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Psychiatric Hospital Nursing Staff's Experiences of Participating in Group-Based Clinical Supervision: An Interview Study

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Group-based clinical supervision is commonly offered as a stress-reducing intervention in psychiatric settings, but nurses often feel ambivalent about participating. This study aimed at exploring psychiatric nurses' experiences of participating in group-based supervision and identifying psychosocial reasons for their ambivalence. Semi-structured interviews were conducted with 22 psychiatric nurses at a Danish university hospital. The results indicated that participation in clinical supervision was difficult for the nurses because of an uncomfortable exposure to the professional community. The sense of exposure was caused by the particular interactional organisation during the sessions, which brought to light pre-existing but covert conflicts among the nurses.

In most of the Western world, the second half of the twentieth century saw a major policy shift regarding people with mental illnesses. This shift was characterized by deinstitutionalisation: The number of psychiatric hospital beds was reduced considerably and psychiatric hospitals began to take on a new role. Prior to the shift, psychiatric hospitals had been seen as total institutions characterised by the "containment" and management of a relatively stable group of mentally ill persons separated from the rest of society (Goffman, 1991). After the shift, these hospitals began to manage "movements" of a continually changing population of patients (Rhodes, 1995). The shift from containment to movement radically altered the psychiatric hospital's function in health systems and had an ongoing effect on the traditional role of the mental health hospital staff by placing unprecedented stressful demands on everyday practices (Higgins, Hurst, & Wistow, 1999).

At the time of writing, psychiatric hospital patients are relatively more acutely ill and their situation and treatment needs are highly complex than before deinstitutionalisation occurred. Patients have more severe mental health symptoms and present with more disturbed and problematic behaviour, which may be influenced by various forms of substance misuse. Moreover, referrals to hospital are commonly made for stabilising treatment, and patients are discharged as soon as possible to other parts of health care services, notably community mental health services and outpatient treatment. This is often associated with an increasing number of involuntary admissions and high occupancy rates (Quirk & Lelliott, 2001; Quirk, Lelliott, & Seale, 2006).

Psychiatric nursing staff make up the largest clinical group in most countries' health systems and their potential impact on patient outcomes and experience is considerable. Within the psychiatric hospital system they are likely to experience increased stress because of the intensified workload in this changed institutional context. However inter-professional conflicts, administrative and organisational concerns, and ideological conflicts also have been noted (Edwards & Burnard, 2003) as stressors for psychiatric nurses. Traditionally, psychiatric nursing staff have enjoyed less professional autonomy compared to psychiatrists, and nurses struggle to become less devaluated in everyday

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interdisciplinary work situations (Pilgrim & Rogers, 2009; Salhani & Coulter, 2009). However, a wider recognition of the psychiatric nurse's professional autonomy is particularly difficult because of traditional social divisions of labour that allocate psychiatric nursing staff to low status work within the close proximity of the patients—secondary to the specialised psychiatric treatment (Barrett, 1996; Salhani & Coulter, 2009). Furthermore, psychiatric nursing is not highly theorised and professional competency often remains invisible—even to students and newly qualified staff members (Hamilton & Manias, 2007). Finally, psychiatric nurses have developed strong ideological orientations towards caring (Hallin & Danielson, 2007). This aspect of their professional identity drives them towards working hard out of a deeply felt concern for the patients (Brown & Crawford, 2003; Crawford, Brown, & Majomi, 2008), and to suffer moral stress when the patients cannot be treated with a perceived minimum of care and dignity (Lützén, 1993).

Clinical supervision, which is often regarded as a central and valuable part of psychiatric nursing practice (Sloan, 2006), is considered to be a stress reducing intervention for psychiatric staff. Within nursing, the term "clinical supervision" subsumes an array of theoretical definitions and practices, emphasising different theoretical facets and practical functions (Lynch, Hancox, Happell, & Parker, 2008). According to Proctor's influential model of clinical supervision, supervision can have three central, but potentially conflicting, functions: forming (developing the supervisee), norming (controlling the supervisee), and restoring (re-creating the supervisee) (Proctor, 1987). In the context of the present paper, we understand clinical supervision as a formalised pedagogical process where a trained supervisor assists a clinician, or a group of clinicians, to develop professional competency. Previously, the definitions of supervision had strong orientations towards managerial concerns and psychoanalytic theory (Yegdich, 1999), but for the last two decades the strongest emphasis in the literature has been on reflective practice as the facilitator of both personal and professional growth (Johns & Freshwater, 2005).

The variety of theoretical and practical definitions may, to some extent, explain why a recent review of empirical research on clinical supervision in psychiatric nursing indicated that there is a paucity of studies demonstrating strong evidence of any measurable effects of clinical supervision (Buus & Gonge, 2009). This review also indicated that psychiatric nurses' experiences of participating in clinical supervision were contradictory; they found participation beneficial and facilitating, but also challenging and stressful.

Qualitative studies of psychiatric nursing staff receiving clinical supervision indicate that the nurses experience a number of benefits when they participate in clinical supervision. These benefits include increased clinical knowledge, competency, and job satisfaction, improved patient care, strengthened professional and personal self-awareness, an increased sense of team, and better intra-professional collaboration (Arvidsson, Löfgren, & Fridlund, 2000, 2001; Berg & Hallberg, 2000; Olofsson, 2005). However, a number of challenges to participation in supervision have been described. Some organisations do not prioritise clinical supervision sufficiently, which has been reported to cause shortage of time and staff, and lead to sessions being cancelled (Grant, 2000; Scanlon & Weir, 1997). Moreover, psychiatric nurses have been described as resisting clinical supervision because they perceive it be to of limited value and as having low clinical relevance (Cleary & Freeman, 2005; Olofsson, 2005). Furthermore, participation in supervision sessions has been described as stressful, in particular when supervision took place in groups. Stress during group supervision was often related to uncomfortable experiences of professional and personal vulnerability. Some nurses felt exposed when they shared their professional reflections on clinical work among groups of peers and were reluctant to engage in self-disclosure (Berg & Hallberg, 2000; Cleary & Freeman, 2005; Olofsson, 2005).

The present analysis was designed to further explore the contradictory issues related to psychiatric nurses' participation in group-based clinical supervision in the wider context of the transformed and intensified work environment. This can help us to understand the overall situation of this significant section of the health care workforce. It has implications for organisational and professional development as well as workforce and quality of care issues more generally. The aim of the study was to investigate psychiatric hospital nurses' accounts of participating in group-based clinical supervision and in particular to see what light psychosocial conceptions of group dynamics might shed on contradictory experiences.

METHODS

Design

The present paper focuses on an interview study (Kvale & Brinkmann, 2009), which was part of a concurrent mixed methods study (Creswell, 2009) of psychiatric nurses' participation in and self-reported benefits of clinical supervision.

Sample

A concurrent questionnaire survey was undertaken of all 187 psychiatric nursing staff working at all 9 general psychiatric wards at a university hospital in Denmark (Gonge & Buus, 2010). The questionnaire booklet comprised sociodemographic questions, the Manchester Clinical Supervision Scale (MCSS), the Copenhagen Psychosocial Questionnaire (COPSOQ), the SF-36, Eysenck's Personality Questionnaire (EPQ), the Maslach Burnout Inventory (MBI), and the Coping Styles Questionnaire (CSQ) (Bjørner, Damsgaard, Watt, Bech, Rasmussen, Kristensen et al., 1997; Elklit, 1996; Eysenck & Eysenck, 1975; Kristensen, Hannerz, Høgh, & Borg, 2005; Maslach & Jackson, 1986; Winstanley, 2000). The 90 (48%) nurses who responded to the survey were used as the population for the interview study. Using a list of names randomly selected by the fourth author (HG), 25 respondents were approached consecutively by

the first author (NB) by telephone, e-mail, or face-to-face and invited to join in the study.

It was initially hypothesised that the survey respondents who had participated least frequently in clinical supervision would have different, relatively less positive, attitudes towards clinical supervision compared to those who participated in clinical supervision most frequently. Therefore we attempted to recruit and subsequently analyse our data with regard to two groups: those who had attended two or fewer self-reported clinical supervision sessions during the previous six months, and those who had attended three or more sessions. However, because most of the respondents that had least participated in clinical supervision were employed part-time and/or worked evening and night shifts, it was not possible to recruit enough of these respondents to obtain a completely balanced sample. Three respondents declined to participate in the study (one frequent participant and two infrequent) because of a lack of personal energy. Thus, the purposive sample (Patton, 2002) for the interview study comprised 22 informants: 15 frequent participants and 7 infrequent participants. A preliminary consecutive analysis indicated that the amount and character of the empirical material based on the 22 informants was sufficient to answer the research questions and recruiting was ended (Patton, 2002).

The sample included 20 women and 2 men. The average age was 46.8 years ($SD = 10.8$). Eleven informants were educated to bachelor level (8 registered nurses and 3 occupational therapists), and 11 had an upper secondary education in health care (3 nursing assistants and 8 social and health care assistants). Twenty informants worked primarily day shifts, 1 primarily worked the evening shift, and 1 primarily worked the night shift. The 15 frequent participants had, on average, participated in 5.5 sessions ($SD = 2.2$) during the previous six months and the infrequent participants were part of, on average, 0.7 sessions ($SD = 0.8$).

In order to determine if the sampling procedure had produced a sample with particular features, the sample was compared to the study-population. There were no significant differences in gender (Pearson's $\chi^2 = 0.68$, 1 df, $p = 0.41$), education level ($\chi^2 = 4.61$, 4 df, $p = 0.33$), primary work shift ($\chi^2 = 3.01$, 2 df, $p = 0.22$), or age (Mann-Whitney test, $p = 0.27$).

Interviews

All interviews were undertaken by the first author, a trained and experienced interviewer, and took place in a quiet private room at the psychiatric hospital in July and August 2008. All interviews were audio-recorded. On average, the interviews lasted 49 minutes (ranging from 37 minutes to 73 minutes). The second author transcribed the interviews into written language, by leaving out hesitations, extra linguistic expressions, and so forth. The interviews were undertaken in Danish and the Danish texts were analysed then translated into English for the purpose of this paper.

An interview guide was used to structure the interpersonal dynamics during the interviews as well as the interview theme. The first part of interview guide was designed to bring out narrative responses regarding the informants' experiences of participating in clinical supervision, including descriptions of typical sessions, ways of preparing for supervision, the emotional climate during supervision, the role of other participants and the supervisor, and the use of knowledge developed during supervision.

The second part of the interview was designed to bring out more considered responses regarding the purpose of clinical supervision and the respondents' stance toward the ideas that: (1) Clinical supervision is part of institutional control, (2) Clinical supervision facilitates reflection, and (3) Clinical supervision has recreational value for the participants. These three issues were taken from Proctor's model of clinical supervision (Proctor, 1987).

The third part of the interview contained questions inviting more speculative responses, for example about future benefits and participation in clinical supervision and suggestions for improvements. The interview guide was tested before the first interview and continually modified during the study as categories became saturated with descriptions and emerging categories were prioritised and further explored. The modifications of the interview guide reflected the interviewer's reflective sensitivity and how he systematically explored issues that came to his attention during interviewing.

Analysis

The analysis was based on Ricoeur's theory of interpretation (Ricoeur, 1976, 2008). The theory implies three levels of textual analysis: a naïve interpretation, a structural analysis, and a critical interpretation. In the naïve interpretation the first (NB) and second (SA) author independently read and interpreted the transcribed interviews (Ricoeur, 2008), both separately and across the interviews. These initial, naïve readings were discussed by the two interpreters and led to the articulation of initial guesses (Ricoeur, 2008) about the texts and to a description of a concept map (Maxwell, 2005) with a range of preliminary, interrelated themes.

In the structural analysis the guesses from the naïve interpretation were challenged and substantiated (Ricoeur, 2008). In this part of the analysis the rudimentary themes were reorganised using a symbolic interactionist approach to analysing social interaction, namely as conditions, actions, interactions, and consequences (Strauss & Corbin, 1998) both inside and outside of supervision settings. The reorganisation of the themes meant that some themes were created or merged with others while others were regarded as redundant in the present analysis and deleted. The three interactionist concepts were used to formulate theoretical links among the themes and to stimulate questions about those themes that were not yet fully developed in the analysis. The structural analysis also included strategically utilising

metaphors to explore the dataset (Miles & Huberman, 1994). For example, thinking of clinical supervision as "physical exercise": it continually needs prioritising, it is hard work, the feeling afterwards is great, but the feeling soon fades and the need for more exercise reappears. The themes were systematically explored by coding the whole dataset with 19 distinct codes. The software programme NVivo 8 was used for coding in the structural analysis. Both the first author and second author coded the first interviews; the discrepancies in their coding practices were discussed and used to further define the scope and content of the codes. Afterwards, the first author coded the full dataset.

In the critical analysis the content of the themes and their relationships were interpreted within a symbolic interactionist theoretical framework asserting that meaning is produced through interpersonal communication and exchange (Blumer, 1969) and by drawing on appropriate psychosocial concepts about group dynamics, notably Tuckman's (1965) model of group dynamics. Using Tuckman's model to organise the themes did not entail a deductive analysis; it was a way of presenting findings that would otherwise be very difficult to present in a relatively simple and coherent way. The appropriateness and fruitfulness of these organising theories were decided on after discussions among the authors and were based on the exact character of the findings from the structural analysis. Interpretations ended when the interpretations seemed to be the most significant among possible interpretations (Ricoeur, 1976), which was decided on in discussions among all authors.

Interpretations were systematically challenged and confirmed throughout the analysis (Ricoeur, 1976, 2008). This included checking for the representativeness of interpretations in the original dataset; checking for interpreter effects though parallel analyses and continuous discussions; and systematic examinations of outliers and surprising data or interpretations (Miles & Huberman, 1994).

Ethics

In line with Danish legislation, the interview study was submitted to the regional research ethics committee and to the Danish Data Protection Agency; neither institution had any objections toward the study. All participants gave their informed consent to participate based on written and spoken information. Interview responses were handled with full confidentiality.

RESULTS

This section is organised around Tuckman's model of group development (Tuckman, 1965). The model was not originally designed to capture stages in supervision groups, but the descriptions of the different types of interactions in a group's life span proved to be an insightful and coherent way of describing the staff members' experiences of participating in the groups. Tuckman's original four-stage model (Forming, Storming, Norming, Performing) described how groups take form, negotiate norms and roles, and, if successful, cooperate and develop a common sense of identity and purpose. Later, Tuckman and Jensen added a fifth stage describing how groups break up (Adjourning) (Tuckman & Jensen, 1977). All groups may not develop unity and evolve through all of the stages, but may skip or get stuck in certain stages (Ilgen, Hollenbeck, Johnson, & Jundt, 2005), for example, in the conflict-ridden storming stage.

Forming: An Open Group in an Open Group

Supervision groups were described as small ad hoc groups within the larger group of nursing staff. The informants described their experiences of participating in supervision sessions by continually drawing parallels between psychosocial events during supervision sessions and psychosocial events outside sessions. This indicated a high level of interdependency between the two settings, and the informants' experiences of participating in supervision groups had to be understood in relation to their experiences of working within the larger group.

The informants learned about their colleagues' personality and professional approaches through both everyday and critical situations. All informants described themselves as having a caring approach: They would try to treat the patient as a unique human being and always take contextual knowledge into consideration in assessing the patient's total situation. This approach was described as in opposition to an uncaring "hard" approach toward patients where nurses would act toward patients according to ward rules and standard protocols and procedures.

The informants stated that the size of supervision groups and the participants who attended varied significantly. According to the nurses, the variation was caused by their shift-work, which meant that supervision often would be scheduled on their day off or during an adjacent shift. Furthermore, poor staffing levels combined with continually shifting workloads could make it very difficult, and often impossible, for the present staff members to leave their work tasks to participate in supervision. At best, supervision was offered continually and regularly, but the interpersonal relationships within the groups would always be discontinuous. Therefore, supervision sessions always included a reinvigorated element of forming the supervision group (Tuckman, 1965), where participants took stock of the other participants' roles and motives for participating.

During the forming process, the participants would draw on their knowledge of and trust in the other staff members from situations outside the supervision sessions. However, as new staff members were continually joining the team and more experienced staff members stopping, the participants would only have a limited knowledge about—and trust in—some of the other participants. This was a problem to some informants, as they found it difficult to self-disclose and expose themselves to people whose response they could not anticipate.

Storming: Exposure and Conflict

The informants described how their supervisor would open session by asking each of the participants about what was

troubling them. This opening round would be used to get a common understanding of the character and severity of problems troubling the participants and, subsequently, to prioritise among these problems. Eventually, the group, guided by the supervisor, would decide on which issue to work. The staff member that brought up the issue, or sometimes the staff member with the most comprehensive knowledge about the issue, would become the supervisee. The most common method was that the supervisor interviewed the supervisee and that the audience functioned as a reflective team that could further contribute with questions or comments according to more or less formalised turn-taking systems.

The informants only described processes of storming (Tuckman, 1965) in relation to latent conflicts in the larger group of nurses. Learning to participate in group supervision and negotiating roles during supervision seemed unproblematic and happened without any apparent effort. In contrast, the sessions would often expose and nourish disagreements and conflicts among the nurses that otherwise were not explicit in everyday work-situations. According to the informants, this particular effect of supervision made some conflict-averse nurses give low priority to participation in supervision. One nurse describes other reasons for low participation in supervision groups:

> There are people who prefer not to talk much about how they think and feel and there are people who make clear that they always know what is right and that they are never wrong. There are probably also those who have no desire to work in that way [with clinical supervision]; to sit and give something of yourself and to take part. There are probably also those who know how to share it with a spouse; we have very different needs for getting our stuff out. (Nurse 13)

The supervisee's role was particularly problematic, as the person had to present the clinical issue in a convincing way to the group and also manage and present personal feelings toward this issue. Most often, the supervisee was not very well prepared for the role and the supervisor's interview would reveal that the supervisee had a limited knowledge of the issue (e.g., a patient's clinical biography or present situation) or that the supervisee found it emotionally straining to care for the patient. Both situations could lead to the supervisee feeling uncomfortable—professionally stripped in front of the group and maybe overwhelmed by an unanticipated emotional response. Other participants could recognise feelings of being professionally stripped, but they did not feel quite as exposed as the supervisee because of their more peripheral role as audience. The informants accepted that supervision should be a little challenging in order to be effective, but many nurses preferred sessions where participants shared experiences in mutual conversation rather than the more formalised methods with interrogating and reflective questions by supervisor and the audience. In this way they could minimise overt signs of anxiety produced during the interrogative parts of the supervision sessions.

Norming and Performing: The Weight of Work and Feeling Stuck

Tuckman's norming and performing stages describe how groups settle conflicts and start to collaborate around a common goal (Tuckman, 1965). The informants described the most important benefits from participating in clinical supervision as receiving assistance (1) in coping with the psychological burden of working in a psychiatric institution and (2) in creating new perspectives on situations where they feel stuck. These benefits were intrinsically related to their experiences of the sources of powerlessness and frustration in everyday clinical work. The informants believed that because clinical supervision reduced feelings of powerlessness and frustration, it reduced the risk of burning out and long-term illness. However, they also believed that one of the first signs of burnout was to give low priority to supervision.

Workload and tasks were rarely predictable because of changes in the patients' mental conditions and behaviour, and the nurses had to continually reschedule plans for their work. Clinical work was rarely standardised and therefore clinical decisions had to be made from one situation to the other. This often generated uncertainty and anxiety, and the informants described how they were highly dependent on other staff members in critical situations and highly interdependent on the others for emotional support.

> It's very good when your colleagues chip in [during clinical supervision sessions] and say that they think that what you do is good, because we are not good at that in daily clinical life. So, during a session it's good when someone says, "I've been worried about you because it's been such a difficult patient." I think that caring aspect is very important in this line of work because it's acute. Because you are often exposed to things you just don't talk about with the others. (Nurse 5)

Regarding emotional benefits, the informants experienced their work as demanding and stressful. Patients could threaten them physically or psychologically, or the informants could be worried about finding suicidal patients severely injured or, in the worst case, dead. Sharing frustrations was described as personally affirming and comforting and as a kind of professional absolution. This made it easier to continue the burdensome work. The informants described how their colleagues were highly important in the process of sharing and acknowledging frustrations and this particular aspect of supervision could, in most instances, take place without much interaction with the supervisor.

Regarding cognitive benefits, it was important for the informants that patients or clinical situations were progressing, and it frustrated the informants when things got stuck in spite of their therapeutic aspirations. Feelings of being stuck could include a variety of situations: a patient who could not be discharged (or keeps being readmitted) or a patient who is lacking progress in his or her behaviour or psychological state. The informants related the frustration to their own lack of ability to see the situation clearly and it was pivotal for them that the supervisor

was external to the ward. This, along with experience and formal education, would provide the supervisor with an alternative perspective from which to explore and challenge the nurses' problems. The nurses' professionalism was dependent on the supervisor and interactions with the supervisor were seen as central in this particular aspect of supervision.

Adjourning: Ending Sessions

Tuckman and Jensen described adjourning as the stage where groups dissolve and the participants must part with each another (Tuckman & Jensen, 1977). Because the supervision sessions were continuing and based on ad hoc groups there were no apparent feelings of interpersonal loss. However, according to the informants, it was one of the supervisor's most important tasks to close sessions properly. A proper closure would include making sure that all participants felt that they had been heard and felt understood and that the supervisor summed up the issue in a way that somehow pointed forward. The nurses found poor closures very frustrating. However, the staff members themselves would often hamper proper endings because they would start to worry about finishing their work outside the supervision session. This ruined the important atmosphere of being undisturbed. This would provoke both overt and covert signs of distracted participants.

The informants stated that they would often continue to reflect on what had been discussed during the sessions. The wards had different rules on whether it was allowed to discuss issues from supervision outside supervision sessions. On some wards it was not allowed and on others it was allowed as long as the issue was related to a patient. Even though the nurses felt that supervision provided them with a feeling of common understanding and a more joint approach to the issues, they found that supervision had a very limited effect outside sessions. This was because there were so few staff members present at supervision and because decisions about new approaches to issues were rarely put into operation. In this sense, clinical supervision had a very short-term effect on the participants.

DISCUSSION

The shift in treatment ideology from containment to movement has had a significant impact on the work conditions of psychiatric hospital staff. Nurses have increasingly high workloads characterised by high proportions of acutely ill patients, high occupancy rates, and high turnover rates (Quirk & Lelliott, 2001; Quirk et al., 2006). This study of informants' experiences of participating in clinical supervision must be interpreted within this transformed context.

The nurses worked within an institutional context characterised by high levels of uncertainty and anxiety, and their professional decision-making was indeterminate rather than technical (Jamous & Peloille, 1970; Traynor, 2009). In many situations, professional decision-making was based on the nurses conforming to social norms for reflection and action, rather than clear-cut technical decision-making (Hamilton & Manias, 2007). The clinical supervision group sessions often challenged the participants' overestimated assumptions about a mutual understanding of clinical issues, which gave rise to increasing anxiety for the individual participant and for the group. Conversely, the group sessions could also strengthen the group members' conformity to group norms and assure the participants about their mutual understanding of clinical issues. In this situation, the participants experienced both the cognitive benefits of increased clinical knowledge and competency and the emotional benefits related to feeling connected to the group (Smith & Mackie, 2007). In other words, the indeterminacy of their professional practice accentuated the nurses' need for feeling connected to their colleagues, and group based clinical supervision could both strengthen and challenge these feelings. This can explain the nurses' ambivalence towards group based clinical supervision identified in the present analysis and in previous research (Berg & Hallberg, 2000; Olofsson, 2005).

Increasing workloads made it difficult for the nurses to find time to participate in the sessions and to stay focused on supervision during the sessions (Cleary & Freeman, 2005). Furthermore, high occupancy rates and high patient turnover combined with shift work made it difficult for the nurses to be fully updated about their patient's condition and situation. Psychiatric nurses have been reported to choreograph their social interactions in order to minimise overt signs of uncertainty or ignorance when they speak or write about patients; they collude to save face and minimise interpersonal conflict (Buus, 2008). However, the supervisors and the structured interactions during supervision did not allow the nurses to collude, as they were able to do in everyday communication. The fundamental uncertainty caused by high workloads was made visible during the supervision sessions, which caused the participants, in particular the supervisee, to be professionally exposed. The anxiety provoking exposure caused by the non-colluding group supervision context may explain why many nurses did not participate in clinical supervision.

The nurses voiced strong opinions about their non-participating colleagues and most used their own participation in clinical supervision to enhance their sense of professional identity. They categorised themselves as belonging to a morally superior group of "caring" nurses in opposition to an out-group of "uncaring" nurses who were rigid and unwilling to challenge routines and learn something new through the potentially unsettling clinical supervision sessions. The nurses could collectively confirm their caring values during supervision sessions and those participants who did not adhere to group norms or share the related moral values were gently sanctioned. However, the nurses believed that the colleagues most in need of sanctions typically were among the non-participants. In this sense, the supervision sessions were socially controlling, which may add to some nurses' reluctance towards participating. Previous research has suggested that clinical supervision could imply a managerial, disciplining function (Grant, 2000). However, the

nurses in the present study explicitly refuted this and described a moral, professional control. Furthermore, studies have emphasised how participants in group supervision are reluctant regarding self-disclosure (Berg & Hallberg, 2000; Cleary & Freeman, 2005). Moral control during group sessions may be a central inhibitor of participants' inclination for self-disclosure.

The nurses did not articulate stressful experiences about a gap between their moral values and the impossibility of actually enacting them (cf Lützén, 1993). This may be because the group supervision sessions fulfilled their need for both clinical competency and ties to the other staff members.

The nurses had adopted an understanding of their professional practice as something continually under threat of becoming an undesirable routine, and therefore they needed an external supervisor to help them to reframe their clinical problems. In some instances reframing was accomplished by exploring questions that led to new reflections among the participants, in other instances reframing was based on teaching or through exchanges of experiences. In effect, the nurses gave the supervisors the key to articulating a higher truth about their professional work. In this sense, the nursing staffs' professional autonomy is controlled and suppressed through the supervisory practices. Ironically, this happened without objections from the nurses who saw the supervisory practices as in full concordance with their own understanding of their clinical work and the benefits of supervision.

The study sample was drawn using data from the survey-based part of the mixed methods study. It was anticipated that nurses participating least in clinical supervision would be negative towards it, and vice versa. Even though it was not possible to get an evenly balanced sample, it was surprising that all participants were very much in favour of supervision. This could be because nurses with negative opinions toward supervision did not respond to the survey and, therefore, were not represented in the interview study's population. Future interview research should apply different sampling strategies, as the non-respondents in this study could include the "uncaring" nurses assumed and described by the participants. Alternatively, field research could be a fruitful strategy for getting a situated understanding of reluctance toward and benefits from participating in clinical supervision and the tensions among groups of staff.

The particular Scandinavian context of providing clinical supervision may have influenced the findings; in particular, clinical supervision is conceived to be a method for professional development after vocational training and that supervisors have special supervision training (Hyrkas, Koivula, & Paunonen, 1999).

CONCLUSION

The study was concerned with psychiatric nurses' experiences of participating in clinical supervision in a changing institutional context. The nurses' views of supervision were tailored to a situation with high workloads and high levels of indeterminacy. On the one hand, they found moral peer support in the group sessions, and supervision added positively to their professional identity. On the other hand, supervision was seen as a valuable pedagogical intervention that could help them when they felt stuck or trapped in their clinical work. However, the clinical effects of participating were seen as both limited and short-term. Because of the high workloads, clinical supervision was only rarely implemented regularly enough to have clinical impact or have long-term value for the individual nurses. Therefore, the nurses would mostly utilise less formal and less anxiety provoking ways of boosting their professional identity and reflecting with peers.

The central challenge for nursing leaders and administrators must be how to organise group based clinical supervision in ways that permit nursing staff to participate regularly and, thereby, establish trusting relationships within the group. An alternative strategy would be to offer individual supervision sessions, which are more expensive, but much less influenced by workloads and staff conflicts.

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