Mental health nurses' experiences of managing work-related emotions through supervision

MENTAL HEALTH NURSES' EXPERIENCES OF MANAGING WORK-RELATED EMOTIONS THROUGH SUPERVISION.

ABSTRACT

Aim

To explore emotion cultures constructed in supervision and consider how supervision functions as an emotionally safe space promoting critical reflection.

Background

Research published between 1995-2015 suggests supervision has a positive impact on nurses' emotional wellbeing, but there is little understanding of the processes involved in this, and how styles of emotion interaction are established in supervision.

Design

A narrative approach was used to investigate mental health nurses' understandings and experiences of supervision.

Methods

8 semi-structured interviews were conducted with community mental health nurses in the UK during 2011. Analysis of audio data used features of speech to identify narrative discourse and illuminate meanings. A topic-centred analysis of interview narratives explored discourses shared between the participants. This supported the identification of feeling *rules* within participants' narratives, and the exploration of the emotion context of supervision.

Findings

Effective supervision was associated with three feeling rules: *Safety and reflexivity*; *Staying professional*; *Managing feelings*. These feeling rules allowed the expression and exploration of emotions, promoting critical reflection. A contrast was identified between the emotion culture of supervision and the nurses' experience of their workplace cultures as requiring the suppression of difficult emotions. Despite this contrast supervision functioned as an emotion micro-culture with its own distinctive feeling rules.

Conclusions

The analytical construct of feeling rules allows us to connect individual emotional experiences to shared normative discourses, highlighting how these shape emotional processes taking place in supervision. This understanding supports an explanation of how supervision may positively influence nurses' emotion management and perhaps reduce burnout.

Keywords

Nurses, mental health, supervisors and supervision, clinical supervision, emotions, narratives, qualitative studies, interviews, feeling rules.

SUMMARY STATEMENT

Why is this research or review needed?

- Nurses require a place to explore the emotional impact of their work to enable them to care, and it is generally assumed that supervision fulfills this purpose.
- There is currently no explanation about the processes through which supervision might positively impact on nurses' emotion management.
- There is little understanding about how supervision can create an emotionally supportive context.

What are the key findings?

- Feeling rules (ideas about what are considered appropriate and acceptable experiences and expressions of emotion) operating in supervision were different to those operating in the organisational culture.
- Supervisors and supervisees were able to create emotion cultures in supervision that allowed the expression and exploration of the supervisee's emotions.
- Where the emotion culture of supervision facilitated critical reflection it promoted processing of difficult emotions; the re-energizing of the supervisee; and action planning for practice.

How should the findings be used to influence policy/practice/research/education?

- Organisations who want to reduce burnout and support emotion work should use these findings to determine what kind of supervision culture they wish to create, and how to do this.
- Educators should use these findings to engage students in understanding mechanisms operating in supervision and how they might apply this to developing the emotion culture of their own supervision practice.
- All disciplines involved in health and social care should consider the implications of these findings for their workforce to promote the wellbeing of practitioners and ultimately, high quality care.

INTRODUCTION

Recent inquiries into failings in UK health services (e.g. MacLean 2014, Francis 2013) have fuelled ongoing debates in nursing about the ability of nurses to care (Stockwell 2015, Fawcett et al. 2015). Compassion fatigue, burnout and the caring work of nurses is under increasing scrutiny, both in the UK and internationally (cf. Nantsupawat et al. 2016, Sheppard 2016).

Smith (2011) argues that 'caring' requires nurses to undertake emotion work. Drawing on Hochschild's (1983) seminal theory on emotions and work, Smith (2011) argues that nurses must manage their own emotions in order to evoke a feeling of 'being cared for' in the patient, but that this important work is largely invisible and often unsupported.

One way of supporting emotion work is through 'supervision' – involving critical reflection-on-practice in the context of a facilitative relationship with a supervisor (Buus et al. 2013, Lyth 2000, Schön 1983). However, little is known about how this is achieved. This paper considers how supervision may influence nurses' emotions and emotion work. Drawing on the findings of a narrative study of the supervision experiences of mental health nurses, emotional processes occurring in supervision and the construction of supportive emotion cultures in supervision are illuminated.

BACKGROUND

Emotions in Supervision

This study explores emotions evoked and experienced in the context of work. To understand these emotions we employ a social constructionist perspective, conceptualising the work context as formed by reality-constructing discourses (Berger and Luckmann 1966). Emotions are therefore a social, as well as individual phenomenon; evoked, expressed and experienced in the context of institutionalised discourses.

Emotion work (management of emotions) is famously explored in Hochschild's (1983) theory of *emotional labour*. Hochschild (1983) explains how certain forms of work depend on the worker's capacity to manage his/her emotions, and addresses the problem of understanding emotions as both individual and cultural phenomena. Emotional labourers suppress or induce emotions in order to produce a desired emotional display, which in turn is intended to elicit a particular response from others (Hochschild 1983). For example, a nurse may suppress feelings of disgust and induce feelings of compassion in order to produce an emotional display that makes the patient feel cared for (Theodosius 2008). First applied to nursing by Smith (1992), Hochschild's work has been used to illuminate the motivations, processes and costs of nursing work (Bolton 2000, Theodosius 2008), but has not been used to understand supervision.

Supervision in Nursing

In recent decades supervision has gradually entered nursing from the fields of psychotherapy and social work, (Yegdich and Cushing 1998). In the UK, supervision has been incorporated into institutional policies (e.g. NHS Education Scotland 2014, Royal Cornwall Hospitals NHS Trust 2013, Sheffield NHS Primary Care Trust 2008). However despite this growing popularity, Sloan (2006) has argued that supervision

practices are of variable quality, and that nurses can be confused about what supervision should actually involve.

The popularity of supervision is reflected in a growing research field. A search of CINHAL for English language, peer reviewed articles on supervision of qualified nurses published between 1995 and 2015, and using key terms such as 'supervision' and 'clinical supervision', retrieves several hundred results, indicating the breadth of the field. Six major literature reviews (Fowler 1996, Hyrkäs et al. 1999, Gilmore 2001, Sloan 2006, Butterworth et al. 2008, Buus and Gonge 2009), show the progression of supervision in nursing over the past 20 years, from having little supporting evidence (Fowler 1996) to the development of an extensive body of research on the topic (Butterworth et al. 2008). The reviews highlight on-going issues in the field: difficulties in conceptualising supervision; idealising of supervision; a lack of knowledge about how supervision is actually done.

Supervision is often idealised with claims made for numerous benefits (e.g. skill-development, risk-management, improved patient outcomes) (Butterworth et al. 2008). However the supporting evidence for many of these is weak (Buus and Gonge 2009). One of the strongest arguments made about nursing supervision is that it helps to sustain the emotional energies required in care (Proctor 2010), and several studies have shown that effective supervision is associated with reduced levels of burnout (Koivu et al. 2012, White and Winstanley 2010, Hyrkäs et al. 2006, Edwards et al. 2005, Hyrkäs 2005).

The varied and context-dependent nature of supervision practices means that the term resists universal definition, and the conceptualisation of supervision has been extensively discussed and problematized in the nursing literature (Yegdich 1999). Responding to these debates, we argue that definitive and abstract conceptualisation is problematic (Flyvbjerg 2001). Rather than reducing supervision to a singular concept, it is helpful to think about supervision *practices* (what is done). Supervision therefore becomes an 'umbrella term' (Butterworth 1992), enabling research participants' understandings and experiences to be compared to understandings of supervision in the literature.

Supervision Feeling Rules

Although a connection between supervision and nurses' emotions has been identified, there is little understanding of how this might actually work, and therefore how nurses might re-produce such an effect in their own supervision practice. Furthermore, little is known about how the emotion context influences supervision practice, although there is evidence that context has an impact on whether practitioners feel supported by supervision (Gonge and Buus 2011, White and Winstanley 2009).

This paper addresses the problem of how supervision impacts on nurses' emotions, through analysis of mental health nurses' accounts of their supervision practices. The construct of *feeling rules* is used to explore the socio-cultural dimension of emotions in supervision.

Feeling rules are the 'scripts' of social-emotional life, telling us what emotions are appropriate in a specific context (Hochschild 1983). Feeling rules connect the individual's emotional experience and the discursive context that they inhabit. The

analysis of feeling rules in accounts of personal experience therefore informs us about those discourses to which an individual is responding when they perform emotion work to suppress or induce a feeling. This helps to illuminate how social and cultural norms and meanings shape what seem to be individual and spontaneous emotional experiences, such as those experienced by a nurse in supervision.

THE STUDY

Aim

Drawing on data from a larger study exploring mental health nurses' and midwives' experiences of supervision, this paper presents an analysis of mental health nurses' feeling rules and emotion cultures in supervision.

Design

Narrative inquiry was used to explore mental health nurses' experiences and understandings of supervision. Narrative was conceptualised as the way of making sense of and communicating experience in the context of socially constructed and institutionalised meanings. Narrative data were therefore understood as representing the participants' experiences of supervision (Ricoeur 1983/1984, Berger and Luckmann 1966).

Participants

Eight community mental health nurses (1 male, 7 female) in a single geographical region of the UK were recruited via emails sent to all community mental health teams. Newly qualified nurses were excluded as the aim was to recruit participants who had experience of supervision. All those recruited had been qualified for more than 10 years.

Data Collection

The researcher ([Author 1] - a registered mental health nurse, who had not worked for the local NHS) interviewed each participant once, on a one-to-one basis, during 2011 in a private room either at the participant's workplace, or a university building. Interviews lasted 60-90 minutes, and used a loosely structured topic guide (Mason 2002), producing richly detailed narratives of the participants' experiences of supervision.

Ethics

Ethical approval for the study was gained from the authors' institutional Research Ethics Committee. Written informed consent was gained from all participants. Participation was voluntary, and confidential to the research team. The coherence and meaningfulness of narratives relies on context-dependent details (Ricoeur 1983/1984), and so a narrative research method poses a particular ethical challenge in maintaining confidentiality. Transcripts were carefully anonymised using pseudonyms, and the precise location of the study was concealed.

Data Analysis

Analysis was carried out by [Author 1], and discussed at each stage with [Author 2] and [Author 3]. There were three stages of analysis.

Stage 1

Narrative sections of discourse were identified and transcribed from the interviews using Gee's (2005) method, which attends to cues in speech (e.g. pauses, inflections). This approach addresses problems of translating oral data into text. Data are presented in a prosodic style, which more closely reflects speech, and draws attention to meanings highlighted by the speaker through rate, rhythm and tone of speech (Gee 2005).

Stage 2
The topics of interview narratives were compared between participants. The use of long, unfragmented data extracts preserved details of context, supporting a nuanced interpretation of meaning. Comparing topics across participants allowed shared discourses around supervision to emerge from the data. This helped illuminate feeling rules present in the data.

Stage 3
We looked for feeling rules expressed in the interview narratives. Feeling rules are elusive and difficult to identify because they operate on a "deeply internalized" level (Hochschild 2003: 82). Analysing narratives helped to identify feeling rules, supporting Sandelands and Boudens' (2000) contention that people do not talk directly or conceptually about their emotions, but instead evoke emotion through stories. *Emplotment* – creating a whole whose meaning is greater than the sum of the parts – allows the audience to imaginatively experience the narrator's emotional process (Ricoeur 1983/1984). In this study, participants' narratives showed how emotions were channelled, suppressed and evoked in supervision and the workplace, allowing the identification of discourses scripting these emotional processes.

A key element assisting in identifying feeling rules in the narratives was that of *wrongness*. Feeling rules tend to become most evident when broken, and Hochschild (1983: 61) describes the sense of "wrongness" which we experience when an emotion does not accord with a feeling rule. In the course of analysis, this sense of wrongness provided an alert to the operation of feeling rules, either where the participant expressed wrongness about a feeling, or where the researcher experienced wrongness in response to the participant's account.

Rigour
Rigour was maintained by the use of a clear conceptual framework for the study (Mason 2002). Collecting data via loosely structured interviews facilitated the production of co-constructed narratives of personal experience. Interpretive validity (Guba and Lincoln 2005) was achieved through in-depth, theoretically informed engagement with the data, using analytic methods to understand the data from both topic-centred, and socio-linguistic perspectives (Gee 1985).

FINDINGS: FEELING RULES IN SUPERVISION
The participants' narratives drew on a variety of experiences of supervision during their careers, covering a range of models. All the nurses had practiced forms of therapy (including cognitive behavioural therapy, cognitive analytic therapy, psychotherapy, and counselling), and supervision was often an integral part of these practices.

Narratives of supervision included what the participants perceived as good/effective and bad/ineffective forms of supervision. Participants characterised what they saw as good/effective supervision as including the use of critical reflection-on-practice; and a supervisor-supervisee structure (with the supervisor being a more expert practitioner in a facilitative role). Good/effective supervision was sustained over time (sometimes years), and sessions were regular (usually once a month). The quality of the relationship with the supervisor was regarded as very important. These features of supervision identified by the participants resonate with successful styles of supervision described in the nursing literature (cf. Hyrkäs et al. 2006, Edwards et al. 2005).

During analysis it became clear that participants' good/effective experiences of supervision were characterised by the creation of a particular emotion culture, and by what the participants saw as productive outcomes. Across the sample, good/effective supervision cultures were associated with a set of three distinct feeling rules:

1. Safety and reflexivity
2. Staying professional
3. Managing feelings

Safety and Reflexivity

This rule expressed the ideal that supervision should be an emotionally safe space in which the supervisee engages in reflection-on-practice. In Alice's description of her supervision group, an emotion culture was created by a skilled supervisor who made the supervisees feel safe and able to be reflective:

> Alice:
>
> [The supervisor] would comment on things but not in a critical way at all but in a
>
> very inspiring way
>
> em and he just made you feel quite grounded actually…
>
> he was just calm and reflective he asked the right questions I suppose
>
> and commented
>
> and there was definitely space for other people to you know
>
> he-he didn't dominate
>
> everybody had their place
>
> everybody's place was valued
>
> what people said was valued
>
> and encouraged you know
>
> he encouraged participation in it all…

The requirement for supervision to be safe and reflexive sensitised the nurses to emotionally unsafe or unsatisfactory supervision. Emma contrasted her experience of

counselling supervision, with the sense of alienation evoked by less emotionally reflective nursing supervision:

> Emma:
>
> it felt less personal
>
> than what I was used to in my counselling supervision…
>
> I think [nursing supervision] sort of gives me the feeling that
>
> I'm not allowed to bring all of me into that work…
>
> the boundary if you like between me as a person and me as a professional is…
>
> it's further away from me as a person

For most, the safety and reflexivity rule was learned through a good experience of supervision, and acted as a benchmark for other experiences of supervision. This rule can therefore be understood as protective, and providing a source of resistance to unsatisfactory practices.

Staying Professional

The nurses argued that the supervision interaction should be *professional*, and this was contrasted with problematic, overly *personal* supervision. This rule was connected to the outcomes of supervision. Desirable outcomes were framed in terms of practice, and the nurse's ability to perform his/her work, while non-professional supervision would not have a positive outcome for practice. For example, Iain was concerned that supervision located in a social context would have a personal (*bitching session*) rather than a professional outcome:

> Iain:
>
> …I know people who get supervision
>
> "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 of that
>
> I would probably turn something like that into a bitching session…

Staying professional shows how the nurses separated work and private life. They experienced their emotional contexts as boundaried and were concerned with how to manage these boundaries in supervision:

> 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…
>
> I think you've got to be really professional
>
> it would be quite easy to make [supervision] a friendly chat
>
> and to have a bitch
>
> and a moan
>
> and a leave

As Faye and Iain described, there was a sense that supervision was potentially transgressive, mixing up work and private life. It was therefore especially important to maintain the division between personal matters and work matters (thereby staying professional).

Managing Feelings

The safety and reflexivity and staying professional rules delineate the emotional scaffolding of supervision, while the third rule, *managing feelings*, describes emotional purpose:

> Clare:
>
> sometimes you carried thi- you were able to carry things more
>
> because you knew that you had [supervision] coming up
>
> and that there would be a release for it
>
> … it probably made you a bit stronger to be able to deal with some things
>
> that you found quite difficult

Supervision helped the nurses to 'hold' feelings triggered in day-to-day clinical work, containing emotions until the next session, when they could actively work with those feelings. They continued to experience the emotional effects of supervision between sessions:

Faye:

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

to do that

so it's some- 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

Managing feelings by putting them in a 'pocket' to be explored in supervision required the nurses to negotiate the work:private boundary:

Clare:

sometimes in a supervision situation you can be pushed into being the parent…

that's not the focus of what you're doing

and neither are you a personal counsellor…

you shouldn't be discussing

…all their personal emotional stuff

Determining which feelings could be appropriately managed through supervision was something which the nurses problematized, critiquing what they saw as inappropriate expression of feelings. Supervision was distinguished from informal or social interactions, in which 'moaning' about things, or simply saying how one felt, was acceptable:

Gina:

they don't know what good supervision is

they think that good supervision is just about

being able to talk openly to a person you're working with

Making the change from informal emotional expression, to the productive discussion of feelings in supervision required a deliberate effort, and Beth argued, a supervisor:

> Beth:
>
> we needed someone to pull [the group]
>
> out of the realms of chat
>
> we all wanted it to be beyond that
>
> but we needed someone to help change the culture

A Triumvirate of Feeling Rules in Supervision

The three feeling rules described above were associated with good/effective supervision. Experiences of supervision where these feeling rules were not in operation were described as unsatisfactory, for example, in emotionally unsafe supervision participants couldn't be fully reflective:

> Dilys:
>
> we very much protected ourselves
>
> in those [supervision] discussions
>
> cos I've been in peer
>
> group supervisions
>
> since
>
> with colleagues
>
> and… there has been a lot more evidence of emotions present
>
> in the room

Equally, supervision could be seen as becoming confused with therapy, in which emotions were expressed freely but without a work-related purpose.

In order for the emotional ecology of supervision to be satisfactory therefore, the feeling rules *safety and reflexivity*, *staying professional*, and *managing feelings* had to be in operation, and this meant constructing and maintaining a particular emotion culture. However, our analysis suggests that these feeling rules operated in contradiction to norms prevalent in the emotion culture present in the nurses' wider work-context.

Feeling Rules in the Organisation

The focus of this study was on participants' individual experiences, but there was also a degree of shared context in that the participants all worked for the same organisation. During data analysis two feeling rules emerged as operating in the shared organisational context, which contrasted with the supervision rules:

1. Being stoical
2. Inferiority

Being Stoical

Mental health nurses' work is fundamentally emotional in nature, but despite this the participants identified a sense of 'having to be stoical' at work. This feeling rule was dominant in their working culture. Beth described how this culture required practitioners to accommodate difficult emotional experiences while maintaining a display of emotional control:

> Beth:
>
> I think there is a bit of that in nursing
>
> a bit of a macho culture
>
> 'just get on with it' you know
>
> no one's died

The requirement for stoicism was emotionally suppressive, but also arguably had a protective function in that it operated as a defence system against anxiety by preventing overwhelming emotional exposure (cf. Menzies 1960). For example, in Dilys' account of a distressing situation at work, she describes how even when emotionally overwhelmed, she tried to maintain a display of coping:

> Dilys:
>
> I remember feeling quite de-skilled and quite inadequate em
>
> and crying
>
> you know I ended up kind of
>
> moving myself out the ward and going into the duty room
>
> in a corner
>
> and just tears coming
>
> and being really embarrassed
>
> and thinking "there's absolutely no way that I'm telling anybody that this has just
>
> happened"

This strategy of suppressing feeling contrasts with supervision as an emotion management strategy. Both strategies involve an in-the-moment concealing of emotions, but supervision allows for future expression and exploration of these, while the stoical organisational culture requires nurses to indefinitely suppress their emotions.

Inferiority

This feeling rule emerged in the nurses' descriptions of feeling of less worth in relation to members of other disciplines, notably medicine and psychology. In part, this rule may have been what McCoyd (2009: 442) has called a "discrepant" feeling rule. Perhaps deriving from the historically low status position of nurses, it does not quite fit in a modern, professional context. Clare described this discrepancy between, on the one hand, a sense of inferiority, and on the other, her sense of herself as skilled and experienced:

> Clare:
>
> that kind of in-built
>
> inferiority you feel anyway as a nurse…
>
> I don't I don't necessarily em kinda naturally feel that way to be honest
>
> I usually feel really quite confident with other professionals but
>
> em
>
> 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

In Clare's account, the differences in status between disciplines can be seen as exerting an internalised, yet contested, pressure on nurses. This was important because many of the nurses had supervision with members of other disciplines, either in the form of small, multi-disciplinary groups, or on a one-to-one basis with a supervisor from another discipline. The nurses were therefore exposed to contexts which seemed likely to trigger the inferiority rule.

When the inferiority rule did operate in supervision it was associated with less satisfactory supervision:

> Iain:
>
> I sometimes find it quite challenging
>
> because eh intimidating I think rather
>
> because the supervision is
>
> you know it is very multi-disciplinary
>
> there's a few psychologists there there's a few psychiatrists…
>
> …I guess I get intimidated by other people's knowledge and expertise and I just see
>
> myself sometimes as a lowly nurse em
>
> it does make me anxious

Remarkably, the inferiority rule was not present in most narratives of supervision. In fact, multi-disciplinary supervision could challenge the sense of inferiority, enabling

the nurses to relate to members of higher status disciplines from a position of felt-equality. This illuminates the subversive possibilities of supervision. The structures and aims of supervision could form an emotion micro-culture within the emotion culture of the organisation, enabling the nurses to avoid the inferiority rule, and providing other possibilities of feeling.

DISCUSSION

Supervision experienced by the participants as good/effective, brought together safety, reflexivity, professionalism and emotions, all in the context of a framework in which work and private life were regarded as segregated.

The nurses' work:private division evokes Hochschild's (1983) work:private life binary, which she uses to distinguish between emotional labour (performed for a wage) and emotion management (performed as part of a gift exchange). Hochschild's binary is problematic, arguably creating an "artificial dichotomy" (James 1989: 39), and neglecting non-commercial motivations for work such as altruism (Bolton 2000, Fisher and Byrne 2012). However the nurses' narratives show that this work:private boundary had meaning for practitioners engaged in managing work-related emotions.

The narratives also create a picture of two emotion cultures, both in the context of working life, but governed by highly contrasting feeling rules (see Figure 1). To be emotionally safe and productive supervision feeling rules had to contravene dominant organisational feeling rules. Satisfactory supervision was therefore predicated upon being an emotionally transgressive activity, requiring the nurses to inhabit both an emotion culture which reinforced emotional suppression and feelings of inferiority, and paradoxically, an emotion culture in which emotions were proactively worked with. This raises the question of how nurses make the transition between such contrasting emotion cultures, and what demands this places upon them.

It is evident that the nurses in this study did manage the transition between suppressive and expressive emotion cultures – and furthermore reported that the emotion work done in supervision strengthened their ability to perform 'stoical' emotion work in the organisation culture. Nevertheless, the transition between cultures and sets of feeling rules was not simple, and the nurses' narratives suggest that it depended upon a range of practical and relational factors. These could be temporal (frequency, length of sessions, protected time in the work schedule), or spatial (a private, peaceful location). The importance of time and space in supporting supervision has been previously identified (Edwards et al. 2005, Hyrkäs 2005). The boundary between emotion cultures could also be relational, established through interaction with the supervisor. There is evidence that where supervisees choose their supervisors they evaluate supervision more highly (Edwards et al. 2005), and the nurses' narratives described the importance of the relationship with the supervisor, who modelled and encouraged positive emotion practice.

Maintaining and crossing boundaries may be more difficult where supervision lacks separateness from the physical workplace. Group supervision involving supervisees who work in the same team has been identified challenging, as supervisees may find it difficult to relate to one another in a different way (Berg and Hallberg 2000, Buus et al. 2010). The difficulty of switching relationships can also be seen where the supervisor is also the supervisee's manager. In this case, supervision may be taken

over by a managerial agenda, shifting the focus to the needs of the organisation as represented by the manager, rather than the needs of the practitioner as the provider of care (Sloan 2006). A hierarchical relationship within supervision may also bring particular feeling rules into operation. For example, Power et al. (2011), have associated social stratification with feeling rules, arguing that emotionally suppressive feeling rules can be imposed on individuals from poorer social classes.

The expression of previously suppressed emotions is not an innocuous activity and requires careful support. Some scholars have observed that there may be an intense interaction when emotions which are suppressed in the workplace emerge in supervision sessions (Hawkins and Shohet 2012, Buus et al. 2010, Buus et al. 2011). The supervisor's role is likely to be crucial in creating a safe emotion culture in which a slowed down, reflexive form of interaction can occur (Hyrkäs et al. 2002). Similarly, Smith (2008: 368) comments that current exhortations to nurses to be compassionate "may actually require them to dismantle such systems they have developed against anxiety". This dismantling may be difficult to achieve: Menzies (1960) famously observed that nurses' defence systems made them resistant to change, and such changes as were implemented tended to reinforce existing anxiety avoidance systems.

Understanding supervision as an emotion culture, different to the organisational emotion culture helps to explain the difficulties nurses may experience in re-negotiating relationships, or creating space for reflective practice. If nurses and other disciplines who engage in supervision understand that supervision may use feeling rules that contradict those dominant elsewhere in the workplace, they can consciously engage with the work of developing a productive emotion culture in supervision, and maintaining the boundary between this culture and the organisational culture.

LIMITATIONS

The small number of participants interviewed for this study limited the variety of experiences analysed. However, the participants were all able to reflect on experiences occurring over a number of years, adding variety to the data. Participants were self-selecting, and several had an interest in supervision developed through their work in psychological therapies. Participants' perspective on supervision may therefore differ from that of nurses in other contexts, e.g. acute care. The clear gender bias within the sample (1 male, 7 female) meant that it was not possible to analyse the influence of gender.

CONCLUSION

The contrast between feeling rules in supervision and in the organisational context suggests that a successful emotion culture can be created in supervision even where the workplace culture mitigates against reflection or emotional expression. This study also shows that the supervision culture can enable nurses to contain and hold difficult emotions outside of sessions. This supports previous research showing that highly evaluated supervision is associated with reduced levels of burnout (cf. Koivu et al. 2012, White and Winstanley 2010, Hyrkäs et al. 2006), but further research is needed to explore this process of holding of emotion.

The contradicting emotion cultures identified in this study also suggests that while supervision may provide a nurturing, supportive experience, this may be negated by

the effort required to move between emotion cultures. We suggest that further research could explore how this may contribute to the phenomenon of practitioners' resistance to supervision observed elsewhere (cf. White and Winstanley 2009, Rice et al. 2007). Survey research has been widely used to investigate supervision, but the methods used in this study have highlighted the multiple, complex influences on understandings, experiences and practices of supervision. We believe that future research in this field should make greater use of methodologies which capture richness and depth of context.

Finally, practitioners who engage in reflective supervision should recognise that one of their tasks is to create an emotional bubble in which the supervision relationship can operate. Where a safe, supportive micro-culture is successfully created, otherwise suppressed and unexamined emotional processes can be explored, enabling nurses' development as emotionally intelligent, critically self-aware practitioners.

REFERENCES

Berg, A. & Hallberg, I.R. (2000) The meaning and significance of clinical group supervision and supervised individually planned nursing care as narrated by nurses on a general team psychiatric ward. *Australian & New Zealand Journal of Mental Health Nursing,* **9**(3), 110-127.

Berger, P.L. & Luckmann, T. (1966) *The Social Construction of Reality. A Treatise in the Sociology of Knowledge.,* The Penguin Press, London.

Bolton, S.C. (2000) Who cares? Offering emotion work as a 'gift' in the nursing labour process. *Journal of Advanced Nursing,* **32**(3), 580-586.

Butterworth, A. (1992) Clinical supervision as an emerging idea in nursing. In *Clinical Supervision and Mentorship in Nursing*(Butterworth, A. and Faugier, J. eds.) Chapman and Hall, London, pp. 3-17.

Butterworth, T., Bell, L., Jackson, C. & Pafnkihar, M. (2008) Wicked spell or magic bullet? A review of the clinical supervision literature 2001-2007. *Nurse Education Today,* **28** 264-272.

Buus, N., Angel, S., Traynor, M. & Gonge, H. (2010) Psychiatric hospital nursing staff's experiences of participating in group-based clinical supervision: an interview study. *Issues in Mental Health Nursing,* **31**(10), 654-661.

Buus, N., Angel, S., Traynor, M. & Gonge, H. (2011) Psychiatric nursing staff members' reflections on participating in group-based clinical supervision: a semistructured interview study. *International Journal of Mental Health Nursing,* **20**(2), 95-101.

Buus, N., Cassedy, P. & Gonge, H. (2013) Developing a manual for strengthening mental health nurses' clinical supervision. *Issues in Mental Health Nursing,* **34**(5), 344-349.

Buus, N. & Gonge, H. (2009) Empirical studies of clinical supervision in psychiatric nursing: a systematic literature review and methodological critique. *International Journal of Mental Health Nursing* **18**, 250-264.

Edwards, D., Cooper, L., Burnard, P., Hannigan, B., Adams, J., Fothergill, A. & Coyle, D. (2005) Factors influencing the effectiveness of clinical supervision. *Journal of Psychiatric and Mental Health Nursing,* **12**, 405-414.

Fawcett, T.N., Holloway, A. & Rhynas, S. (2015) If I have seen further it is by standing on the shoulders of giants: finding a voice, a positive future for nursing. *Journal of Advanced Nursing,* **71**(6), 1195-1197.

Fisher, P. & Byrne, V. (2012) Identity, emotion and the internal goods of practice: a study of learning disability professionals. *Sociology of Health & Illness,* **34**(1), 79-94.

Flyvbjerg, B. (2001) Making Social Science Matter. Why social inquiry fails and how it can succeed again. Cambridge University Press, Cambridge.

Fowler, J. (1996) The organization of clinical supervision within the nursing profession: a review of the literature. *Journal of Advanced Nursing,* **23**(3), 471-478.

Francis, R. (2013) Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009. London.

Gee, J.P. (1985) The narrativization of experience in the oral style. *Journal of Education,* **167**(1), 9-35.

Gee, J.P. (2005) *An Introduction to Discourse Analysis Theory and Method. Second Edition,* Routledge, New York and London.

Gilmore, A. (2001) Clinical supervision in nursing and health visiting. A review of the UK literature. In *Fundamental Themes in Clinical Supervision*(Cutcliffe, J. R., Butterworth, T. and Proctor, B. eds.) Routledge, London and New York, pp. 125-140.

Gonge, H. & Buus, N. (2011) Model for investigating the benefits of clinical supervision in psychiatric nursing: a survey study. *International Journal of Mental Health Nursing,* **20**(2), 102-111.

Guba, E.G. & Lincoln, Y.S. (2005) Paradigmatic controversies, contradictions, and emerging confluences. In *The SAGE Handbook of Qualitative Research. Third Edition.*(Denzin, N. and Lincoln, Y. eds.) SAGE Publications, London, pp. 191-216.

Hawkins, P. & Shohet, R. (2012) *Supervision in the Helping Professions. Fourth Edition.,* Open University Press, Maidenhead.

Hochschild, A. (1983) *The Managed Heart. Commercialization of Human Feeling.,* University of California Press, Berkeley.

Hochschild, A. (2003) *The Commercialization of Intimate Life. Notes from home and work.,* University of California Press, Berkeley and Los Angeles, California.

Hyrkäs, K. (2005) Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in Finland. *Issues in Mental Health Nursing,* **26**, 531-556.

Hyrkäs, K., Appelqvist-Schmidlechner, K. & Haataja, R. (2006) Efficacy of clinical supervision: influence on job satisfaction, burnout and quality of care. *Journal of Advanced Nursing,* **55**(4), 521-535.

Hyrkäs, K., Appelqvist-Schmidlechner, K. & Paunonen-Ilmonen, M. (2002) Expert supervisors' views of clinical supervision: a study of factors promoting and inhibiting the achievements of multiprofessional team supervision. *Journal of Advanced Nursing,* **38**(4), 387-397.

Hyrkäs, K., Koivula, M. & Paunonen, M. (1999) Clinical supervision in nursing in the 1990s - current state of concepts, theory and research. *Journal of Nursing Management,* **7**, 177-187.

James, N. (1989) Emotional labour: skill and work in the social regulation of feeling. *Sociological Review,* **37**(1), 15-42.

Koivu, A., Saarinen, P.I. & Hyrkas, K. (2012) Who benefits from clinical supervision and how? The association between clinical supervision and the work-related well-being of female hospital nurses. *Journal of Clinical Nursing,* **21**(17/18), 2567-2578.

Lyth, G.M. (2000) Clinical Supervision: a concept analysis. *Journal of Advanced Nursing,* **31**(3), 722-729.

MacLean, R.H.L. (2014) The Vale of Leven Hospital Inquiry. Crown Copyright 2014, Edinburgh.

Mason, J. (2002) *Qualitative Researching. 2nd Edition.,* SAGE, Los Angeles.

McCoyd, J.L.M. (2009) Discrepant feeling rules and unscripted emotion work: women coping with termination for fetal anomaly. *American Journal of Orthopsychiatry,* **79**(4), 441-451.

Menzies, I.E.P. (1960) A case-study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital. *Human Relations,* **13**, 95-121.

Nantsupawat, A., Nantsupawat, R., Kunaviktikul, W., Turale, S. & Poghosyan, L. (2016) Nurse Burnout, Nurse-Reported Quality of Care, and Patient Outcomes in Thai Hospitals. *Journal of Nursing Scholarship,* **48**(1), 83-90 8p.

NHS Education Scotland (2014) Flying Start NHS. Clinical Supervision. NHS Education Scotland, Edinburgh.
Power, C.A., Cole, E.R. & Fredrickson, B.L. (2011) Poor women and the expression of shame and anger: the price of breaking social class feeling rules. *Feminism & Psychology,* **21**(2), 179-197.
Rice, F., Cullen, P., McKenna, H., Kelly, B., Keeney, S. & Richey, R. (2007) Clinical supervision for mental health nurses in Northern Ireland: formulating best practice guidelines. *Journal of Psychiatric & Mental Health Nursing,* **14**(5), 516-521.
Ricoeur, P. (1983/1984) *Time and Narrative Volume 1,* University of Chicago Press, Chicago and London.
Royal Cornwall Hospitals NHS Trust (2013) Clinical Supervision Policy. Royal Cornwall Hospitals NHS Trust, Cornwall.
Sandelands, L.E. & Boudens, C.J. (2000) Feeling at Work. In *Emotion in Organizations*(Fineman, S. ed. SAGE Publications Ltd., London, pp. 46-63.
Schön, D.A. (1983) *The Reflective Practitioner,* Temple Smith, London.
Sheffield NHS Primary Care Trust (2008) Clinical supervision policy for registered nurses, allied health professionals and pharmacists. Sheffield.
Sheppard, K. (2016) Compassion fatigue: Are you at risk? *American Nurse Today,* **11**(1), 53-55 3p.
Sloan, G. (2006) *Clinical Supervision in Mental Health Nursing,* John Wiley, Chichester.
Smith, P. (1992) *The emotional labour of nursing : its impact on interpersonal relations, management and the educational environment in nursing,* Basingstoke : Macmillan, 1992.
Smith, P. (2008) Guest editorial: compassion and smiles: what's the evidence? . *Journal of Research in Nursing,* **13**(5), 367-370.
Smith, P. (2011) *The Emotional Labour of Nursing Revisited. Can Nurses Still Care? Second Edition.,* Palgrave MacMillan.
Stockwell, F. (2015) The care conundrum: what causes caring nurses to lose their purpose? *Journal of Advanced Nursing,* **71**(7), 1449-1450.
Theodosius, C. (2008) *Emotional Labour in Health Care. The Unmanaged Heart of Nursing,* Routledge, London and New York.
White, E. & Winstanley, J. (2009) Implementation of clinical supervision: educational preparation and subsequent diary accounts of the practicalities involved, from an Australian mental health nursing innovation. *Journal of Psychiatric & Mental Health Nursing,* **16**, 895-903.
White, E. & Winstanley, J. (2010) A randomised controlled trial of clinical supervision: selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *Journal of Research in Nursing,* **15**(2), 151-167.
Yegdich, T. (1999) Clinical supervision and managerial supervision: some historical and conceptual considerations. *Journal of Advanced Nursing,* **30**(5), 1195-1204.
Yegdich, T. & Cushing, A. (1998) An historical perspective on clinical supervision in nursing. *Australian & New Zealand Journal of Mental Health Nursing,* **7**(1), 3-24.