different reasons in the interview, to illustrate different arguments which Faye is making. By extracting the sections and putting them together the reasons behind their telling have been obscured. However, I believe that the advantage of extracting the sections from the white noise of the interview has been to illuminate aspects of Faye's account and provide a way of communicating these aspects with some degree of context.

Returning to my original problem of how to capture the meaning found in juxtaposition, I now conclude that adopting a narrative approach has *not* allowed me to escape fragmentation of the data. It has instead involved me in a *cycle* of

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fragmentation and configuration. Thinking in terms of narrative has meant that I have framed analysis as coming from and returning to, a whole, and so have paid particular attention to the implications of configuration.

Figure 1 – Picturing a Storied Interview



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Below is a series of extracts from Faye's interview, showing how the interview text was analysed to produce a topic centred story (The High Risk Client), and then finally a storied interview.

1. Example 1.

J	Um what do you think it does for your kinda thought processes about a client for example
Faye	I just think you can get so stuck with a client you know and especially with the way we work you know ward based you were working with people short term and you were kinda getting a refreshment with new people coming in with our caseload you're trying to meet certain objectives with people whether that's getting them back to work getting the more socially isolated eh engaged within the community whether it's just improving their mental health as a kinda medical side of their condition but so you're always constantly working and if you're not achieving that then you can get so stuck with it um and certainly with the client I discussed before she she was so high risk and I just kept trying all these different avenues and it was really refreshing to go to clinical supervision and sometimes I would come away with new ideas or just the fact that I was doing things right or the things that I was doing em you know I was always putting a lot of work into
J	Yeh
Faye	So it was very reassuring that client specifically actually died later em [J Mm] due to the risks [J Yeh] so to have that supervision to have said discussed it before she died to have that kinda reassurance of supervision and then obviously post her dying [J Mm] em it was nice to have had that prior because you knew you'd done everything so when she died [J Mm] I could sit comfortably and say you know I did try everything and have that reassurance and have discussed that with somebody and you know I could go back to supervision and she she quite openly kinda said you know you've gone down every route with her you tried everything you could do and she felt that support from you and you know she showed this by doing these things that you discussed in supervision before and it does it helps you to kinda reflect and look back and say right okay you know rather than kinda thinking it would be quite easy to turn round and think your objective your objective wasn't met and you haven't kept that person safe you know so
J	Yeh yeh I can imagine particularly with a really emotional case like that
Faye	Yeh absolutely

2. Example 2

Faye	and certainly with the client I discussed before she she was so high risk and I just kept trying all these different avenues and it was really refreshing to go to clinical supervision and sometimes I would come away with new ideas or just the fact that I was doing things right or the things that I was doing em you know I was always putting a lot of work into
J	Yeh
Faye	So it was very reassuring that client specifically actually died later em [J Mm] due to the risks [J Yeh] so to have that supervision to have said discussed it before she died to have that kinda reassurance of supervision and then obviously post her dying [J Mm] em it was nice to have had that prior because you knew you'd done everything so when she died [J Mm] I could sit comfortably and say you know I did try everything and have that reassurance and have discussed that with somebody and you know I could go back to supervision and she she quite openly kinda said you know you've gone down every route with her you tried everything you could do and she felt that support from you and you know she showed this by doing these things that you discussed in supervision before and it does it helps you to kinda reflect and look back and say right okay you know rather than kinda thinking it would be quite easy to turn round and think your objective your objective wasn't met and you haven't kept that person safe you know so

3. Example 3

A High Risk Client

Section 1

a previous client of mine was particularly high risk of suicide but also accidental death due to kind of self-harming behaviours [J Mm] em and she was particularly difficult to manage and so she would be somebody I would kinda bring to the team as well [J yeh] em who's kinda consistent and it's very frustrating to work with because you you don't feel that you ever get anywhere with that kinda client

you know it's very difficult to make changes and to recognise the small changes that you do make so

bringing that to the team and trying to see if there's anything else you can do or different approaches that you can do

em

Section 2

talking about the client before

em

you know I would come in with suggestions to the peer supervision

trying to get suggestions from the team or

other ways of doing things

but

when it came to my frustrations of dealing with that particular client

I could use clinical supervision for that or something so

[JMm]

so I can kind of separate that

and use that more as a trying to get knowledge from our team so

Section 3

and certainly with the client I discussed before

she

she was so high risk

and I just kept trying all these different avenues

and it was really refreshing to go to clinical supervision

and sometimes I would come away with new ideas or

just the fact that I was doing things right

and the things that I was doing

em

you know

I was always putting a lot of work into

[J Yeh]

so it was very reassuring

that client specifically actually died later em

[J Mm]

due to the risks

[J Yeh]

so

to have that supervision
to have said discussed it before she died
to have that kinda reassurance through supervision and then obviously post
her dying [J Mm]

em
it was nice to have had that prior
because you knew you'd done everything
so when she died [J Mm]

I could sit comfortably and say
you know I did
try everything
and have that reassurance and have discussed that with somebody and you know I could go
back to supervision and she
she quite openly kinda said you know
“you’ve gone down every route with her
you tried everything you could do and she
felt that support from you and
you know she showed this by doing these things that you discussed in supervision before”
and it does it helps you to kinda reflect and say
right okay
you know rather than kinda thinking
it would be quite easy to turn round and think
your objective
your objective wasn’t met
and you haven’t kept that person safe you know so

Section 4

I mean she was so high risk and so difficult to manage she was
she wasn’t every session but
em
we would sometimes revisit [J Mm]
em
how I was feeling about
managing her

Appendix 11: Examples Illustrating the Process of Analysis

because she
for example she would probably be the equivalent of three
people on my caseload
as compared to a kinda normal ones caseload [J Mm]
and this lady
required some sort of level of involvement everyday [J Wow]
em [J Yeh]
so she would take a lot out of you you know
and you you'd have to reflect on
I had to be
she
the kind of
things that were going on with her
and she had a she had a very severe personality disorder
you could quite easily kind of fall into kind of getting a a friendship and a relationship with
her which
in
in some circumstances it's okay to have some sort of relationship with the clients we work
with
you know you work with them for so long that it would be unnatural not to
em
but you had to really watch with somebody like that with her
because she was [J Mm]
she would always do specific behaviours and you could see that she was almost eliciting a
kind of
mother like figure from you and things so
supervision really helped identify that [J Mm]
and to try and not react to that and to fall into those kinda traps
and
you know it was interesting that way to kinda reflect back and say
okay so
you know although she would do that completely subconsciously
you know
it was
it was just a way of kinda

Appendix 11: Examples Illustrating the Process of Analysis

getting some care from somebody

the kinda care she wanted

you would try and kinda work your way round that rather than kinda getting into that

4. Example 4

