

**A thematic analysis of psychodynamically-oriented supervision of  
observations in an acute inpatient ward**

**Thesis submitted to the University of Leicester**

**School of Psychology – Clinical Section**

**Faculty of Medicine**

**In partial fulfilment of the requirements**

**for the degree of**

**Doctorate in Clinical Psychology**

**By Rebecca Blacker**

**May 2009**

### **Declaration**

I confirm that the literature review and research report  
contained within this thesis have not been submitted  
for any other degree, or to any other institution.

## **Acknowledgements**

I would firstly like to thank all of the participants who made this study possible. To the staff and patients on the ward, I thank you for your openness and co-operation. To the members of the supervision group, I am greatly appreciative of your time, dedication and careful consideration.

I feel I owe so much to my academic supervisor, Arabella Kurtz. I thank you for your support, containment and creativity. I know this project would not have happened without you. I would like to thank my field supervisor Anne Goodwin. You provided me with an experience I have learnt so much from and will think about often.

To my fellow trainees, your continual support and guidance has been invaluable. I would like to thank Laura, Sue and Ros for being there when the going got really tough!

I know I could not have done this without my family and friends. Thank you for listening, being patient and just being around. To my housemate Fran, thank you for sharing in this journey with me. Thank you for proof-reading my work, putting up with me over the last few months and providing the distractions I needed in order to keep going.

Finally, to James, your unwavering belief in me gave me belief in myself. Thank you for your understanding, your support and for always being there. Here's to our next chapter together. I love you.

### Word count

<b>Part 1:</b>	Literature Review	5495	(references 1147)
<b>Part 2:</b>	Research Report	13855	(references 871)
<b>Part 3:</b>	Critical Appraisal	5623	(references 207)
<b>Total:</b>	(excluding references)	24973	
	(including references)	27198	

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(in two separately bound volumes)

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## **Thesis summary**

The literature review synthesises and critiques the research literature pertaining to the efficacy of clinical supervision within the psychology profession. Five electronic publication databases and two journals were examined in a systematic literature search according to particular inclusion and exclusion criteria. The search revealed studies examining the supervisory relationship, supervisee characteristics and supervisor confidence and competence. A notable omission from the review was empirical research investigating the effectiveness and outcomes of clinical supervision. It is posited that research exploring this area would represent a significant contribution to the literature on clinical supervision.

The research study attempted to gain an understanding of the experiences of staff and patients on an acute adult inpatient ward through the use of a psychodynamically-orientated observation methodology. The influence of supervision group meetings on observational learning was also explored. Six planned observation sessions took place and qualitative data was collected through the audio-recording and transcription of supervision group meetings. The data was thematically analysed according to the procedure of Braun and Clarke (2006). The suggested findings of the analysis appeared to illustrate a complex system which impacted upon ward atmosphere, relationships, behaviour and perception of job role and responsibility. The research process also appeared to highlight important considerations relating to the role of affect and the process of learning in qualitative research. The suggested findings are considered in terms of previous research and relevant theory. Clinical implications are discussed.

The critical appraisal provides an exploration of the research journey and presents the research process as a challenging yet rewarding learning experience.

## **Part 1**

### **Literature Review**

What makes clinical supervision effective? A review of the research literature within  
psychology

## **What makes clinical supervision effective? A review of the research literature within psychology**

**Purpose:** The current review aimed to systematically review and critique the research literature pertaining to the efficacy of clinical supervision within the psychology profession.

**Method:** A computerised literature search was conducted using five key publication databases. Additional articles were identified from previous reviews and a systematic search of the journals target journals which publish research on supervision within the psychology field. Particular inclusion and exclusion criteria were employed.

**Results:** The search revealed studies examining 1) the supervisory relationship, in particular research exploring events occurring within the supervisory relationship, attachment theory, disclosure, and the impact of shared cultural understanding on the supervisory relationship 2) supervisee characteristics, including supervisee development, knowledge and individual differences and 3) supervisor confidence and competence

**Conclusions:** A notable omission from the review was empirical research investigating the effectiveness and outcomes of clinical supervision. It is posited that research exploring this area would represent a significant contribution to the literature on clinical supervision.

**Target Journal:** British Journal of Clinical Psychology

## **1. Introduction**

### **1.1 Aim of review**

The current review aimed to systematically review and critique the research literature pertaining to the efficacy of clinical supervision within the psychology profession. Since the definitions, features and tasks of supervision all state an essential component as being ensuring the quality of professional services on offer to clients, an interesting finding of the current review was a lack of studies relating to therapeutic outcome. The empirical research does not appear to have reflected this vital element of the supervisory process. Instead the research literature appears to have focused upon factors assumed to influence therapeutic outcome, such as the supervisory working alliance and supervisor competence.

### **1.2 Definitions**

The term ‘supervision’ has attracted a number of definitions. One widely held, and largely accepted, modern definition is that of Bernard and Goodyear (2004). The authors define supervision as ‘...an intervention provided by a more senior member of the profession to a more junior member of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purpose of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession’ (p.8).

According to Proctor (1994) the main aim of supervision is to offer the most effective service for clients, in accordance with the goals, expectations, and ethical and professional standards of the organisation and profession involved. The skills, knowledge, attitudes, competencies, and practices of staff required in order to achieve such goals, are believed to be enhanced through the processes and practices of supervision.

### **1.3 Clinical supervision and mental health professions**

Clinical supervision has been regarded as a distinctive, profession-specific way of informing practice that is common to all of the mental health professions (see Goodyear, Bunch & Claiborn, 2005; Spence, Wilson, Kavanagh, Strong and Worrall, 2001). However, supervision can differ in terms of style, format and focus (Bernard & Goodyear, 2004). Goodyear, Bunch & Claiborn (2005) contend that each mental health profession approaches supervision differently with respect to both practice and research.

### **1.4 Professional guidelines**

The British Psychological Society (BPS) Division of Clinical Psychology, in its Supervision Guidelines (2003), states that all clinical psychologists are expected to engage in regular supervision of their own work, irrespective of stage of career or work context. Supervision is perceived as being a core clinical activity, the aim of which is to ensure the delivery of effective and high quality services. The Health Professionals Council (HPC) standards of education and training (2009) documents the importance of learning, teaching and supervision in order to encourage safe and effective practice,

independent learning and professional conduct.

### **1.5 Supervision vs. clinical supervision**

It is acknowledged that the terms ‘supervision’ and ‘clinical supervision’ are often used interchangeably in the literature and in policy documents in the UK (Scaife, 2009), however useful distinctions do exist. Inherent in the term ‘clinical supervision’ is a focus on supervision of clinical or practical work (Scaife, 2009).

A model of clinical supervision offered by Cogan (1973) highlighted not only the importance of a review of performance, but also the supervisory alliance and the need for a collegial relationship between supervisor and supervisee. The author contended that decisions regarding the supervisory focus, the identification of strengths and weaknesses, and consideration of the goals of supervision should all be the responsibility of the supervisee.

### **1.6 Features of supervision and the task of supervision**

Scaife (2009) highlighted the various definitions accompanying the term ‘supervision’, and discussed the importance of this for different individuals, professions and cultures. However, Scaife (2009) stipulated an intention not to offer a further, definitive meaning for supervision. Instead the author proposed a number of features which characterise the supervision endeavour. These include:

- The purposes of supervision are to ensure the wellbeing of clients and to improve the service offered to clients by the professionals who work there.

- Effective supervision requires a formal relationship, characterised by mutual respect and trust.
- Supervision should comprise an agreement or contract, the purpose of which is to outline factors such as the purposes, aims and method of supervision.
- The function of supervision can be either formative, restorative or normative.

(Scaife, 2009)

The BPS Division of Clinical Psychology (2003) provided guidance on the tasks of supervision. The tasks include: conducting an assessment of needs, implementing the appropriate supervision, and evaluating its effectiveness. Within the implementation of supervision the guidance highlights the importance of reflection, conceptualisation, planning and experiencing. Evaluation is stated to be the ‘least embraced’ of the supervisory tasks by psychologists.

### **1.7 Trends in the existing literature**

Davy (2002) presented a discursive reflection on the literature pertaining to clinical supervision, drawing attention to four major strands of psychological literature on clinical supervision. These comprise: a comprehensive literature developing theoretical models and frameworks of supervision, often based on supervisors’ experience, the use of analogies with therapy, developmental processes and skills development; literature on the process of supervision; literature proposing practical guidance on the implementation of supervision; and literature exploring supervisees’ experiences of supervision.

## **1.8 Previous reviews**

A search revealed three reviews pertaining to research into supervision within the profession of psychology. One of these was a methodological critique of clinical supervision research from 1981 to 1993 (Ellis, Ladany, Krenzel & Schult, 1996). This review was not limited to the psychology profession; fields of therapy included psychiatry, psychiatric nursing, counselling and social work, as well as counselling psychology and clinical psychology. Similarly, another review examined a range of theoretical issues and the empirical evidence relating to clinical supervision in four mental health professions (clinical psychology, occupational therapy, social work and speech pathology) (Spence, Wilson, Kavanagh, Strong & Worrall, 2001). The final review (Goodyear, Bunch & Claiborn, 2005) was limited to the psychology profession; however the aim of this paper was to review five years of supervision related articles and therefore was not solely concerned with empirical evidence.

No systematic reviews of the current empirical literature within psychology were found and it was concluded that such a review could provide a valuable contribution to the literature.



## **2. Method**

### **2.1 Search procedures**

The research articles which form the basis of this review were identified via a three part search strategy and were selected for inclusion on the basis of specific criteria. Firstly, five key publication databases were examined: PsychInfo, PsychArticles, Scopus, Web of Science and PsychExtra, using the following search terms: 'Psychology' 'Clinical Psychology', 'Counselling Psychology', 'Health Psychology', 'Forensic Psychology', 'Supervision' 'Supervise', 'Supervising' and 'Clinical Supervision'. Additional articles were identified from previous reviews, thus making use of the ancestry approach (Cooper, 1989) and a systematic search of the journals 'Journal of Counselling Psychology' and 'Professional Psychology: Research and Practices', target journals which were found to publish research on supervision within the psychology field.

### **2.2 Inclusion-exclusion criteria**

A number of inclusion and exclusion criteria were used. Ellis, Ladany, Krenzel and Schult (1996) conducted a comprehensive review of the clinical supervision research from 1981-1993, within which the authors assessed the scientific rigour and quality of methodology of empirical studies in clinical supervision published within this period. In order to prevent overlap and keep the present review as contemporary as possible, the current paper aimed to include research published from 1994 to 2009. The studies were required to be from within the professional discipline of Psychology and it was necessary for the papers to comprise empirical work on supervision. The studies were also required

to be published within a peer-reviewed journal and the English language. Dissertations and other unpublished articles were not included. However, in order to obtain a wide-ranging view of the literature, papers were not excluded on the basis of quality of scientific design. In the first instance, the studies retrieved were examined on the basis of the abstract, and those that appeared to fulfil the inclusion criteria were appraised on the basis of the full report.

### **2.3 Search selection**

The search procedure yielded 267 papers. The abstracts were examined on the basis of the inclusion-exclusion criteria noted above. Twenty-four potentially relevant abstracts were identified and the full papers were retrieved for more detailed information. All of these articles were screened using a data extraction tool. One data extraction tool was designed for use with quantitative studies (appendix 1) and another for use with qualitative studies (appendix 2). The purpose of this tool was to ensure that each study was examined on the basis of its sampling procedures, methodology and analysis. The relevance of each paper was judged according to its aims, population and research topic. The use of a data extraction tool allowed a consistent approach to the reviewing of each article retrieved. Four articles, which used a research methodology to explore issues relating to service delivery, were excluded at this stage, as they did not fulfil the criteria of the current review.

### **3. Results**

Twenty articles were deemed to meet the selection criteria and were included in the comprehensive critical review. A narrative of the findings is depicted within this section.

The research topics of each of the studies were considered from a thematic perspective. From reading the papers, three main subject areas appeared to emerge from the literature: ‘supervisory relationship’, ‘supervisee characteristics’ and ‘supervisor confidence and competence. Of the twenty articles obtained, thirteen employed a quantitative methodological approach and seven a qualitative methodological approach. Information regarding the specific methodological characteristics of the studies utilising a quantitative approach can be found in table 1 (appendix 3), and table 2 (appendix 4) depicts the methodological characteristics of the studies employing a qualitative approach.

#### **3.1 Supervisory relationship**

Much of the research focusing upon therapeutic effectiveness has concentrated on the therapeutic relationship or working alliance, that is, the relationship formed between therapist and client. Bordin (1983) suggested the utility of the concept of the working alliance in the understanding of supervisory relationships, and the working alliance is now regarded as pivotal to supervision (Ladany, Walker & Melincoff, 2001). Through the work of Bordin (1983), three factors are regarded as essential for effective supervision: an agreement between supervisor and supervisee regarding the goals and tasks of supervision, an agreement on the tasks required to attain the goals and a mutual, positive

emotional bond. A strong supervision working alliance has been found to be related to a responsive supervisory style (Ladany et al, 2001) and effective evaluation practices in supervision (Lehrman-Waterman & Ladany, 2001). A weak supervision working alliance, on the other hand, has been found to be associated with counterproductive events in supervision (Gray, Ladany, Walker and Ancis, 2001) and difficult supervisor relationships (Nelson & Friedlander, 2001). The current review highlighted a lack of evidence demonstrating that a positive working alliance within the supervisory relationship results in a positive therapeutic outcome for clients. Instead, it appears that the analogy from therapy has been accepted without much question.

Within the present review, six of the studies retrieved focussed upon the supervisory relationship (Burke, Goodyear & Guzzard, 1998; Henry, Hart & Nance, 2004; Hess, Knox, Schultz, Hill, Sloan, Brandt, Kelley & Hoffman, 2008; Knox, Burkard, Edwards, Smith & Schlosser, 2008; Riggs & Bretz, 2006 and Worthen & McNeil, 1996). This section has been divided into four sub-themes ('events occurring within the supervisory relationship', 'attachment theory and the supervisory relationship', 'disclosure and the supervisory relationship' and 'the impact of shared cultural understanding on the supervisory relationship') on the basis of the specific areas explored within the studies.

### **3.1.1 Events occurring within the supervisory relationship**

Burke et al (1998) utilised a quantitative approach to examine the weakening and repairs in supervisory alliances. The authors made use of Bordin's (1979) notion that therapeutic outcome ultimately depends upon the ways in which client and therapist resolve a

repeating process of weakening and repair, and considered this in relation to the understanding of the supervisory relationship. Supervisors and supervisees in ten supervisory dyads audio-recorded ten consecutive supervision sessions. The measures used within the study were the Working Alliance Inventory- Modified (a modified version of Working Alliance Inventory, Horvath & Greenberg, 1989), the Session Evaluation Questionnaire- Modified (a modified version of Session Evaluation Questionnaire, Stiles & Snow, 1984) and an outcome rating scale. Both of the modified questionnaires were adapted for the purpose of the study and information regarding the reliability and validity of these new measures were not detailed. The ratings were used to ascertain which sessions contained weakening events. Two raters listened to tapes of the identified sessions to describe the weakening and repair process.

The authors found that the stage of trainee professional development was particularly important in affecting both the weakening events and ensuing repair attempts. The perceived power differential between supervisor and trainee and the evaluative role of supervision also contributed to weakenings in the alliance. The different weakening events (e.g. difficulties with basic terminology and differences in theoretical orientation) and repair processes (e.g. adjusting comments to match the skill level of the trainee or encouraging difference) were described within the paper, however there was no mention of any associations in relation to resolution of weakenings and increased learning or general improvements in the working alliance. Generalisation of the findings of this study need to be approached with caution given the small sample size ( $n = 20$ ) and lack of information regarding the ethnicity of the participants.

Henry and colleagues (2004) also utilised the work of Bordin (1983) as the basis of their study, in particular the importance of an agreement between supervisor and supervisee on the goals of supervision. The aim of the study was to investigate the understanding between supervisor and supervisee about the goals of the supervisory sessions. The authors employed a quantitative design and made use of a 12-topic survey, devised for the purpose of the study. The sample size of the study was relatively large (n=190). The two topics most often identified as important, and agreed upon by both supervisees and supervisors, were 'personal issues' and 'skills and techniques'.

Worthen & McNeil (1996) explored the experience of "good" supervision events from the perspective of supervisees using a phenomenological research methodology. The authors highlighted the paucity of such research and posed the following questions: 'what did the experience of good supervision consist of for supervisees?' and 'are there any central factors that must be present for good supervision experiences to occur?' (Worthen & McNeil, 1996, p25). Semi-structured interviews with eight participants (all supervisees) were conducted, audio-recorded and transcribed verbatim. A qualitative phenomenological approach (cited as 'pattern outlined by Giorgi, 1985') was adopted and a description of the seven steps of the analysis was provided. The analysis gave rise to four phases of a good supervision experience for advanced supervisees: existential baseline (description of this phase included 'aversion to overt evaluation and desire for rewarding supervision'), setting the stage (description of phase included 'global to domain-specific response to sensed inadequacy'), good supervision experience

(description of phase included ‘supervisory relationship experienced as empathic, non-judgemental, and validating’) and outcomes of good supervision (description of phase included ‘strengthened confidence and refined professional identity’).

### **3.1.2 Attachment theory and the supervisory relationship**

The use of attachment theory in conceptualising counselling and supervision processes has gained relevance over recent years (e.g. Pistole & Waktins), owing to the theory being based on the principle that emotionally significant relationships are an essential component of human development. Riggs and Bretz (2006) conducted an exploratory investigation of attachment processes in the supervisory relationship and found that perceived supervisor attachment style was significantly associated with supervisor task and bond between supervisor and supervisee. Supervisor task was defined as behaviours within a supervision session perceived by both members as relevant and effective, and for which each member accepts responsibility and supervisor bond was defined as being characterised by mutual trust, acceptance and confidence. Regardless of their own attachment style, participants reporting secure supervisors rated the supervisory bond higher than participants reporting insecure supervisors. In addition, parental indifference, compulsive self-reliance, and perceived supervisor attachment style were found to be particularly important in shaping the supervisory alliance. An important factor in the consideration of this study is that supervisees were responsible for rating the attachment styles of their supervisors; therefore the associations have not been independently measured.

### **3.1.3 Disclosure and the supervisory relationship**

The impact of the supervisory relationship upon disclosure in supervision was investigated in two separate studies. Hess and colleagues (2008) explored predoctoral interns' experience of nondisclosure in supervision and Knox et al (2008) considered the use of supervisor self-disclosure in supervision. Nondisclosure for interns in good supervisory relationships related to personal reactions to clients, whereas nondisclosures for interns experiencing problematic supervisory relationships related to global dissatisfaction with the supervisory relationship. Supervisors used self-disclosure to enhance supervisee development and normalise supervisees' experiences. Supervisor self-disclosure was reported to occur in good supervision relationships, was prompted by a supervisee in difficulty, was intended to teach or normalise and was focused on supervisors' reactions to their own or their supervisees' clients.

### **3.1.4 The impact of shared cultural understanding on the supervisory relationship**

An appreciation of differences in relation to ethnicity, gender and sexual orientation has been referenced as a crucial element of the therapeutic relationship (Fassinger & Richie, 1997) and a vital component of therapeutic competence (Brown & Landrum-Brown, 1995). Whilst the literature on supervision has suggested the importance of cultural variables in the supervisory relationship, much of the multicultural supervision literature has been theoretical (Bernard & Goodyear, 2004). Previous research investigating differences and similarities in the ethnicity of client and therapist has elicited mixed results concerning therapy outcome (Takeuchi, Mokuau & Chun, 1992). However, it has



been acknowledged that much of this research neglected to consider whether cultural differences or similarities were attended to within the therapeutic relationship (Gatmon Jackson, Koshkarian, Martos-Perry, Molina, Patel & Rodolfa, 2001). Three of the studies forming the basis of the current review considered the impact of a shared cultural understanding on the supervisory relationship (Constantine & Wing Sue, 2007; Gatmon et al, 2001 and Nilsson & Anderson, 2004).

Gatmon et al (2001) utilised a quantitative approach to explore discussions of cultural issues in supervision and their influence on supervisory satisfaction and working alliance. The findings indicated that few discussions took place. However, when these discussion did occur, supervisees described an increased working alliance with their supervisor and enhanced satisfaction with supervision. The role of acculturation, role ambiguity and multicultural discussion when supervising international students was explored by Nilsson and Anderson (2004). The findings indicated that students who reported feeling less acculturated also reported less counselling self-efficacy, weaker supervisory working alliances, more role difficulties in supervision, and more discussion of cultural issues in supervision. Considering the two studies together, the sample sizes ranged from 42 (Nilsson and Anderson, 2004) to 289 (Gatmon et al, 2001), all of the participants were supervisees and the majority were women. Generalisability on the basis of sample size and gender needs to be borne in mind when considering the findings of these studies.

Constantine & Wing Sue (2007) investigated perceptions of racial microaggressions by White supervisors towards Black supervisees in cross-racial dyads. Racial

microaggressions were defined as ‘brief and commonplace verbal, behavioural, or environmental indignities (whether intentional or unintentional) that somehow communicate negative or denigrating messages to people of colour’ (Constantine & Wing Sue, 2007, p. 143). Ten self-identified Black doctoral supervisees in counselling and clinical psychology were interviewed and the data was analysed using Interpretative Phenomenological Analysis (Smith & Osbourne, 2008). Seven themes were identified from the data: invalidating racial-cultural issues, making stereotypic assumptions about Black clients, making stereotypic assumptions about Black supervisees, reluctance to give performance feedback for fear of being viewed as racist, focussing primarily on clinical weaknesses, blaming clients of colour for problems stemming from oppression and offering culturally insensitive treatment recommendations. A important factor with regard to all of the studies within this sub-section is that the findings represent the supervisee perspective, therefore cannot be regarded as representative of the perceptions of the supervisory dyad.

### **3.2. Supervisee characteristics**

Seven of the studies considered within the current review explored supervisee characteristics (Carter Sobell, Manor, Sobell & Dum, 2008; Cikanek, McCarthy Veach & Braun, 2004; Foster, Lichtenberg & Peyton, 2007; Havercamp, 1994, James, Allen & Collerton, 2004; Lochner & Melchert, 1997 and Tyron, 1996). Within this sub-section supervisee development, supervisee knowledge and supervisee individual differences were investigated.

### **3.2.1 Supervisee development**

One of the main aims of clinical supervision is to develop a supervisee's competence as a psychotherapist (Rosenbaum & Ronen, 1998). Developmental models of supervision contend that changes in supervisees' behaviour, throughout supervised clinical practice, reflect the move through the developmental processes, and that tailoring the supervision environment to the developmental level of the individual augments supervisees' development (Hollway, 1992).

Three of the studies considered supervisee development through the use of self-critiques (Carter Sobell, Manor, Sobell & Dum, 2008), self-monitoring (Havercamp, 1994) and self-rating (Tyron, 1996). James and colleagues (2004) explored supervisee development from the perspective of an association between learning and performance and level of emotional arousal.

The importance of evaluation and feedback as an aspect of supervisee development is cited within the literature (see Chur-Hansen & Mclean, 2006; Heckman-Stone, 2003). Carter Sobell et al (2008) explored the use of self-critiques of audio-taped therapy sessions as a motivational procedure for facilitating feedback during supervision. The findings revealed that self-critiques were evaluated positively by trainees as helping them accept critical feedback and allowing them to provide suggestions for their own clinical skill development. Havercamp (1994) investigated the relationship between self-monitoring status and several variables relevant to counselling practice and supervision. The results indicted a relationship between self-monitoring and the Jackson Personality

Inventory (Jackson 1976) measure of conformity. An association between anxiety and self-monitoring was also found. The self-rated development of 25 clinical and counselling psychology supervisees was examined by Tyron, (1996); this study reported longitudinal supervisee gains in self-rated and self-other awareness and independence over the course of an advanced practicum year. Considering the three studies together, the sample sizes were  $n=25$  (Tyron, 1996),  $n=62$  (Carter Sobell et al, 2008) and  $n=65$  (Havercamp, 1994) and the majority were women. Only one of the studies reported information relating to ethnicity (Carter Sobell et al, 2008) and within this study the majority of the participants were White. The potential impact of the sample size, gender, and ethnic background of participants needs to be borne in mind when considering the generalisability findings of these studies.

James and colleagues (2004) stressed the association between emotional arousal and learning and performance. The authors drew attention to Yerkes and Dobson's (1908) suggestion of an inverted-U relationship between level of arousal or tension and learning, with optimal learning taking place at a moderate level of arousal, and examined this notion within their study to determine the relative range of emotions and arousal occurring within the supervision sessions (James et al, 2004). The study employed an exploratory design, the aim of which was to examine the process of change occurring over four supervision sessions. Analysis revealed that the trainee experienced a wide range of emotions in all of the supervision sessions, with anxiety being the most frequent. The emotions appeared to be responsive to the supervisor's own attempts to ensure appropriate affective arousal. An important factor with regard to the reliability of the

findings of this study is that a case study approach was employed. Just one supervisory dyad was investigated and as such the study involved two participants only.

### **3.2.2 Supervisee knowledge**

Cikanek and colleagues (2004) explored advanced doctoral students' knowledge and understanding of clinical supervisor ethical responsibilities. Supervision ethics was the chosen area of study owing to supervisors' responsibility for supervisee behaviour and client welfare (Bernard & Goodyear, 1998). An inductive analysis procedure was employed and seven themes emerged on the basis of the analysis. The themes were entitled: ethics codes and supervision, supervisor responsibilities and risks, self-protection strategies, informed consent for clinical supervision, addressing concerns about supervisees' competence, accountabilities to certain constituencies and supervisor legal and ethical responsibilities. Owing to a 'superficial knowledge and understanding of supervision ethics' (Cikanek et al, 2004, p. 195), training programs which developed awareness of supervisors' ethical responsibilities were recommended.

### **3.2.3 Individual differences of supervisees**

The individual differences of supervisees were explored through supervisee attachment styles (Foster et al, 2007) and supervisee cognitive style and theoretical orientation (Lochner & Melchert, 1997).

Foster et al (2007) used attachment theory as a mode of conceptualising the supervisory relationship. Within their study the supervisory attachment relationship as a predictor of

the professional development of the supervisee was explored. A questionnaire design was employed, and findings indicated that supervisees' classified as secure, preoccupied, fearful or dismissive within their close, personal relationships were attached in a similar way to their supervisor. Findings regarding insecure attachment and professional development were mixed: supervisees displaying an insecure attachment to their supervisor displayed low levels of professional development when based on self-report, but not when based on supervisor report. The effects of cognitive style and theoretical orientation on trainees' judgements about the type of supervision found to be most beneficial was studied by Lochner & Melchert (1997). Trainees' cognitive styles and behavioural emphasis of their theoretical orientation were significantly related to their preferences for these types of supervisory environments.

### **3.3 Supervisor confidence and competence**

Loganbill, Hardy & Delworth (1982) regard the supervisor's greatest responsibility as being the monitoring of quality of care offered to the client. Furthermore, when supervising a trainee coming into the profession, supervision also forms a gate-keeping role in terms of professional quality control (Holloway & Roehlke, 1987). Four studies within the current review considered supervisor confidence and competence (Gizara & Forrest, 2004; Gonsalvez & Freestone, 2007; Johnson & Stewart, 2008 and Robiner, Saltzman, Hoberman, Schirvar, 1997) and, in particular, explored factors such as self-efficacy, supervisory experiences and reliability and validity of assessment of supervisee performance.

### **3.3.1 Supervisor confidence**

Clinical supervisors' self efficacy beliefs (Johnson & Stewart, 2008) and experiences (Gizara & Forrest, 2004, Robiner et al, 1997) were examined in relation to supervisors' perceived confidence in their role.

Johnson & Stewart (2008) highlighted the paucity of published empirical research on clinical supervisors' self-efficacy beliefs. Making use of Bandura's (1997) model of competency development, the authors investigated individuals' perceived competence in supervisory roles. Multiple-regression analyses indicated that a set of 7 measures representing training, experience, context and aptitude accounted for substantial variance in self-efficacy in the roles of teacher, counsellor and consultant. Among the set of predictors, unique contributions to supervisory self-efficacy were made by directive aptitude (the skills required to undertake directive supervisory tasks), nurturant aptitude (the skills required to foster a strong supervisory alliance) and satisfaction with workplace support. Robiner et al (1997) explored psychology supervisors' training, experiences, supervisory evaluation and self-rated competence. The findings indicated that supervisors had received limited training in supervision, had read little regarding supervision, and did not have much supervision experience. Overall, supervisors judged their own supervisory and evaluation skills to be 'adequate', and most reported 'reasonable confidence' in evaluating supervisees.

The supervisor as a 'gatekeeper' for quality control, in relation to supervising trainees, was considered by Gizara & Forrest (2004). The authors stressed the importance of knowing more about trainee impairment, and highlighted the lack of information

available about this. As such, supervisors' experience of trainee impairment and incompetence was explored (Gizara & Forrest, 2004). Results of the study indicated that the areas identified as important with regard to participants' ability to intervene appropriately included: lack of preparation for the evaluative role of supervision, the degree of agency and collegial support for supervisors, and the emotional difficulty of intervening.

### **3.3.2. Supervisor competence**

Gonsalvez & Freestone (2007) were concerned with the reliability and validity of field supervisors' assessments of trainee performance. The findings of their study indicated that earlier placement ratings were poor predictors of subsequent placement ratings by different supervisors. Ratings on 11 broad performance dimensions yielded a single clinical skills factor within which items congregated into two clusters: 'Assessment and Intervention' and 'Interpersonal and Professional skills'.

## **4. Discussion**

### **4.1 Trends within the literature**

An initial finding from the search procedure was the relative lack of empirical research found within this area; a finding is echoed in previous reviews conducted within the realm of clinical supervision (Goodyear, Bunch & Claiborn, 2005 and Spence et al, 2001). Instead, the literature largely related to reflective accounts of supervision and theoretical presentations of models of supervision. Lack of research regarding models of



supervision has also been highlighted, with supervision models being criticised owing to the tenuous empirical foundations (Watkins, 1998). The subject areas of the empirical papers retrieved were grouped on the basis of three themes that emerged from the literature ('supervisory relationship', 'supervisee characteristics' and 'supervisor confidence and competence'). The resultant topics closely resemble those provided by Davy (2002) in his discursive account of trends in the literature, specifically, developmental processes and skills development, the process of supervision and literature exploring supervisees' experiences of supervision.

An interesting finding from the current review was the dearth of literature pertaining to therapy outcome. This too is reminiscent of Davy's (2002) account, whereby the author states 'there is little evidence concerning the effectiveness and outcomes of clinical supervision. In particular, research on the significance of clinical supervision for client outcomes, or even client experience of process, is lacking' (p.228). Pervasive in all the definitions of supervision (e.g. Bernard and Goodyear, 2004; Proctor, 1994; Scaife, 2009) is the need to ensure the wellbeing of clients and to improve the service offered to clients by the professionals; however this link was not reflected within the empirical literature. What appeared to be focused upon within the research was mediating factors, for example the supervisory relationship. Holloway (1984) suggested a potential reason for this omission by highlighting some of the difficulties associated with research within this area. The author stated that due to the vast array of intervening variables between psychotherapy supervision and treatment outcome (e.g. therapist characteristics, client's presenting difficulties, psychotherapeutic approach used), unambiguous research findings

would be difficult to obtain and therefore such research would be a challenging endeavour (Holloway, 1984).

The articles obtained within the current review represented a heterogeneous sample. As such, direct comparison is a difficult endeavour and negates the possibility of a meta-analytic approach. As such, drawing general conclusions presents a challenge. However, the sample of literature on offer highlights the vast array of research possibilities within this area and is perhaps reflective of the complex nature of supervision.

A common feature within all the articles comprising the present review is the use of supervisees who are also trainees within an applied field of psychology. None of the studies retrieved considered a supervisor-supervisee dyad whereby both parties were qualified within the profession. An inherent feature of the trainee supervisee-supervisor relationship is the evaluative role fulfilled by the supervisor and the gate-keeping role in terms of professional quality control (Holloway & Roehlke, 1987). The potential importance of this dynamic was highlighted in the findings of Burke and colleague's (1998) study on weakening and repairs in supervisory alliance. The authors discussed the perceived power of the supervisor in the role of evaluator directly contributing to weakenings in the alliance. Trainees experienced inhibitions in discussing problems in the supervisory relationship due to a fear of negative evaluations. In addition, supervisors were reported as appearing to experience discomfort when discussing evaluations. The potential impact of such a dynamic within the relationship needs to be borne in mind when considering the findings of studies utilising a trainee population.

## **4.2 Limitations of the current review**

The purpose of the current review was to examine the research literature relating to the efficacy of clinical supervision within psychology. As discussed in section one of this paper, the practice of supervision is not exclusive to the psychology profession, in fact it is quite the opposite of this, with supervision being an endeavour common to all of the mental health professions. Whilst understanding the differences each discipline brings to the theory and practice of supervision is an important achievement, acknowledging the research contributions made by the other professional groups is also crucial (see Ellis, Ladany, Krenzel & Schult, 1996; Spence, Wilson, Kavanagh, Strong & Worrall, 2001).

The methods employed within the current review could have resulted in potential biases. For example, the search terms used to find relevant articles, which may not have been broad enough to retrieve all the relevant literature. Furthermore, the inclusion/exclusion criteria could have excluded papers from the review that demonstrated important findings (e.g. unpublished papers and dissertations).

## **4.3 Summary**

The current review highlighted the nature of the empirical, published literature within the psychology profession within the last fifteen years. The search revealed studies examining: the supervisory relationship, in particular research exploring events occurring within the supervisory relationship, attachment theory, disclosure, and the impact of shared cultural understanding on the supervisory relationship; supervisee characteristics, including supervisee development, knowledge and individual differences and supervisor

confidence and competence. A notable omission from the review was empirical research investigating the effectiveness and outcomes of clinical supervision. It is posited that research exploring this area would represent a significant contribution to the literature on clinical supervision.

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## **Appendices**

<b>Appendix 1</b>	Data extraction tool – quantitative studies
<b>Appendix 2</b>	Data extraction tool – qualitative studies
<b>Appendix 3</b>	Table 1: Methodological characteristics of the studies utilising a quantitative approach
<b>Appendix 4</b>	Table 2: Methodological characteristics of the studies utilising a qualitative approach
<b>Appendix 5</b>	Guidelines to authors for journal targeted for literature review

*Data Extraction Tool – Quantitative Studies*

Title:

Author(s):

Year of publication:

Journal:

Volume:

Number:

Pages:

Keywords / Definitions:

Aims:

Method:

Area of Psychology:

Sampling / Participants (including whether supervisors/supervisees, gender, age range and ethnicity):

Measures Used:
Results (including information about power calculations):
Controls / Validity/ Reliability:
Conclusions:
Extra Notes:



*Data Extraction Tool – Qualitative Studies*

Title:

Author(s):

Year of publication:

Journal:

Volume:

Number:

Pages:

Keywords / Definitions:

Aims:

Method:

Area of Psychology:

Sampling / Participants (including whether supervisors/supervisees, gender, age range and ethnicity):

Type of Analysis:
Results (including information about power calculations):
Information relating to Location of interview, Reflexivity and Rigour of analysis:
Conclusions:
Extra Notes:

Table 1: *Methodological characteristics of the studies utilising a quantitative approach*

Author(s) and Year of Publication	Design	Area of Psychology	Number of participants	Number of supervisors/ supervisees	Gender of participants	Age of participants	Ethnicity of participants	Measures used	Power calculation
Burke, Goodyear & Guzzard, 1998	Quantitative	Predoctoral interns in Psychology	N = 20	Supervisors: N = 10  Supervisees: N = 10	Supervisors: 5 women 5 men  Supervisees: 7 women 3 men	Supervisor: Mean 41.8 yrs  Supervisee: Mean 30.3 yrs	Not reported	Working Alliance Inventory- Modified (Modified version of Working Alliance Inventory, Horvath & Greenberg, 1989; cited in Burke et al, 1998). Modified for the purpose of the study)  Session Evaluation Questionnaire- Modified (Modified version of session Evaluation Questionnaire, Stiles & Snow, 1984; cited in Burke et al, 1998. Modified for the purpose of the study)  Outcome Rating Scale	Not reported

Carter Sobell, Manor, Sobell & Dum (2008)	Quantitative	Clinical Psychology	N = 62	All supervisees: N = 62	64.5% women 35.5% men	Range: 23 to 54 yrs Mean: 28.60 yrs	64.5% White 17.7% Hispanic/Latino 9.7% Black/African American 4.8% Indian 1.6% Asian/America 1.6% Other	Evaluation forms were created for the purpose of the study. The forms were anonymised and asked supervisees to rate the use of self- critiques as part of clinical supervision	Not reported
Foster, Lichtenberg, Peyton (2007)	Quantitative	Clinical & Counselling Psychology	N = 180	Supervisors: N = 90  Supervisees: N = 90	Supervisors: 70% women 30% men  Supervisees: 81% women 19% men	Supervisors: Mean 44 yrs  Supervisees Mean 29 yrs	Supervisors: 87% Caucasian (other ethnicities not reported)  Supervisees: 82% Caucasian (other ethnicities not reported)	Supervisee Levels Questionnaire Revised (SLQ-R; McNeill, Stoltenberg & Romans, 1992; cited in Foster et al, 2007)  Supervisee Levels Scale (SLS; Wiley & Ray, 1986; cited in Foster et al, 2007)  Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994; cited in Foster et al, 2007)	Not reported
Gatmon, Jackson, Koshkarian, Martos-Perry, Molina, Patel & Rodolfa (2001)	Quantitative	Predoctoral Psychology Interns	N = 289	All supervisees N = 289	70.2% women; 29.8% men	Not reported	6.6% African American; 0.3% Arab American; 5.9% Asian American;	Working Alliance Inventory (Horvath & Greenberg, 1989; cited in Gatmon et al, 2001)  Supervision	Not reported

5.2% Latino;  
73.4% European  
American;  
5.2%  
Jewish/Caucasian;  
3.1% multiracial

Questionnaire-Revised  
(Worthington &  
Roehlke, 1979; cited in  
Gatmon et al, 2001);  
  
Discussion of cultural  
variable questions

Demographic questions

Gonsalvez & Freestone (2007)	Quantitative	Clinical Psychology	N = 261	Supervisors: N = 130  Supervisees: N = 131	Supervisors: 59% women 41% men  Supervisees: 79% women 21% men	Not reported	Not reported	Supervisor Rating Form (12 item form used in training institution)	Not reported
Haverkamp (1994)	Quantitative	Counselling Psychology	N = 65	All supervisees (N = 65)	77% women 23% men	Not reported	Not reported	Demographic form  Self Monitoring Scale (Snyder & Gangestad, 1986; cited in Havercamp, 1994)  Jackson Personality Inventory (Jackson, 1979)	Not reported
Henry, Hart & Nance (2004)	Quantitative	Counselling Psychology	N = 190	Supervisors: N = 78  Supervisees: N = 112	Supervisors: 55 women 23 men  Supervisees: 54 women 58 men	Supervisors: Range: 28 – 53 yrs Mean: 32 yrs  Supervisees Range: 22 – 56 yrs	Supervisors: 77% Caucasian; 15% African American; 3% Asian; 2% Hispanic; 1% Bi- racial  Supervisees:	Survey comprising 12 topics: treatment planning, trust, independent decisions and actions, theoretical conceptualization, personal issues, skills and techniques,	Not reported

						Mean: 29 yrs	65% Caucasian; 22% African- American; 5% Asian; 5% Hispanic; 1% Bi- racial	supervisory relationship, support, awareness, therapy relationship, monitoring, evaluation	
Johnson & Stewart (2008)	Quantitative	Any area of psychology listed in the Canadian Council of Professional Psychology Programs' Directory	N = 156	All supervisors (N = 156)	55% women 45% men	Range: 30 – 70 yrs Mean: 44 yrs	Not reported	Developed a supervision survey for the purpose of the study	Yes. Enough power to report an effect of moderate size
Lochner & Melchert (1997)	Quantitative	APA accredited Psychology students	N = 106	All supervisees (N = 106)	65% women 35% men	Mean = 32 yrs	84% White/European – American (other ethnicities not reported)	Demographics form;  Keirsey Temperament Sorter (Keirsey & Bates, 1984; cited in Lochner & Melchert, 1997);  Supervisory Styles Inventory – Trainee Version (Friedlander & Ward, 1984; cited in Lochner & Melchert, 1997).	Not reported

Nilsson & Anderson (2004)	Quantitative	Educational Psychology & Clinical Psychology & Counselling Psychology	N = 42	All supervisees (N = 42)	62% women 38% men	23-41 yrs Mean: 29.5 yrs	40% Asian; 21% European; 19% South American; 14% North American; 2% African; 2% Australian	<p>Counseling Self-Estimate Inventory (Larson, 1992; cited in Nilsson &amp; Anderson, 2004);</p> <p>Role Conflict and Role Ambiguity Inventory (Olk &amp; Friedlander, 1992; cited in Nilsson &amp; Anderson, 2004);</p> <p>American-International Relations scale (Sodowsky &amp; Plake, 1992; cited in Nilsson &amp; Anderson, 2004);</p> <p>International Student Supervision Scale (Nilsson &amp; Dodds, 2004; cited in Nilsson &amp; Anderson, 2004);</p> <p>Supervisory Working Alliance Inventory – Trainee Form (Efstation et al, 1990; cited in Nilsson &amp; Anderson, 2004).</p>	Not reported
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Riggs & Bretz (2006)	Quantitative	Educational Psychology & Clinical Psychology & Counselling Psychology	N = 86	All supervisees (N = 86)	77% women  23% men	Age range: 25 – 54 yrs (mean: 32.6 yrs)	78.2% Caucasian; 9.2% Asian American/ Pacific Islander; 3.4% Hispanic/ Latino American; 4.6% biracial/of another ethnicity; 1.1% African American	Demographic form  The Working Alliance Inventory (Horvath & Greenberg, 1994; cited in Riggs & Bretz, 2006)  Measure of Parental Style (Parker et al, 1997; cited in Riggs & Bretz, 2006)  Reciprocal Attachment Questionnaire (West & Sheldon-Keller, 1994; cited in Riggs & Bretz, 2006)  Relationship Questionnaire (Bartholomew & Horowitz, 1991; cited in Riggs & Bretz, 2006)	Not reported
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Robiner, Saltzman, Hoberman, Schirvar (1997)	Quantitative	Clinical Psychology	N = 62	All supervisors (N = 62)	Not reported	Not reported	Not reported	Developed questionnaire for purpose of the study:  'Supervisory Background and Opinion Questionnaire'	Not reported
Tyron (1996)	Quantitative	Clinical & Counselling Psychology	N = 25	All supervisees (N = 25)	68% women 32% men	Mean = 28 yrs	Not reported	Supervisee Levels Questionnaire Revised (SLQ-R; McNeill, Stoltenberg & Romans, 1992; cited in Tyron, 1996)	Not reported

Table 2 (part 1): *Methodological characteristics of the studies utilising a qualitative approach*

Author(s) and Year of Publication	Design	Area of Psychology	Number of participants	Number of supervisors/ supervisees	Gender of participants	Age of participants	Ethnicity of participants
Cikanek, McCarthy Veach & Braun (2004)	Qualitative Inductive Analysis	Counselling Psychology	N = 10	All supervisees (N = 10)	7 women 3 men	Not reported	7 White 1 Bi-racial 1 Other
Constantine & Wing-Sue (2007)	Qualitative Interpretative Phenomenological Analysis	Clinical & Counselling Psychology	N = 10	All supervisees (N = 10)	8 women 2 men	Range: 25 – 38yrs	8 African American 1 West Indian American 1 Black Dominican American
Gizara & Forrest (2004)	Qualitative Constant Comparative Method	Counselling Psychology	N = 12	All supervisors (N = 12)	Not reported	Not reported	Not reported
Hess et al (2008)	Qualitative	Counselling Psychology	N = 14	All supervisees (N = 14)	11 women 3 men	Range: 27 – 38 yrs Mean 31 yrs	10 White/European American 2 African American 2 Asian American
James, Allen & Collerton (2004)	Qualitative	Clinical Psychology	N = 2	Supervisor N = 1	Supervisor Man	Not reported	Not reported
				Supervisee N = 1	Supervisee Woman		
Knox, Burkard, Edwards, Smith & Schlosser (2008)	Qualitative	Clinical & Counselling Psychology	N = 16	All supervisors (N = 16)	7 women 9 men	Range: 30 – 67 yrs Mean 49 yrs	15 European American 1 Asian
Worthen & McNeill (1996)	Qualitative	Counselling Psychology	N = 8	All supervisees (N = 8)	4 women 4 men	Range: 23 – 54 yrs	8 European American

Table 2 (part 2): *Methodological characteristics of the studies utilising a qualitative approach*

Author(s) and Year of Publication	Method of data collection	Location of interview	Type of analysis	Reflexivity	Rigour of analysis
Cikanek, McCarthy Veach & Braun (2004)	Telephone semi-structured interviews Duration range: 20 – 60 mins	Telephone (no further information provided)	Qualitative study (specific details not provided)	No information provided regarding the researchers	Stages of analysis not reported.
Constantine & Wing-Sue (2007)	Semi-structured interviews (audio recorded) Details provided regarding devising interview protocol	Private office	Interpretative Phenomenological Analysis (Smith 1996; cited in Constantine & Wing-Sue, 2007)	Information provided regarding the primary researchers background, experiences and biases	Stages of analysis reported.
Gizara & Forrest (2004)	Information provided regarding pilot interview Semi-structured interviews (audio recorded and transcribed verbatim) Duration approximately two hours Information provided regarding pilot interviews Interview protocol provided	Not reported	Constant Comparative Method (Lincoln & Guba, 1985; cited in Gizara & Forrest, 2004)	The use of the researcher's field journal was reported as part of the research design (specific details regarding content of this not provided)	Participants received a copy of their transcript to reflect and comment on the accuracy and completeness of the manuscript. Rationale for choice of method of analysis reported. Data from the individual interviews were triangulated to maximise the credibility of the results. The five stages of data analysis are reported.
Hess et al (2008)	Semi-structured interviews (audio recorded and transcribed verbatim) Protocol devised by lead author, based on a review of relevant literature Code numbers used to ensure confidentiality	Not reported	Consensual Qualitative Research (Hill, Thompson & Williams, 1997; cited in Hess et al, 2008)	Information provided regarding research team (ethnicity, age and theoretical orientation)	Brief information regarding analysis procedure.

James, Allen & Collerton (2004)	Audio recorded reflection of supervision sections (recorded directly onto audio tape, according to an instruction sheet provided)	Not reported	Exploratory design (details of analysis not provided)	Details of rater provided	Lack of details regarding stages of analysis.
Knox, Burkard, Edwards, Smith & Schlosser (2008)	Semi-structured interviews (audio recorded and transcribed verbatim)  Protocol developed by researchers  Information provided regarding pilot interview	Telephone (no further information provided)	Consensual Qualitative Research (Hill, Thompson & Williams, 1997; cited in Knox et al, 2008)	Information given regarding demographics of researchers. Biases reported in appendix	Three steps of analysis highlighted
Worthen & McNeill (1996)	Semi-structured interviews (audio recorded and transcribed verbatim)  Duration range: 40 – 45 mins  Interview protocol provided	Not reported	Utilised pattern outlined by Giorgi (1985; cited in Worthen & McNeill, 1996)	Details of researcher provided (including ethnicity and view of supervision)	Description of the seven steps of the analysis

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# **British Journal of Clinical Psychology (BJCP) Notes for Contributors**

The **British Journal of Clinical Psychology** publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

## **1. Circulation**

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

## **2. Length**


Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

## **3. Submission and reviewing**

All manuscripts must be submitted via our [online peer review system](#). The Journal operates a policy of anonymous peer review.

## **4. Manuscript requirements**

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. Please see the document below for further details:

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- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
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These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

## 6. Publication ethics

All submissions should follow the ethical submission guidelines outlined in the documents below:

 [Ethical Publishing Principles – A Guideline for Authors](#)

 [Code of Ethics and Conduct \(2006\)](#)

## 7. Supplementary data

Supplementary data too extensive for publication may be deposited with the [British Library Document Supply Centre](#). Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

## 8. Copyright

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## **Part 2**

### **Research Report**

A thematic analysis of psychodynamically-oriented supervision of observations in an  
acute inpatient ward.



## **Abstract**

The present study attempted to gain an understanding of the experiences of staff and patients on an acute adult inpatient ward through the use of a psychodynamically-orientated observation methodology. The influence of supervision group meetings on observational learning was also explored. Six planned observation sessions took place and qualitative data was collected through the audio-recording and transcription of supervision group meetings. The data was thematically analysed according to the procedure of Braun and Clarke (2006). The suggested findings of the analysis appeared to illustrate a complex system which impacted upon ward atmosphere, relationships, behaviour and perception of job role and responsibility. The research process also appeared to highlight important considerations relating to the role of affect and the process of learning in qualitative research. The suggested findings are considered in terms of previous research and relevant theory. Clinical implications are discussed.

## **1. Introduction**

### **1.1 Acute inpatient care provision**

Supporting people to live independently through better care and treatment in the community has been a major aim of mental health care in England in recent years. The National Service Framework (NSF) for Mental Health (1999) provided recommendations relating to the provision of local specialist mental health services by community mental health teams, stating that service users were more likely to stay in contact with and accept treatment from community rather than hospital-based services. The document detailed the development of services such as early intervention, assertive outreach and crisis resolution and home treatment teams (NSF, 1999). However, it has been suggested that the increased importance placed on developing community services has resulted in acute inpatient services not always receiving the attention required to ensure that care is safe and effective (Healthcare Commission, 2008).

The purpose and aim of adult inpatient care is defined as providing a service which delivers a “high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness” (DoH, 2002, p.5). However, the same document indicates “incontrovertible and compelling evidence” that the experience of acute inpatient care is regarded by service users as “neither safe nor therapeutic” (DoH, 2002). Service users reported, amongst other concerns, a poor physical and psychological environment for care, insufficient information about their condition and treatment and on how the ward and service operates, inadequate staff contact, particularly one-to-one contact with staff, and a lack of “something to do”,

especially activity that is useful and meaningful to recovery (DoH, 2002). A national survey of individuals who had previously been admitted for acute psychiatric inpatient care by Baker (2000) corroborates these findings. Results of this survey indicated that previous inpatients felt their contact with staff was insufficient, their environment was not therapeutic, admission had a detrimental effect on their mental health and the environment was unsafe.

### **1.2 Staff needs in inpatient settings**

Issues in relation to the provision of care in inpatient settings are not the only concern. Staff turnover is a particular difficulty within mental health settings, which impacts upon recruitment and training and the quality of services provided (Glisson, 2002). Working in a highly stressful environment, lack of support and low pay has been linked with the rate of turnover. Low staff morale, ineffectiveness of staff and decreased productivity have been regarded as the resultants of a high turnover of staff in mental health organisations (Bingley and Westergaard-Nielsen, 2004). Norton (2004), in a review of psychiatric inpatient care, posited that processes such as team splitting, absences and sick leave were likely to result in a frustrated staff team, potentially leading to low morale and staff burnout. The author highlighted the risk of staff becoming over-worked, stressed and experiencing mental health difficulties themselves. DoH (2002) guidance has emphasised the need for action in relation to the quality of nurses' work lives, and called for provisions to be made to improve education and the research base of the profession.

### **1.3 Ward Atmosphere and the use of quantitative methodologies**

Evidence within the research literature supports the notion that ward atmosphere and the social environment in inpatient healthcare settings are important to both patient treatment (e.g. Timko & Moos, 1998) and staff wellbeing (e.g. Parkes & Von Rabenau, 1993).

Much of the research conducted within this area relies on the use of quantitative questionnaires such as the Ward Atmosphere Scale (WAS; Moos & Houts, 1968a) (e.g. Caldwell, Gill, Sclafani & Grandison, 2006; Dorr, Honea & Pozner, 1980; Kirby and Pollock, 1995; Squier, 1994). The WAS, a 100 item, 10 subscale rating scale, was developed as a method of capturing the impact of the ward environment on both patients and staff.

Caldwell and colleagues (2006) examined the association of ward atmosphere with burnout and attitudes of a multi-disciplinary treatment team in a psychiatric hospital. The findings indicated that burnout among the professional staff was highest in nurses, compared to other members of the multi-disciplinary team. Potential consequences of nursing staff experiencing a sense of hopelessness and negativity about their work were regarded by the authors as being harm to organisational culture and a reduction in the quality of interpersonal communication occurring between patient and caregiver (Caldwell et al, 2006). Squier (1994) investigated the relationship between ward atmosphere and staff attitude to treatment in four psychiatric inpatient units and the results of the study provided information regarding the structure of ward atmosphere: the WAS sub-scales of ‘order and organisation’, ‘programme clarity’ and ‘support’ represented a more traditional, structured and custodial approach to treatment of patients,

reflected in the relationship between these sub-scales and conservative, biological treatment attitudes in nursing staff. Conversely, the WAS sub-scales of ‘anger and aggression’, ‘personal problem orientation’ and ‘involvement’ were found to be correlated with a more liberal, social approach to psychiatric treatment (Squier, 1994). The author stated that one of the most important findings of the study was that staff reported a link between ‘order and organisation’ and ‘programme clarity’ and a supportive ward environment, whereas control was perceived as a hindrance to autonomy, spontaneity and practical achievement (Squier, 1994).

Whilst studies such as these do provide useful insights into ward atmosphere, there are limitations. Standardised scales such as the WAS offer the opportunity to capture certain characteristics of a particular ward, however these are within the constraints of those included within the instrument, thus resulting in the potential restriction of exploration of more individual aspects of different settings.

#### **1.4 Qualitative approaches to understanding inpatient settings**

The experiences of staff working within an inpatient setting for young people with mental health difficulties who had committed an offence were explored in a study by Kemp (2008, unpublished thesis). The author described a sense of there being ‘something missing’ from the data obtained from interviews with staff members. Kemp (2008) commented upon the blandness of some of the descriptions, which did not appear to fit with other participant accounts and her personal expectations or experiences of working in such a setting. Kurtz and Turner (2007) conducted an exploratory interview study of

the needs of staff who care for offenders with a diagnosis of personality disorder. When reflecting upon this study, A. Kurtz (2009, personal communication, December, 2008) commented upon her sense that the interview method did not fully capture what was interesting about staffs' experiences of working within a medium secure unit for offenders with a diagnosis of personality disorder. Illustrations such as these appear to represent a cumulative frustration with the interview method.

### **1.5 The contribution of observation studies**

In contrast to the quantitative method of studying ward atmosphere, observational studies allow a more flexible approach to exploring the ward environment within complex mental health settings, thus permitting a more in-depth consideration of the subtleties of the ward environment. The use of observational methodologies to obtain understanding is recognised in the literature. For example Shepherd, Muijen, Dean & Cooney (1996), in their review of residential care, recommended that further research should be undertaken on staff stress and satisfaction and that this should be achieved through direct observation methodologies.

Menzies Lyth (1960) produced a seminal paper exploring the stresses and coping mechanism of nurses working in a large general hospital, utilising an observational approach. The author described the function of organisational structures as a way of preventing the potentially overwhelming anxieties and strong emotion, generated by close contact with death and illness, from reaching consciousness. Donati (1989) conducted an observational study of staff and patients in a complex mental health setting.

This was replicated by Goodwin and Gore (2000), in order to investigate its relevance to more modern mental health inpatient settings. Both studies described dynamic processes inherent within the culture of the ward that would not have been captured using a standardised questionnaire. For example, Goodwin and Gore (2000) found that together with efforts to rehabilitate residents, nurses appeared to behave in ways that were inconsistent with the task; e.g. the authors posited that these behaviours seemed to function as a way of protecting the staff group from the unconscious anxieties the work provoked.

## **1.6 The research questions**

The main research questions of the present study are:

1. What can be learned about the experiences of staff and patients on an acute adult in-patient ward from a series of six weekly observation sessions?
2. What influence does a psychodynamically-oriented supervision group have on observational learning about the experiences of staff and patients on an acute adult in-patient ward?

## **2. Method of enquiry adopted**

### **2.1 Research design**

#### **2.1.1 Choice of method: Qualitative analysis of supervision of a psychodynamically-oriented series of ward observations**

Consideration of the most appropriate methodology was informed by the apparent cumulative frustration with the interview method. Kemp (2008, unpublished thesis) reported a sense of there being ‘something missing’ from the interview data and Kurtz (2009, personal communication) remarked upon her notion that the interview method had been unable to capture the aspect of real interest. Hollway and Jefferson (2000) proposed the concept of the ‘defended subject’ in relation to collecting qualitative data through interviews. The authors used the notion to suggest that individuals protect themselves against any anxieties arising from the information provided in a research context (Hollway & Jefferson, 2000).

In order to address this apparent area of difficulty, Hollway and Jefferson (2000) utilised the concept of free association with regard to conducting research interviews. The authors stated that the benefit of such an approach is due to the notion that free association allows an individual to say whatever comes to mind. As such the kind of narrative elicited is not structured according to conscious logic, but according to unconscious logic and the associations are defined by emotional motivations, rather than rational intentions. By eliciting a narrative according to the principles of free association, the authors contended



that they are able to access a person's concerns which may not be visible using a more traditional method (Hollway & Jefferson, 2000).

Whilst recognising the potential benefits associated with conducting research interviews differently, for the purpose of the current study the use of observation as a method of data collection was decided upon. The use of a psychodynamic framework was regarded as particularly important, owing to the concept of the 'defended subject' (Hollway & Jefferson, 2000) and the contribution made by previous observation studies conducted within psychoanalytic tradition (e.g. Donati, 1989, Goodwin & Gore & Menzies Lyth, 1960). The current study aimed to take forward the use of this approach in a research context by audio-recording, transcribing and qualitatively analysing the supervision sessions; an inherent feature of the psychodynamic observation approach. Recording and transcription of these sessions would allow for naturalistic, original data appropriate for analysis using a qualitative approach.

### **2.1.2 The psychodynamic approach to observations**

Menzies-Lyth (1959), Donati (1989) and Goodwin and Gore (2000) utilised a psychodynamic framework as a way of observing the social environment of a ward setting. Applying psychodynamic ideas outside of a more traditional therapeutic endeavor began in the 1940s when Bick pioneered infant observation (Bick, 1964). This method of observation has since been adopted as a way of understanding organisations and institutions (see Hinshelwood & Skogstad, 2000 and Obholzer & Roberts, 1994 for a more detailed account).

The aim of organisational observation is to piece together the researcher's experience of what it feels like to be an observer within an organisation, the events happening and the emotional impact of what is observed. The possible meanings of what is observed is considered in terms of the organisation's task, how the task was carried out and whether or not the organisation's structure and defences helps or hinders the completion of the task (Miles, 1999). The psychodynamic method relies largely upon the observers' subjective experiences and encourages the observer to come close to evolving life situations. The observer attempts to attend to both the physical and emotional experiences of the situation (Rustin, 2003). Inherent within this model is the notion of emotional reflexivity, required in order to locate the source of particular subjective experiences evoked by observations. Reflective supervision represents a pivotal role in facilitating this process (Rustin, 2003).

As detailed above, this approach comprises both conducting observation sessions and the regular meeting of a supervision group. The aim of supervision is to listen to and discuss process reports of the observation sessions, and to assist and advise on the understanding of the observation material from within a psychodynamic framework (Hinshelwood & Skogstad, 2000). This procedure is inherent within this tradition and dates back to the method of infant observation (Bick 1964).

## **2.2 Context of the study**

The setting in which the current study took place was an acute psychiatric ward within a mental health unit located within a rural location in the Midlands. The ward had 11 beds

and was staffed on a 24 hour basis by both qualified and unqualified nursing staff.

Members of the multidisciplinary team visited the ward on a regular basis to meet with both patients and staff members.

## **2.3 Procedure**

Ethical approval for the present study was sought and obtained from the National Research Ethics Service (Derbyshire Research Ethics Committee) (appendix 1). The study comprised three separate groups of participants: members of the supervision group, staff on the ward at which the observations took place and clients on the ward at which the observation took place.

### **2.3.1 Supervision group participants**

The researcher's field supervisor contacted clinicians within the local geographical area by email. Clinicians were asked if they would be interested in joining a supervision group for an observational research project. Respondents were issued with an invitation letter (appendix 2) and participant information sheet (see appendix 3) and were offered the option of an informal meeting or telephone conversation if further information was required. Supervision group participants were then asked to sign a consent form (appendix 4) and reminded that after signing the consent form the option of withdrawing from the study remained available.

### **2.3.2 Staff group participants**

Permission to approach staff within the ward was obtained from both the service manager and unit manager. All staff who worked on the ward were regarded as potential participants. The ward manager was responsible for the delivery of a participant information sheet (appendix 5) and all staff were offered the option of an informal meeting or telephone conversation if further information was required. The researcher attended two staff meetings in order to provide an overview of the study and explain procedures relating to consent, confidentiality, opting out and withdrawal. This also provided an opportunity for potential participants to ask questions. Following this, each staff member was asked if they would be willing to take part in the study and sign a consent form (appendix 6). Individuals were reminded that after signing the form they were still able to opt out of the observation session.

### **2.3.3 Client group participants**

Permission to approach clients was obtained from both the service manager and unit manager. All clients residing on the ward at the time of the planned observation sessions were regarded as potential participants. Each client's medical consultant was approached regarding an individual's capacity to consent to take part in the research project. The researcher attended two of the ward community meetings, in order to provide an overview of the study and to explain procedures relating to consent, confidentiality, opting out and withdrawal. This also provided an opportunity for potential participants to ask questions. At this stage participant information leaflets were handed out (appendix 7). One-to-one meetings between the clients on the ward and the researcher were arranged in

order to re-visit the nature of the research project and answer any questions arising from the previous meetings and information sheet.

Each client was then asked if they would be willing to take part in the study and sign a consent form (appendix 8). Individuals were reminded that after signing the form they were still able to opt out of the observation session.

Prior to the start of each observation session, the researcher met with the nurse in charge to find out if any of the clients had chosen to opt out of the observation session.

#### **2.3.4 Choice of observer location**

The observations took place within the dayroom of the ward. This location was chosen because it was the main area of the ward where staff-client interactions occurred and the largest communal space within the ward. Furthermore, if a member of staff or client did not wish to take part in the observation session, it was possible for them to avoid the dayroom area for the duration of the observation.

#### **2.3.5 Visitors to the ward**

Since the aim of the observation sessions was to capture, as closely as possible, a true representation of day-to-day ward life, visitors were able to enter and leave the ward throughout the duration of the observation. Visitors to the ward were made aware of the observation session by the use of a poster that was displayed on the ward.

### **2.3.6 Observation and supervision procedure**

In accordance with Hinshelwood and Skogstad's (2000) approach, each observation session lasted one hour and following the observation, detailed process notes were written by the researcher, in preparation for discussion within the supervision group. These notes were written once the observation session had ended. The researcher assumed a consistent approach to the observations (i.e. a time and position was decided upon and this remained stable for the duration of the observation period) and endeavoured to adopt an attitude of 'open interest'.

The overall aim of each observation was to achieve a sense of the atmosphere of the organisation, both generally and specifically, and the emotional quality of the interactions observed. The researcher attended to the objective events happening, the emotional atmosphere and her own inner experiences. The process notes comprised a written account of these experiences. The researcher endeavoured to provide as accurate and unfiltered an account of the observation session as possible. The process notes were largely descriptive in nature, as the aim of the supervision group was to attempt to analyse and interpret the material recorded.

Six observation sessions took place, approximately weekly, over a period of two and a half months. A total of ten supervision sessions were conducted, and each meeting was audio-recorded and transcribed verbatim. The arrangement of the supervision sessions included: two initial meetings to discuss the set-up of the group and issues such as gaining entry to the unit, supervision sessions to process material from six observation

sessions and a final two supervision sessions to consider the observation experience as a whole.

The researcher met with a group of local psychologists, who provided supervision for the observation. The supervision group consisted of the researcher (observer), a facilitator (a consultant clinical psychologist experienced in supervising psychodynamically-informed observations) and two other individuals, who were both clinical psychologists with an interest in psychodynamically-informed observations. The members of the supervision group were aware of the ward at which the observations took place, but were not part of the staff team working on the ward.

The supervision group was set up for the purpose of the study, and the main aim of the group was to reflect upon the observation material and help the researcher make sense of the material gathered. The group employed a psychodynamic approach to supervision (Hinshelwood & Skogstad, 2000). Within the supervision group meetings the researcher read aloud the process notes that had been prepared in advance from the preceding observation session. Owing to the length of the process notes, half of the content was read aloud, followed by a period of discussion from the supervision group members. Approximately half way through the meeting, the second half of the observation notes were then read aloud and discussed in a similar way.

The researcher benefited from two supervisors (an academic supervisor and a field supervisor), each adopting a different supervisory role. The field supervisor also fulfilled

the role of the facilitator within the supervision group meetings, and her remit was to aid in the observation arrangements and processing of the observation material. The academic supervisor maintained a more critical stance, and her role was to ensure the robustness of the data and procedure from a qualitative research perspective.

### **2.3.7 Transcribing**

An individual experienced in transcribing for qualitative research projects transcribed the audio-recordings of each of the supervision sessions verbatim. Pseudonyms were used for all participants and all other individuals mentioned during the supervision sessions. In addition, any potentially identifying information (such as the unit's name and place names) was removed or altered. The individual employed to do the transcribing was asked to sign a declaration of confidentiality form. The completed transcripts are included as an addendum to the thesis, accompanied by the transcript conventions. The conventions used within the study were based on the guidelines provided by Burman (1994). Since the researcher did not conduct the transcribing, time was spent familiarising herself with the data. The transcripts were checked against the original audio-recordings for accuracy, in accordance with the procedure described by Braun and Clarke (2006).

### **2.3.8 Sources of data**

The current study comprised the collection of different sources of data. Details of these are, as follows

- Observation notes: the process notes written immediately after an observation session had been conducted. These notes were read out verbatim in the



supervision group meetings. An excerpt from the observation notes can be found in appendix 9.

- Supervision session transcripts: the transcribed accounts of the audio-recording of each supervision group meeting. These meetings comprised the reading aloud of the observation notes and the ensuing discussions. This material was analysed using thematic analysis and all of the transcripts are contained in the addendum accompanying this report.
- Accounts of sense-making: accounts written by the researcher following the analysis of the supervision session transcripts, in order to address the second research question. Five accounts of sense-making were written and these can be found in the addendum accompanying the report.
- Reflective diary: a diary kept by the researcher. Any interesting features occurring during the research process were noted and the diary was used to detail the development of the themes and sub-themes during the analysis process. An excerpt of this can be found in appendix 10.

## **2.4 Data analysis**

### **2.4.1 Thematic analysis**

Thematic analysis was chosen because the method already involved interpretative work, which the researcher aimed to describe in the analysis. Within thematic analysis, the method adopted can be described as aimed at transparency, rather than interpretation, since interpretative work had already taken place in the observation sessions and supervision group meetings.

Thematic analysis allows the identification, analysis and reporting of patterns (i.e. themes) within a data set. The data is organised and described in detail (Braun & Clarke, 2006). However, it is often the case that analysis goes further than this, by including the interpretation of various aspects of the research topics (Boyatzis, 1998). Thematic analysis is not strongly attached to any pre-existing theoretical framework, therefore can be used within different theoretical frameworks, and can be employed to achieve different aims within them. Thematic analysis can be a realist, constructionist, or 'contextualist' (e.g. critical realism) method and as such can be a procedure that operates to reflect both reality and unpick the surface of 'reality' (Braun & Clarke, 2006). Thematic analysis therefore offers a flexible approach to analysing qualitative data.

The current study comprised two stages of data analysis. Part one of the analysis related to the first research question and part two to the second research question. Each stage will be considered separately in the present sub-section. A statement of the researcher's position can be found in appendix 11.

#### **2.4.2 Part one: what can be learned about the experiences of staff and patients on an acute adult inpatient ward from a series of six weekly observation sessions?**

Consistent with the approach posited by Braun and Clarke (2006), a number of decisions were considered and made prior to the analysis commencing:

- A thematic unit was considered to be an item of learning about the experience of staff and patients on an acute adult inpatient ward. Either the staff or clients on the ward, the researcher during the observation sessions, or the supervision group,

could be the source.

- A rich thematic description of the entire data set was aimed for, rather than a detailed account of one particular aspect, in order for the reader to get a sense of the predominant and important themes.
- Inductive, as opposed to theoretical, thematic analysis was aimed for. A process of coding the data without trying to fit it into a pre-existing coding frame or analytic preconceptions was adopted.
- The aim was for themes to be identified at a semantic, rather than latent, level (i.e. the themes were identified within the explicit meanings of the data).

The analytic process then involved a progression from description (where the data had been organised to show patterns in semantic content and summarised) to interpretation (where attempts were made to theorise the significance of the patterns and their broader meanings and implications). The phases of thematic analysis, as outlined by Braun and Clarke (2006), were adhered by the researcher when conducting the analysis. Table 1 outlines these phases.

#### **2.4.3 Part two: what influence does a psychodynamically oriented supervision group have on observational learning about the experiences of staff and patients on an acute adult inpatient ward?**

The second part of the analysis aimed to consider how sense-making was achieved. The following steps detail the stages of the analysis process with regard to this part of the analysis:

Table 1. *Phases of thematic analysis*

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribe data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Taken from Braun and Clarke, 2006, p87

- In accordance with the thematic analysis (Braun and Clake, 2006) procedure described in section 2.4.2, the aim was to analyse how sense-making was achieved within the observational data and supervision group meetings. A thematic unit was considered to be an occrance that informed meaning making.
- The researcher began this process and was struck by the nature of the codes elicited using this approach; they described the procedural aspects of the group supervision process. It was felt by the researcher that this method of analysis was not capturing important aspects of how sense-making was achieved.
- The researcher discussed this apparent dilemma with her academic supervisor. Throughout this process a realisation emerged whereby it was considered that

learning took place in a dynamic way, throughout the phases of the supervision group meetings, analysis and academic supervision, rather than at any static point. Within any future studies the final academic supervision sessions (when there is opportunity to reflect upon the process as a whole) would be audio-recorded and transcribed. However, since this was not possible within the current study, the researcher wrote a series of accounts of perceived sense-making that occurred during the data collection process. These accounts comprised sense-making taking place at each stage of the research process (i.e. the supervision group meetings, analysis and academic supervision) and the aim was to track learning over time. The researcher chose five ‘stand-out’ anecdotes from the data-set and wrote a reflective account of what occurred during each stage of the data collection process.

- Making use of the thematic analysis (Braun & Clarke, 2006) approach, the researcher reviewed the five sense-making accounts, in order ascertain recurrent themes present within the data.

## **2.5 Enhancing quality**

An all-encompassing criterion for the evaluation of qualitative research is regarded by Stiles (1993) as ‘trustworthiness’. Standards of good practice include: honesty regarding the researcher’s orientation and preconceptions, repeated rotation between data and interpretation, close engagement with data and the grounding of interpretations with examples (Stiles, 1993). Much of the information provided by this author reflects the

process inherent, and therefore followed, within the thematic analysis (Braun & Clarke, 2006) approach adopted in the current study.

Yardley (2000) discussed the characteristics of good qualitative research. These include: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. These were considered by the researcher in the following ways:

- Sensitivity to context: The researcher endeavoured to develop a sound knowledge base of the relevant literature, including current debates and dilemmas within the area of study.
- Commitment and rigour: The researcher was a member of a qualitative research group and attended research supervision (with her academic and field supervisor) on a regular basis. As a method of enhancing inter-rater reliability, an excerpt of a transcript was coded by a member of the qualitative research group. The final analysis was presented to a member of the qualitative support group and the supervision group members for consultation.
- Transparency and coherence: The researcher was transparent about the stages of the analysis and the procedures involved in the research. Information about the researchers own position has been included as part of the current study. As part of the research process, the researcher kept a 'reflective diary', the aim of which was to make note of any interesting features of the process and keep track of the development of the themes and sub-themes.
- Impact and importance: The current project was considered to be a value to the research base concerned with this area of study.

### 3. Analysis of data

#### 3.1 Introduction

This section provides an account of the analysis of the ten supervision session transcripts and the accounts of sense-making. The section comprises two parts. The first relates to the first research question and the second relates to the second research question.

In relation to part one of the analysis, a thematic map, constituting the three main themes and thirteen sub-themes, is presented in diagrammatic form. A description of each main theme is provided, along with an overview of the corresponding sub-themes, each illustrated by direct quotes<sup>1</sup> from the transcripts.

For part two of the analysis, five themes are presented. Descriptions of each, accompanied by direct passages<sup>2</sup> from the five accounts of sense-making during the study, are provided.

#### 3.2 Part one: what can be learned about the experiences of staff and patients on an acute adult inpatient ward from a series of six weekly observation sessions?

The thematic analysis of the data gave rise to three main themes; these have been named

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<sup>1</sup> Quotes are indented, written in italics and accompanied by a reference to the transcript's location (transcripts are provided as an addendum), in the following format: I (supervision session number), participant/observation note identifier (written as participant A to D or observation notes): line number(s). For example 6, participant A: 539-541 refers to a quote taken from the transcript of supervision session six, spoken by participant A, and can be found in lines 539-541. Additional supporting quotes can be found in appendix 12.

<sup>2</sup> Passages are indented, written in italics and accompanied by a reference to the passage's location within the accounts of the sense making during the study (the accounts are provided as an addendum), in the following format: I (anecdote number), line number(s). For example 1: 31-34 refers to a passage taken from anecdote number 1 and can be found in lines 31-34.

‘fear of engagement’, ‘state of confusion’ and ‘alone and responsible: ‘the responsibility is actually terrifying’’. A detailed description of the themes is provided and a thematic map of the analysis is depicted in figure 1.

### **3.2.1 Main theme: Fear of engagement**

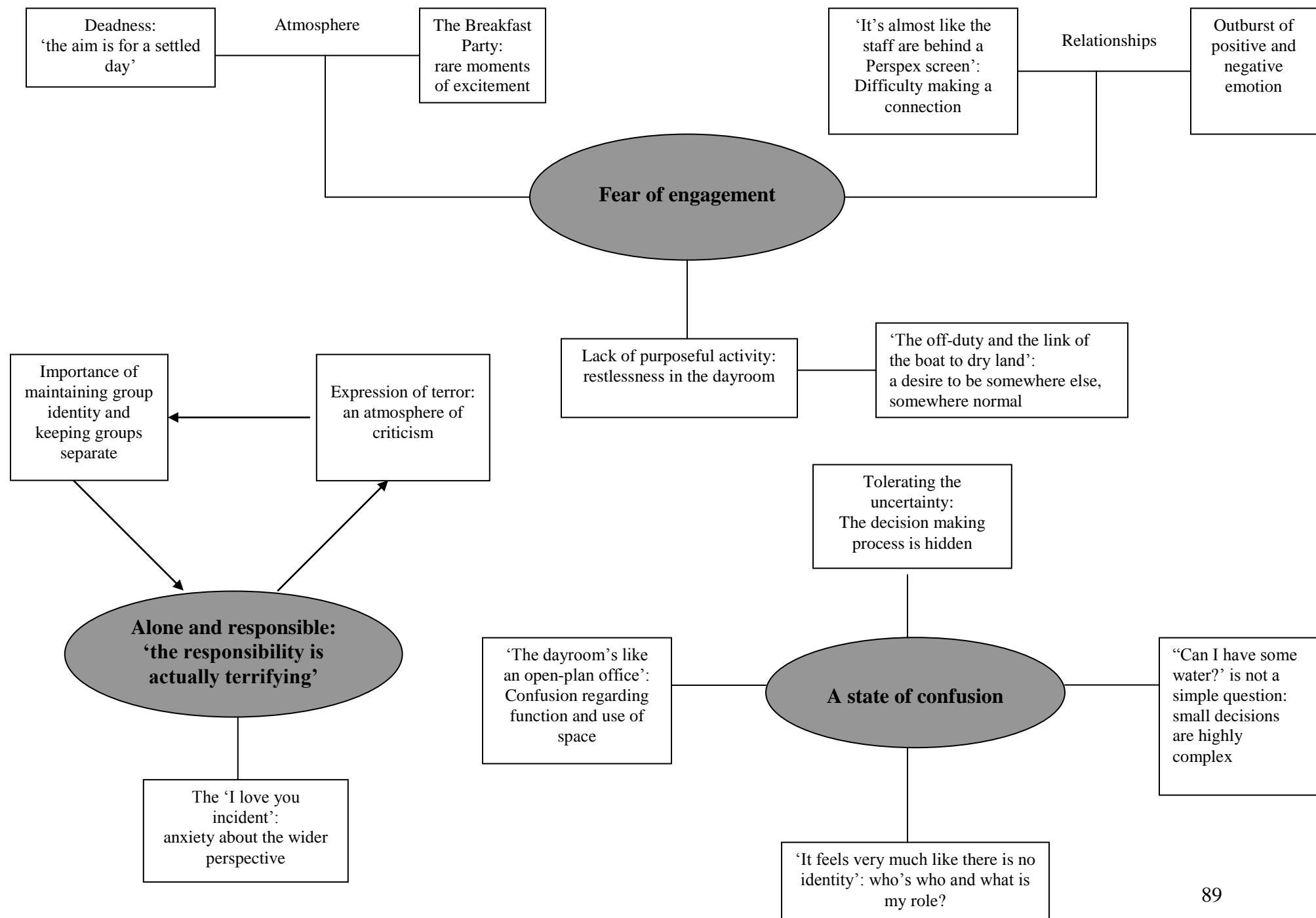
A fear of engagement appeared to permeate the entire data-set. This fear seemed to have an impact upon the atmosphere of the ward, the relationships within it and the way people behaved in the dayroom area. There were repeated examples within the observation material of the apparent difficulty associated with staff, patients<sup>3</sup> and visitors connecting with each other. The sense of the ward atmosphere acquired through hearing the observation material was that of ‘deadness’. The members of the supervision group shared their feelings of anger in relation to staff seemingly not connecting with the patients, and there was an overriding sense of the ward being ‘not a nice place to be’ – not for anyone: staff, patients or visitors. The supervision group was interested, however, in moments within the observational material where excitement was displayed or an outburst of emotion was displayed. These moments appeared important aspects of ward atmosphere and the way relationships were managed. Repeated examples of restlessness in the dayroom were observed. The supervision group members commented upon a lack of purposeful activity and that nobody appeared to ever settle in the dayroom area.

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<sup>3</sup> Prior to this section of the research project, the term ‘patients’ has not been used. For example, within the method section the term ‘client’ is used to refer the individuals who were residing on the ward at the time of the study. ‘Patients’ was the term used within the supervision group meetings as it was the term used by the staff working within the acute inpatient service. This term will be used by the research within the current section in order to remain close to the data contained in the transcripts. For the purpose of consistency the term ‘patients’ will also be used within the following section of the research report, when the suggested findings of the study are discussed.



Figure 1. *Thematic map*



### **3.2.1.1 Sub-theme one: ‘It’s almost like the staff are behind a Perspex screen’:**

#### **difficulty making a connection**

This refers to the way relationships with others on the ward appeared to be managed. Despite some effort being made by patients and visitors to connect to the nursing staff, it seemed that this was not often achieved. Staff-other interaction appeared to be minimal. This also encompassed the ignoring of others that appeared to take place within the dayroom area. There were repeated examples in the observation material of staff not acknowledging others and much time was spent discussing this within the supervision group meetings. The members of the supervision group often become frustrated with the staff for the amount of ignoring that appeared to be taking place. This became a repeated pattern of conversation within the supervision group meetings.

Participant D discussed a patient’s attempts to get a member of staff’s attention:

*“And I was thinking after, you know Laura actually put a lot of effort into trying to make a connection with someone [mmm]. It started off about putting her head down on the table, no, no response and then about the knee and then about the water. And you think blimey that is a lot of effort to try and get some kind of response. And it’s not surprising that you have to, it either has to be something really big or nothing happens”* (8, participant D: 632-638).

### **3.2.1.2 Sub-theme two: Outburst of emotion**

The current sub-theme captures the moments of expressed emotion present within the observational data. These seemed to be either moments of warmth and affection, or moments of frustration and hostility.

This example refers to a section of the observation notes when a moment of warmth and affection was observed.

*“Lucy and George were both watching her. It looked as though they were both desperately trying to understand what she was saying. Amy then put her hand on George’s shoulder and said ‘I love you’. Lucy clapped her hands together and, in an excited high pitched voice, said ‘you spoke English, well done’. George started to laugh and said ‘thank you’. Amy was laughing as well. I was filled with an overwhelming feeling of warmth. I also wanted to smile widely”* (4, observation notes: 199 – 206).

### **3.2.1.3 Sub-theme three: Deadness: ‘the aim is for a settled day’**

In response to the observation material, the supervision group discussed the seemingly strong sense of staff working to ‘keep things calm’ and ‘keep things settled’. These words, however, did not appear to capture the group’s sense of the atmosphere of the dayroom. It was not calm and relaxed; it appeared to be uncomfortable, people were detached from one another, and it was difficult to be there.

During one of the observation sessions, a member of nursing staff sat next to me and said the following:

*“You see, I don’t want to be coming to work and fighting all day. What I aim for is a nice settled shift, like today. We don’t get many incidents now on here. It’s good. I mean, don’t get me wrong, you’re always ready for something to happen. You need to be. But it’s not been too bad here recently”* (7, observation notes: 539-544).

A member of the supervision group shared her initial response, when the reading aloud of a section of the observation material came to an end:

*“I think it just, it just feels a little bit horrible actually. I just imagine sitting there and not being spoken to, not being involved in anything, everyone is segregated into different sections where it just feels very separated off. It doesn’t feel a nice place to be at all (laughs). I think that was my first impact, I was thinking oh god”* (3, participant D: 235 – 240)

#### **3.2.1.4 Sub-theme four: The Breakfast Party: rare moments of excitement**

The observation material contains moments when the atmosphere of the dayroom appeared to completely change and people become lively and excited. These moments of excitement appeared to be triggered by events that were perceived as positive to staff members, such as going for breakfast, being given a box of chocolates, the introduction of a new uniform and discussing an upcoming night out. Whilst these moments were rare within the observation material, the supervision group members were very curious about them. The group’s curiosity appeared to be linked to the pattern that appeared to repeat itself in relation to these moments: the atmosphere would be ‘deadness’, a moment of excitement would erupt and not be sustained,

followed by a sharp return to the ‘deadness’. The supervision group members wondered about the function and importance of these moments for the staff.

A passage from the observation notes regarding a moment of excitement:

*“I noticed a change in the energy levels when breakfast was mentioned. Before the atmosphere felt flat and I had been feeling quite sleepy myself. Once breakfast had been mentioned the staff seemed to be roused somewhat and I felt quite excited myself”* (3, observation notes: 190-194).

An excerpt from the supervision group regarding the staff going for breakfast:

*“I was really struck by the change in the whole atmosphere when breakfast was mentioned. Was it because everybody was hungry? But you know, it was as soon as breakfast was mentioned it was like everyone was going to a party. It was like something really really exciting was happening”* (3, participant B: 406-410).

### **3.2.1.5 Sub-theme five: Lack of purposeful activity: restlessness in the dayroom**

This represents the ‘comings and goings’ of the dayroom. It seemed that people (staff, patients and visitors) did not settle in the dayroom for very long. Observation was made of how people appeared to go in, partake in a small activity, such as making a cup of tea, leafing through the off-duty file, and then walk out of the dayroom area.

A member of the supervision group commented on the movement in the dayroom:

*“I did feel with this. You said nobody stays anywhere for very long. I did feel it quite hard to take in some of the comings and goings, this movement there to*

*there. I found that quite confusing to listen to. Like there was a lot going on but not much substance” (4, participant A: 989-992).*

### **3.2.1.6 Sub-theme six: ‘The off duty and the link of the boat to dry land’: a desire to be somewhere else, somewhere normal.**

This sub-theme refers to the staff’s apparent desire to be somewhere else, a desire to be somewhere more ‘normal’. The observation material contained repeated examples of staff coming into the dayroom area, walking directly to a table where the off-duty file was often placed and starting to read it. The supervision group were struck by the amount of attention the off-duty file seemed to receive and became curious about this. An analogy was developed in supervision session nine, whereby the ward was viewed as the sea, home as dry land and the table where the staff members sit as a lifeboat. The function of the off-duty file was thought of as being a reminder of home, as a reminder to staff that they would be leaving and returning to a place more normal than the ward.

A supervision group member used the lifeboat analogy to consider the function of the off-duty file:

*“I was thinking of erm about the off duty being like a transitional object and the link of the boat to dry land. Which is erm when they are not at work, when its almost like, and there was the other thing the phone call, the private phone call that somebody took, the sense of they need to keep reminding themselves that they will actually leave and they will get to dry land (laughs) at some point erm” (9, participant A: 797-803).*

### **3.2.2 Main theme: A state of confusion**

Confusion appeared to permeate the whole data-set. As an observer, the researcher reflected upon her confusion regarding issues such as decision-making and the function and use of the space. There were repeated examples of the supervision group members being unsure of who was who and much time was spent discussing the role of staff on the ward. On occasion the supervision group became frustrated with the staff for the apparent lack of clarity. Over time, however, the complexity associated with small decisions emerged and the supervision group began to consider the lack of simplicity accompanying seemingly simple questions.

#### **3.2.2.1 Sub-theme one: Tolerating the uncertainty: the decision-making process is hidden**

This refers to a lack of transparency in relation to decision-making. Within the observation material, repeated examples of decisions being made with ‘the middle bit missing’ were noted. That is, a request would be observed, often followed by a period of apparent inactivity, and then a decision would ensue. The supervision group became curious about the ‘middle bit’ of decision-making: the negotiations, ambiguity and uncertainty. There seemed to be little evidence of this in the dayroom. We wondered if this process was avoided, or if it was grappled with elsewhere, for example the staff room, where it could be dealt with in private.

A member of the supervision group discusses the decision-making process:

*“yes it does feel like that kind of middle bit is missing. So you get the beginning which is either the person wanting water or a cigarette or to go or*

*whatever. And then you eventually kind of get the end part which is the person goes for a cigarette. But the bit in the middle, the bit where you can maybe start up a negotiation with somebody, you could start explaining the complexities, you know. Or get in to some sort of dialogue either with staff to staff or staff to patient or as a group or whatever, about well if we go at this time then this, and I need to go and make these phone calls. Its like that middle bit doesn't happen erm or there is no evidence of it where I have been sitting"* (8, participant B:1031-1048).

### **3.2.2.2 Sub-theme two: "Can I have some water?" is not a simple question: small decisions are highly complex**

This represents the difficulties associated with seemingly simple questions. At times the supervision group members became frustrated by the apparent challenge posed to staff when responding to what appeared to be simple requests (e.g. Can I have some water? Can I go for a cigarette?). What emerged over time, however, was the complexity associated with such questions. For example, with respect to a patient's request for some water, the supervision group began to think about questions such as, 'Has a team decision been made in relation to this?' 'Am I colluding with the patient's difficulties?' and 'Do I have the responsibility to make this decision?' Simple questions no longer appeared to be simple.

A member of the supervision group discussed the simple versus complex dilemma:

*"But there being a genuine dilemma about something, what you pointed out was about something so small. And almost this sense of any little decision about how to respond is huge really [mmm]. And how mad that is, how*



*artificial it is, erm. And it's kind of like the ordinary responses of generosity and kindness to people are blocked"* (8, participant A: 525-530).

### **3.2.2.3 Sub-theme three: 'It feels very much like there is no identity': who's who and what is my role?**

This sub-theme relates to the confusion in determining who was who within the observation material and making sense of individuals' roles on the ward. Developing a clear sense of the nursing staff's task presented a challenge to the group. On occasions, the identity of staff members and patients became mixed up and a patient was mistaken to be a member of staff.

The confusion regarding staff or patient is reflected upon:

*"I found it quite hard to actually keep in mind which were the patients and which were the staff, with all the names, it was almost like they were very much kind of jumbled up together, erm"* (4, participant A: 238-240).

A supervision group member considered why an appreciation of the task might be difficult:

*"Perhaps something that is quite missing is that, or discouraged, that opportunity to actually work out what they do think and have that challenged, and develop a sense of well actually what is this job?"* (7, participant A: 911-913).

#### **3.2.2.4 Sub-theme four: ‘The dayroom’s like an open-plan office’: confusion regarding function and use of space**

This sub-theme refers to the apparent confusion associated with the function and use of the dayroom area. Developing a clear understanding of this appeared to present a challenge for the supervision group members. The observation material contained repeated illustrations of the staff members sitting at a dining table in the dayroom area engaging in a variety of paperwork and administrative tasks. The supervision group members became confused by this and wondered why the dayroom area had become a space where ‘office tasks’ were carried out: Was it because there was no other desk space elsewhere? Was it because staff were required to be in the dayroom and do paperwork at the same time due to issues such as staffing levels? The supervision group contemplated the potential consequences of this for the patients on the ward and thought about the way patients used the space as well.

The difficulty associated with making sense of the function of the dayroom is considered during a supervision session:

*“Yeah, it makes me think is it for something maybe. And going back to the signs on the doors, because I suppose that is an area that doesn’t have a sign on the door, because it’s like you go through the front door and you are in the space. Whereas the other places have these signs that don’t necessarily match with what might go on in there. But I think we discussed that before, the importance of these signs. And maybe part of what’s difficult about that space is that it doesn’t have a clear function” (4, participant A: 955-963).*

### **3.2.3 Main theme: Alone and responsible ‘the responsibility is actually terrifying’**

This theme relates to the apparent position of the nursing staff. There were repeated examples within the observation notes of the differentiation of groups (i.e. nursing staff, the patient group and visitors) and the supervision group members were struck by the seemingly isolated position of the nursing team. An atmosphere of criticism permeated the data set. It appeared that the nursing team were hyper-vigilant and hyper-sensitive to criticism. The supervision group members reflected upon the critical position they adopted at times and the difficulties associated with being a critical other. Alongside the isolation was the responsibility held by members of the nursing staff. The supervision group considered the responsibility associated with the job and there was a strong sense of this actually being terrifying. A preoccupation with the perspective of the wider system, such as senior managers within the organisation, appeared to have an impact upon staff members’ view of their responsibility.

#### **3.2.3.1 Sub-theme one: Expression of terror: an atmosphere of criticism**

This refers to a sense of criticism that was a common topic of discussion for the supervision group. It appeared that the nursing team were ‘at risk’ of being criticised by any individual who was not a member of nursing staff. The supervision group members commented upon the critical role they adopted at times and were curious about other members of the organisation’s ability to criticise. For example, the group wondered if a request from a medical consultant for feedback and patients’ requests for attention were regarded as a criticism of the nursing staff.

The following excerpt is taken from the observation material, which illustrates the reaction of a member of the nursing staff to a request from a consultant psychiatrist:

*“Carl said ‘Oh but Dr X is in the staff room waiting for you, she wants a hand over’. Rachel’s eyes widened and she said ‘Are you taking the piss?’ She looked straight at me, and I thought she looked scared” (3, observation notes, 819-821).*

A supervision group member reflecting upon the patient’s request as criticism:

*“Almost that the request is a criticism [yeah], rather than it’s a request. It feels that these patients are saying that they want something that hasn’t been provided and that in itself feels like a criticism of the staff” (5, participant A: 539-542).*

### **3.2.3.2 Sub-theme two: Importance of maintaining group identity and keeping groups separate**

This represents the apparent importance of belonging to a distinct group (i.e. nursing staff, patients, visitor to the ward) and the effort made to keep the groups separate from each other. There were repeated examples within the observation material of conversations that appeared to reinforce nursing staff’s position as nursing staff and their difference from, in particular, the patient group. The consequences of a ‘too tight’ group identity were considered within the supervision group, for example where was the room for flexibility? What happens if someone wanted to do something differently?

A supervision group member commented upon the inability of the observer to tolerate sitting in a position that was in-between the staff and patient areas in the dayroom:

*“It was very interesting how unbearable it was when you put yourself in-between”* (3, participant A: 298-299).

A supervision group member commented upon the excitement generated by the talk of uniforms within an observation session:

*“But they seemed quite excited by it didn’t they [mmm] and like you were saying, D, that it helps to differentiate them from....”* (3, participant A: 521-523).

### **3.2.3.3 Sub-theme three: The ‘I love you incident’: anxiety about the wider perspective**

This sub-theme captures the preoccupation by staff with the wider perspective, for example, senior managers within the organisation. Anxiety regarding the outsider perspective appeared to be related to issues such as boundaries between staff and patients and how others might perceive this. An individual’s job role also seemed to be important in relation to this, as the more responsibility held in terms of job title, appeared to be linked to how responsible you were for holding a boundary in place.

An excerpt from the observation notes:

*“Joe then entered the day room and walked straight over to the table with Lucy, Amy and George seated at it. Lucy looked up at him and said ‘Amy’s just spoken some English, she said I love you to George’, she was smiling as she said this. George laughed slightly and shook his head. Joe looked down at*

*the table and did not respond, he was quiet for a moment and then said ‘Amy, take your hand off George’ (4, observation notes: 206-212).*

A discussion between supervision group members regarding the notion of boundaries, responsibility and taking a risk is detailed below:

*“I think it’s like, it’s reminding us there is another context to it isn’t it, like there is a bigger world outside where things are evaluated differently, where actually a touch between a patient and staff might have a more negative meaning. Erm, so almost like he had a different responsibility and he can’t enjoy it because he’s kind of on the boundary, more between the inside and outside. That it’s okay here but, you know, managers out there or whatever, erm” (4, participant A: 542-549).*

### **3.3 Part two: what influence does a psychodynamically-oriented supervision group have on observational learning about the experiences of staff and patients on an acute adult inpatient ward?**

Five themes were identified within this stage of the analysis. These have been named ‘recovering lost affect’, ‘sense-making over time’, ‘the importance of a group to study a group’, ‘learning is continually evolving’ and ‘process and outcome are as one’.

Each theme will now be considered in further detail.

#### **3.3.1 Theme one: Recovering lost affect**

This theme refers to a process which appeared to occur, following the completion of the supervision group meetings, during further supervision sessions. These supervision sessions comprised the researcher and the research supervisor or the

researcher, the research supervisor and the supervision group facilitator. These meetings took place after the majority of the first stage of the analysis had been achieved and the aim of the meetings was to reflect upon the observation period and supervision group meetings as a whole. The members of the latter supervision session meetings reflected on the loss of affect that appeared to have taken place during the first stage of the analysis. The researcher spoke about a ‘pile of emotions’, emotions that had been elicited either within the observation session or the supervision group meetings, and the difficulty integrating these directly into part one of the analysis. The supervision members were curious about this. We decided to spend time attending to the affect, and by doing this we appeared to be able to easily recall the emotions engendered within the process, and recover some of the lost affect.

The following excerpt refers to reflections made by the researcher of a conversation between the researcher and her research supervisor, in a supervision session which took place after the completion of the observations and supervision group meetings:

*“I wanted to stress the feeling I experienced was terror. Not a milder emotional response, it was terror. I recalled clearly how wide open the nurse’s eyes were as I felt this. I demonstrated this to Arabella<sup>4</sup> as a way of trying to communicate the intensity of what I experienced” (1: 31-34)*

In a further supervision session, with the researcher’s academic and field supervisor, the field supervisor remembers a strong emotional experience from one of the supervision group meetings:

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<sup>4</sup> Within the passages from the reflective accounts the researcher included her academic and research supervisor’s real names. The researcher sought, and granted, permission to real names rather than pseudonyms. This decision was made as the identity of the academic and field supervisor represents information accessible within the public domain.

*“Anne recalled how disconnected she felt and how distressing that was for her. She said she felt completely hopeless and depressed. I remembered what it was like during the observation itself and we discussed the shared experience of feeling hopeless and extremely sad” (4: 205-208)*

### **3.3.2 Theme two: Sense-making over time**

This refers to the importance of time in making sense of the observational material. The notion of time is communicated through the use of a timeline placed next to each anecdote within the accounts of sense-making during the study. As the research process progressed, it became apparent that sense-making occurred in a number of different phases of the process: within the observation session itself, within the supervision group and within the research/ academic supervision sessions following the observations and group meetings. The latter supervision meetings appeared to be of particular importance to the processing of affect, and the use of this to inform the analysis as a whole.

The following are examples of the researcher’s reflections of sense-making which occurred in one of the academic supervision sessions. This session took place following the observation session and supervision group meeting, thus illustrating the importance of time in making sense of the data:

*“We also reflected upon the position of superiority the group had adopted, in our assumption that we could do better and find a solution. We also wondered if we had been minimising the complexity surrounding the issue of taking patients for a cigarette, and in doing so, had separated ourselves from the experience of the staff” (5: 252-255).*



### **3.3.3 Theme three: ‘The importance of a group to study a group’**

This theme refers to a comment on process, which occurred when discussing the ‘anger at the emptiness’ experience (anecdote 2). This theme was only found once in this data set, but was felt to be of relevance to existing theory and was therefore included. When thinking about this illustration, the researcher and supervision group facilitator commented that they had not shared the feelings of anger that were expressed by another member of the group.

Within the researcher’s reflective accounts, the importance of having a group to study a group was considered:

*“Anne and I recalled not sharing this anger, and wondered whether we would have had access to such an understanding if we had not have been making sense of the observation material within a group setting. Anne and I wondered whether we tended to align ourselves with the staff, and reflected upon the usefulness of a group member who appeared to be more aligned with the patient experience at that point” (2: 86-90).*

### **3.3.4 Theme four: Learning is continually evolving**

This represents the apparent continually evolving nature of the learning. The latter supervision sessions provided a space to reflect upon the observation sessions, the observation material and the supervision group sessions. Within this process, the emerging agenda was that of re-connecting with the emotional experience, as it was felt that attending to the affect itself had been lost during the first stage of the analysis. During the latter supervision session, members discussed the importance of both an in-depth view of the data (part one of the analysis) and a ‘bird’s eye’

consideration of both the data and the process (part two of the analysis). It was felt that the later academic supervision sessions comprised an important part of the learning process, thus illustrating the continually evolving nature of the learning.

The following is an example of reflecting on the supervision group experience, from the researcher's reflective account of sense-making. This occurred in a final supervision session with the researcher and academic supervisor (following the observation sessions, supervision group meetings, a supervision session with the academic supervisor and a supervision session with the academic supervisor and field supervisor):

*“We stayed with the theme of attack on vulnerability and wondered if the group, at that point, were assuming the position of the powerful, critical others” (1: 53-54).*

### **3.3.5 Theme five: Process and outcome are as one**

This theme represents the apparent relationship between the process and the analytic outcome. For each of the accounts within this section, the anecdote appeared to link back to the first stage of the analysis. This seemed to reflect the connectedness of both parts of the analysis process, and through this the notion emerged that each part of the analysis was not, in fact, a separate entity, instead both parts were required to interact in order to achieve the understanding that has been accomplished with this research process.

This example reflects the links being made between the process and the analytic outcome achieved in the first stage of the analysis. This occurs at the end of the sense-making account of the fourth anecdote:

*“Anne’s sense of not being able to connect with the observation material and the ensuing discussions appeared to relate to the fear of engagement theme and difficulty making a connection sub-theme generated in the first stage of the analysis. The response of the nurse to Roger, which I experienced as hostile, appeared to reflect the outburst of emotion sub-theme. This experience also appeared to encapsulate the complexity surrounding seemingly straightforward questions (Can I go for a cigarette? vs. Can I have some water?) and the deadness of the atmosphere of the ward” (4: 215-221).*

#### **4. Discussion**

The aim of the current study was to explore the experiences of staff and patients on an acute inpatient ward for people with complex mental health difficulties. In particular, the researcher was interested in the following questions: a) what can be learned about the experiences of staff and patients from a series of six weekly observation sessions? and b) what influence does a psychodynamically-oriented supervision group have on observational learning about the experiences of staff and patients on an acute adult inpatient ward? The suggested findings appeared to illustrate a complex system which impacted upon ward atmosphere, relationships, behaviour and perception of job role and responsibility.

The present section comprises a brief summary of the findings, in relation to each

research question, accompanied by consideration of previous research and relevant theory. Clinical implications are discussed.

#### **4.1 Part one: what can be learned about the experiences of staff and patients on an acute adult inpatient ward from a series of six weekly observation sessions?**

##### **4.1.1 Fear of engagement**

A fear of engagement appeared to be pervasive across the data-set. The supervision group were struck by the repeated difficulty of connecting with others, and the atmosphere of the dayroom was felt to be one of 'deadness'. Staff appeared to move about the space in a way that lacked purposeful activity and an apparent desire to be somewhere else was a repeating theme; staff, patients and visitors were not observed to remain in the dayroom for sustained periods of time.

Psychoanalytic accounts of the dynamics of the therapeutic relationship may be of use in attempting to make sense of the suggestive findings. Winnicott (1949) regarded the needs of individuals with complex mental health difficulties as being so basic, so great and so immediate as to put staff in an intensely demanding position; similar to that of a caregiver with a newborn baby. Caring for somebody with significant mental health difficulties often involves being in close contact with experiences of severe mental pain, depression, severe anxiety, breakdown, violence and self-destructiveness (Hinshelwood & Skogstad, 2000). Hinshelwood and Skogstad (2000) posit that individuals working with people with complex mental health difficulties are likely to experience, consciously or unconsciously, the fear of being contaminated by such feelings and losing control over themselves. Experiencing feelings of hate and fear are

regarded as being likely consequences of close contact with such individuals (Winnicott, 1949). Dynamics such as these mean that connecting with people with complex mental health difficulties can be a very painful process (Lucas, 1993).

It is recognised that a significant demand is made on mental health nurses by the necessity to be close to people that others avoid (Lavender, 2002) and, despite having chosen to work with disturbance, it is likely that nurses share in some of society's anxieties about 'madness' (Bott, 1979). Staff's anxieties about 'madness' could be avoided by keeping a distance from patients (Goodwin and Gore, 2000), as talking to patients and empathising with them could be felt to be dangerous (Hinshelwood & Skogstad, 2000).

The suggestive findings of the current study appear to confirm findings of other studies within the literature, in addition to providing a development to research within this area. Service-user feedback contained in the document providing guidance for the provision of adult acute care (DoH, 2002) highlighted an inadequacy of contact (in particular one to one contact with members of staff), a lack of something to do (especially activity that is useful and meaningful to recovery) and a poor physical and psychological environment for care. Insufficient contact with staff and a non therapeutic and unsafe environment was reported in Baker's (2000) survey of individuals who had previously been admitted for acute psychiatric inpatient care. Caldwell et al (2006) provided a potential explanation for the low quality of interpersonal communication between patient and caregiver in psychiatric inpatient units for adults with complex mental health difficulties. The authors posited this could

be due to a nursing team experiencing a sense of hopelessness and negativity about their work.

The themes obtained in Goodwin and Gore's (2000) observational study of a long stay psychiatric ward included 'lifelessness', 'busyness' and 'expression of emotion'. The 'lifelessness' theme referred to the observer's feeling that the ward environment often felt 'lifeless' and 'stultifying', with aimless bursts of activity. The authors stated that "despite frequent comings and goings of both staff and residents, people drifted in and out with little apparent purpose" (Goodwin and Gore, 2000, p.314). It was detailed that activity was mentioned as happening elsewhere and staff were focussed on their days off. The 'busyness' theme captured the apparent importance of keeping active; the authors stated that keeping active appeared to be more important than achieving something. Goodwin and Gore (2000) commented that talking about another project away from the ward provided the nurses with a sense of liveliness. 'Expressed emotion' was a theme which described the rarity of direct expression of nursing staff's feelings. The authors commented that even when a nurse was assaulted, strong feelings were not expressed.

The suggestive findings presented above appear to strongly echo the sub-themes associated with the main theme of fear of engagement. There is a familiarity with regard to the atmosphere of the ward, in this study described as deadness punctuated by rare moments of excitement. Within the present study, emotional connections were not often made, however there were noticeable exceptions, when outbursts of both positive and negative emotions were observed. A lack of purposeful activity appears

to be common to both the present study and the suggested findings of Goodwin and Gore (2000), alongside a desire to be somewhere else.

The suggestive findings in relation to the 'fear of engagement' theme appeared to build upon the work of Goodwin & Gore (2000) in understanding the purpose of the desire to be somewhere else. A repeated feature within the observation material was the apparent preoccupation of staff members with the off-duty file and this began to be thought about in the supervision group meetings as fulfilling the role of a transitional object. Winnicott (1971) introduced the concept of transitional objects in reference to a particular developmental sequence occurring in early childhood. The term 'transition' refers to an intermediate developmental phase between the psychic and external reality. A transitional object is regarded by Winnicott (1971) as serving a soothing function for children, providing both emotional and tangible comfort, especially during times of stress. These security objects are thought of as having a calming effect on children and aid in separation from the parent. It is posited that the object is a reminder of the parents and therefore has the ability to calm by giving them a peace of mind. In this sense the transitional object is seen as a defence against anxiety (Winnicott, 1971). Within the current study, this notion has been transferred to the inpatient environment in order to aid the understanding of the apparent reliance of staff on the off-duty file. It is contended that the off-duty, in its potential role as transitional object, may increase feelings of security in the ward environment, in order to remain in the here and now.

#### **4.1.2 A state of confusion**

A state of confusion permeated the data retrieved. In particular, this related to decision-making, function and use of space, and identity. 'Role uncertainty' was a theme highlighted in the observational study by Goodwin and Gore (2000). This captured staff's uncertainty about the value of their work, ambiguity regarding their role and an occasional lack of clarity regarding whose needs the ward was there to serve. The authors discussed the wide range of the nurses' apparent responsibilities and the observer commented upon the difficulty she experienced in getting a coherent sense of the nurses' remit. Such factors feel reminiscent of, in particular, the 'who's who and what is my role' sub-theme evident in the current study.

The suggested findings of the current theme highlighted a nursing team aiming for a 'settled' and coherent environment, however, what appeared to emerge from the observation material and supervision group discussions was actually quite the opposite. Squier (1994) found that the WAS sub-scales of 'order and organisation' (described as the importance of order and organisation) and 'programme clarity' (described as the explicitness of rules and procedures) were related to a supportive ward environment. The findings of this study are interesting in relation to the current theme.

The question arises as to whether such a disparity highlights the differences between collecting information through self report (e.g. the WAS) and the use of an observational methodology. One possible way of conceptualising the difference in the findings would be to consider what the staff team are consciously aiming for, and what is actually achieved. The observation material collated as part of the current



study contained examples of staff members talking about the importance of routine and order, and this notion appears to resonate with the findings of the study by Squier (1994). It appears as though the staff team are consciously striving for order and clarity, however, the suggested findings of the present study highlighted a confused system. It may be that, whilst aiming for order and clarity, this is not actually achieved, and it is only through the use of indirect methods of data collection (i.e. not through self-report) that this information can be accessed.

This apparent sense of confusion may also be linked to service-users' reflections that they were not provided with sufficient information on their condition and treatment, and on how the ward and service operates, in relation to their experiences of inpatient care (DoH, 2002). If, indeed, staff are working within an environment exemplified by confusion it may be that they are unable to provide patients with clear, coherent information regarding these areas. Rather than being able to present patients who arrive on the ward with a reasoned overview of the service, the staff members may have to avoid these conversations owing to the underlying confusion typifying ward life.

#### **4.1.3 Alone and responsible**

Maintaining group identity appeared to be extremely important. The observer reflected upon the 'tangibility' of the different spaces for different groups. The staff team appeared to be alone in their endeavours, and accompanying this isolation seemed to be a sense of the staff team being open to, and highly aware of, criticism from others. The views of the wider system appeared to promote a sense of anxiety

within the staff team, which seemed to have an impact upon individual nursing staff's responses.

In an exploratory study of the needs of staff who care for offenders with a diagnosis of personality disorder, Kurtz and Turner (2007) interviewed all members of the multidisciplinary team and a sample of the nursing team. The authors described a core category of 'risk of isolation'. The suggested findings of the present theme appear to resonate with this. Within the study of Kurtz & Turner (2007), unit staff described themselves and the patients as physically and psychologically cut-off from the rest of the world. External to the hospital, society and the media were described as having an unsympathetic attitude towards secure hospital patients and staff members appeared to feel attacked by the 'outside'.

#### **4.1.4 Social defence system**

Menzies Lyth (1960) discussed a system's ability to operate in such a way as to allow individuals to avoid certain anxieties and conflicts, in particular those evoked by the institution's primary task. According to this model, the social system acts to support more primitive defence mechanisms in individuals. The unconscious defence mechanisms are echoed in shared, socially required defensive attitudes and in the particular ways in which the work is conducted. This process has been termed 'social defence system' (Menzies Lyth, 1960). Hinshelwood (1987a) described a social defence system in which 'madness' was kept in patients and sanity in staff and rigid barriers were created to prevent contamination. The consequence of this was regarded as serious difficulties in patients' ability to re-discover sane parts of themselves.

It is proposed that this concept could be of use when considering the overall analysis achieved within the current study. Attempts were made to link together the main themes of the analysis in such a way as to be able to attribute the suggestive findings to a theoretical understanding. This proved to be difficult, and the researcher did not want to prescribe theory when the potential links were unclear from the data obtained.

However, the concept of the social defence system was regarded to be an important consideration with regard to the suggested findings. For example, the main theme of fear of engagement could represent a deep, underlying anxiety evoked in the staff and the sub-themes associated with fear of engagement (e.g. difficulty making a connection, a deadened atmosphere and restlessness in the dayroom) could represent the defences used by the individuals. Since these processes appeared to be pervasive throughout ward life, it could be that these defence mechanisms represented shared, socially required defensive attitudes. In a similar way, the main themes of 'alone and responsible' and 'a state of confusion' could also represent an underlying anxiety, and the associated sub-themes could be regarded as the defence mechanisms used collectively by the individuals within the social environment.

## **4.2 Part two: what influence does a psychodynamically-oriented supervision group have on observational learning about the experiences of staff and patients on an acute adult inpatient ward?**

### **4.2.1 The role of affect in qualitative research**

A key feature of the psychoanalytic approach to observation is the use of the concepts of transference and countertransference (Likierman, 1997). This is achieved by the observer noticing the feelings and states evoked during the observation and then, through the use of the supervision group, trying to position the place of these within the observation experience (Likierman, 1997). The methodological approach of the current study appeared to highlight the potential dilemma surrounding the role of affect in qualitative research. The theme ‘recovering lost affect’ relates specifically to this.

Working with emotional responses<sup>5</sup> was a key feature of the observation sessions and supervision group meetings, however during the thematic analysis process the focus upon affect seemed to get lost. During the supervision sessions following the data collection, the researcher appeared to ‘rediscover’ some of the emotional reactions contained within the data-set. It appeared as though this process was essential in relation to connecting back with some of the emotional content, as there was a sense of this being lost, and also distorted, during the thematic analysis of the data. Some of

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<sup>5</sup>‘Working with emotional responses’ refers to a number of different processes. Examples include: the observer noticing an emotional response during the observation session and recording this to share with the supervision group. Similarly, noticing and recording the emotional responses of others during the observation session. Within the supervision group meetings examples include, countertransference responses being shared with group members and discussed in order to attempt to understand the potential significance of such responses and being curious about group members responding in different ways to the observation material.

the potential challenges facing qualitative researchers in relation to integrating affect into research appeared to be highlighted by the current theme.

One possible way of thinking about the process described above is to consider the anxiety-defence model, fundamental to psychoanalysis, whereby conscious and unconscious anxieties and conflicts are dealt with by psychological defence mechanisms (Hinshelwood & Skogstad, 2000). The distortion and loss of affect which appeared to occur during the course of the analysis may represent a defence process. That is, during the qualitative analysis of the data defence processes guarded against the emotional responses elicited during the observation session and supervision group meetings, and as a consequence the affect became distorted and forgotten. Hollway and Jefferson (2000) utilised the concept of the ‘defended subject’ in relation to research participants protecting themselves against anxieties arising from the information provided in a research context, when conducting interviews with individuals. The suggestive findings of the current study seemed to draw attention to the importance of defensive processes within the researcher as well as the research participant.

#### **4.2.2 The process of learning in qualitative research**

Three of the themes resulting from the second stage of the analysis appear to relate to the process of learning in qualitative research: ‘sense-making over time’, ‘learning is continually evolving’ and ‘process and outcome are as one’. A crucial element in relation to these themes appeared to be a sense that learning forms an ongoing process. A particularly interesting feature in relation to this was the sense that learning did not end following the data collection period and analysis of the data. Instead, what

emerged from the research process was the importance of the supervision sessions that followed observation sessions and supervision group meetings and the data analysis. These sessions provided an opportunity to reflect on the research process and analysis of the material, and over time the apparent necessity of these meetings in contributing to the learning was recognised by the research team.

Schon (1983) provides a distinction between thinking in action and thinking on action. Thinking in action refers to the comparatively spontaneous deed of using an awareness of self in moment-to-moment experience, and thinking on action refers to the retrospective analysis of experience and requires the use of theoretical knowledge to make sense of what has occurred. Whereas Schon's (1983) model entails distancing from experience through reflection and the incorporation of lived experience into cognitive awareness, the suggested finding from the current study appeared to illustrate how aspects of an experience can be lost due to its near-immediate psychological impact but can be restored over time through reflection in supervision aimed at an understanding of defensive processes.

#### **4.2.3 The importance of a group to study a group**

During supervision group meetings which followed the data collection period, the researcher and field supervisor reflected upon the differing responses of individual members of the supervision group in response to some of the observation material. In particular, the researcher and field supervisor discussed the feelings of anger experienced by one group member, which was not shared by others. Exploring the powerful emotional experience was regarded as an important part of the learning about the experiences of staff and patients, and the researcher and supervisor queried

whether this would have been achieved if the observation material had not been processed as a group of individuals. Menzies Lyth (1989) suggests the value of a group of people being necessary to study a group and in particular makes reference to the potential for differing transference and countertransference responses.

### **4.3 Methodological issues**

The value of the current study depends upon the reliability and validity of the methodological procedure adopted. In accordance with the psychodynamic approach to observing organisations (Hinshelwood & Skogstad, 2000) notes were not taken until the researcher had left the ward. Whilst every care was taken to provide as accurate and unfiltered an account as possible (e.g. the observation notes were written on the same day as the observation session), some important data could have been lost through selective memory.

Inherent within the approach was the use of researcher's subjective experience, in particular the concepts of transference and counter-transference. The use of such experiences warrants consideration. Casement (1991) makes a distinction between the part of a therapist's response which offers indication of an individual's unconscious communication (termed 'diagnostic response') and that which is personal to the therapist (termed 'personal countertransference'). Whilst this distinction is made within the clinical context, it is felt that such clarification is of use to the research realm. The information obtained from the observer which is regarded as providing a useful insight into organisational functioning could be regarded as the 'diagnostic response' (Casement, 1991), whereas the personal countertransference of the observer may impact upon the suggestive findings in an unhelpful way. Reflexivity of the

observer and the existence of the supervision group aimed to facilitate an understanding and uncovering of the two processes. As such, the potential impact of personal countertransference should have been reduced.

The observations, which formed the basis of the current project, occurred over a one hour time period on six occasions, over a period of two and a half months. It is possible that what was observed was not representative of the general ward functioning. In response to this critique, however, Hinshelwood and Skogstad (2000) contend that the “culture, or atmosphere, though fluctuating somewhat in the day (and throughout the space), will tend towards a constant quality that can be sensed throughout” (p. 21). A period of approximately three months is recommended by Hinshelwood and Skogstad (2000), which is considerably shorter than the period of infant observation (one to two years) upon which the approach is based. The authors contend that, in contrast to infant observation, which has a developmental focus, organisations, in terms of cultural aspects will change over a much longer timeframe. The aim of the approach is to achieve a moment-in-time description, rather than a study over time.

The strength of the psychodynamic observation method is that it provides a way of accessing potential unconscious motivations; however it fails to give the research participants an active voice (Goodwin & Gore, 2000). Feedback sessions have been planned between the researcher and ward members and it is hoped that these meetings will allow an opportunity for dialogue. One possibility for expanding the project would be to incorporate feedback from the research participants into the research design. Such an addition would allow an opportunity for the active voice of the



participant to be heard, thus making use of concepts such as triangulation and participant validation and thereby permitting a more detailed and balanced picture of the situation (Altrichter, Posch & Somekh, 1996).

Using observation material as the basis for collecting qualitative data requires the consideration of the potential impact of an observer on the setting being observed. Linkerman (1997), in a paper on psychoanalytic observation in community and primary health care, argued that it would not be possible for a setting to accommodate an observer without some shifts in dynamics. The likelihood is that when a stranger enters an organisation a range of reactions, including curiosity, suspicion, expectations or desires are triggered, all of which the author contended, create subtle ripples that unsettle the pre-existing routine. Such process, Linkerman (1997) stated, are integral to the observation task and attention to these forms an important part of the learning process.

#### **4.4 Clinical implications**

The analysis contained within the current report, suggested a system characterised by fear of engagement, confusion and a nursing team both isolated and responsible. Consideration of the themes acquired highlighted the complex nature of settings such as the one forming the basis of the current report, and the potentially painful repercussions associated with connecting with the inevitable distress and disturbance of the individuals who come into contact with acute inpatient services. It has been proposed that staff who care for those with complex and long-standing psychological and social difficulties will be profoundly influenced, often unconsciously, by contact with such individuals (Winnicott, 1949). Menzies Lyth (1960) suggested that if

feelings aroused by such work are not acknowledged and understood, staff will develop defensive attitudes and practices which will obstruct therapeutic work. The author proposed that pressure may be applied for people to conform at unconscious levels and described how this pressure could lead to interference in job satisfaction, demoralisation and high rates of attrition of staff (Menzies Lyth, 1960). Additionally, Obholzer and Roberts (1994) intimated that an approach to work that is 'essentially and consistently defensive is bad not only for the work but also for the individual workers' (p.178).

Regular, ongoing supervision, with the aim of exploring the dynamics that develop in the therapeutic relationship, is considered as invaluable in aiding clinicians acknowledge the personal impact of contact with people in distress (Cox, 1996). Self-awareness of individuals working with people with complex mental health problems is regarded as an essential requirement, in order to reflect upon the meaning of feelings and experience within the therapeutic relationship (Winnicott, 1949). It seems likely that such supervision, which promotes a reflective approach to practice, would be of value for a nursing team working on a ward in an acute inpatient environment.

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### **Part 3**

#### **Critical Appraisal**

## **1. Choice of research project**

I came to this research project with an interest in the inpatient setting, in particular organisations that work with people with complex mental health difficulties. For a number of years I worked in a high secure hospital and through this experience developed an interest in the experience of both staff and patients working or living within such environments. I was fascinated by the dynamics occurring within such services and the functioning of the social environment.

During a university research fair, my academic supervisor delivered a presentation regarding an ongoing study which aimed to explore the experiences of staff working in forensic child and adolescent mental health services (FCAMHS). Whilst the client group did not specifically resonate with my experience at that time, I became interested owing to the nature of the study and my previous experience of working within inpatient settings.

A trainee in the cohort above me had already started the first stage of this project. My academic supervisor explained that the intention was to use a series of projects to address, as thoroughly as possible, the overall research question relating to the experiences and needs of staff working in FCAMHS. When I joined the project, there was a plan regarding how this might be achieved. The first stage involved exploratory interviews with members of the multidisciplinary team, analysed using Interpretative Phenomenological Analysis (IPA; Smith & Osbourne, 2008). This comprised the thesis of the trainee in the year above, and therefore the specific research question and design had been thought about and planned in detail. The other stages of the project,

however, were in their infancy. The loose framework that did exist, detailed stage two of the project whereby semi-structured questionnaires would be used and analysed using template analysis (King, 1998). The intention was to use the emergent themes from stage one to inform the template required for the analysis. The plan for stage three was to conduct a questionnaire study.

Whilst the proposal had been considered, my academic supervisor was keen to stress the flexibility of the research plan. We discussed the most appropriate way to progress, with regard to deciding upon the specific research question(s) of the stage of the project I was taking ownership of. I was keen to make use of the emerging analysis and suggested findings of stage one of the research project. However, I was also aware of the requirements and deadlines of the course. The dilemma arose whereby I wanted to remain close to the experience of the researcher conducting stage one of the analysis, however needed to make decisions regarding my design in order to submit a research proposal in a timely fashion.

The initial decision I made was to remain close to the original research plan. My first draft of the research proposal detailed a project with approximately 25 participants, using semi-structured questionnaires as a way of collecting qualitative data. My intention was to use template analysis (King, 1998) to analyse the data and use both a review of the existing data and the suggested findings from the explorative first stage project to inform the *a priori* codes<sup>6</sup>.

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<sup>6</sup> Within template analysis, analysis often begins with a number of *a priori* codes, codes which highlight themes strongly expected to be relevant to the analysis. These codes, however, can be modified or eradicated if it is found that they are not useful or appropriate to the actual data examined (King, 2007).

Whilst in the proposal stage of the project, I became particularly interested in the notion of pragmatism. In particular, I was keen to explore pragmatism as a basis for combining qualitative and quantitative inquiry (see Yardley & Bishop, 2007). I was aware that the project as a whole aimed to potentially make use of both qualitative and quantitative approaches and I wanted to consider both the advantages and potential limitations of this. It has been stated that the aim of inquiry for pragmatists is not to seek a truth that is independent from human experience, but to achieve a better, richer experience and that this can be achieved through scientific analysis, artistic exploration, social negotiation, or any combination of different approaches that is regarded as affective (Maxcy, 2003). I was particularly struck by this. It made sense to me and I felt a connection to it. This became a frequent area of discussion within supervision with my academic supervisor. I stressed my desire to feel confident that the approach I was employing for my study was regarded by myself, and other members of the research team, as the most appropriate way of addressing the research question.

Whilst this work was taking place, the researcher in the year above me was beginning her analysis. Due to the important links between the two research projects we arranged a series of joint supervision sessions. The aim of these sessions was for the trainee conducting stage one of the analysis to discuss her emerging analysis and for myself and the academic supervisor to consider this, both in light of the developing stage one analysis and also as a mode of informing and shaping my research plans.

A recurring theme within these supervision sessions was the sense of ‘something missing’ from the data obtained from interviews with staff members. The trainee who

conducted the interviews and was in the process of analysing them commented upon the blandness of some of the descriptions, which did not appear to fit with other participant accounts and her personal expectations or experiences of working in such a setting. We became curious about this as a supervision group. The academic supervisor shared her own experience of conducting a research project regarding the needs of staff working with individuals with a diagnosis of personality disorder who are considered to be a risk to others. She said that her sense was that the interview method employed somehow impeded the ability to get to what was really interesting. As a group we considered the notion of 'defended subjects' (Hollway & Jefferson, 2000).

Another interesting impression resulting from these supervision sessions was the apparent importance of the environment. This seemed to become an important part of the analysis of the exploratory interviews with staff and I started to think about the role of ward atmosphere and the social environment. I became very interested in this, and it struck a personal chord for me, in relation to my own experience of working in inpatient settings.

I began to reflect upon these factors. I started to question the assumption I had made regarding obtaining information directly from staff members (through the use of either semi-structured questionnaires or interviews) and thought about other ways of obtaining data. I discussed this with my academic supervisor and together we wondered whether my initial research ideas were the best way of developing this research endeavour. I said I would like the opportunity to think in more detail, and

potentially make changes to my research design. My research supervisor was in support of this.

## **2. Choice of methodology and design**

At this stage I was considering a number of different factors in relation to a methodological approach which I felt would be the most appropriate way of addressing the research question. In particular these related to: how can I try and make sense of the ‘something missing’? Is obtaining information directly from the staff members the most appropriate way of collecting data? How can I incorporate the concept of the ward environment? These questions became a key feature of supervision at that time. Through discussion with my academic supervisor, I decided to explore the use of observational methodologies.

I familiarised myself with the observational literature base and considered the different types of observation approaches, for example ethological observations and participant observations (Hayes, 2000). My academic supervisor and I considered the use of participant observation through the use of a research placement at one of the FCAMHS inpatient services. I began to consider the practicalities of this, for example, what would I record? How would I record it? What would be the duration of the placement? I spent some time thinking about such questions. As I was doing this I became familiar with the work of Hinshelwood and Skogstad (2000). In the book ‘Observing Organisations’ the authors presented a unique approach to understanding organisations, derived from direct participant observation of small units within institutions in the health and social services sector. This model employed a psychodynamic approach to observations. I was aware of some of the literature

pertaining to psychodynamic observations of organisations; therefore re-visited this and conducted a further literature search.

Through conversations with my academic supervisor, I decided the psychodynamic approach would provide a potentially beneficial means of addressing the research questions. I was aware that an aspect that appeared to be missing from the psychodynamic observation studies was a method of analysing the data that was expressed within a research tradition. My academic supervisor and I considered this. Initially we wondered whether the observation notes and written reflections, based upon the discussions of the supervision group meetings, could form the data that would then be subjected to qualitative analysis. A concern we held in relation to this, however, was that all of the data would be written by myself and therefore would not be considered original data. Following a period of a couple of weeks, and a number of consultations with other qualitative researchers, we decided upon an approach that appeared to address this potential limitation.

It was decided that the supervision group meetings would be audio-recorded and transcribed verbatim, thus producing a naturalistic data-set which could be analysed using a qualitative approach. Owing to the fact that the method already involved interpretative work, thematic analysis was chosen as the qualitative method of analysing the data. Within thematic analysis, the method adopted can be described as aimed at transparency, rather than interpretation, since interpretative work had already taken place in the observation sessions and supervision group meetings.



### **3. Locating a setting**

Once I had decided upon a methodological approach, the next stage was to apply for ethical approval. Before I was able to submit an ethics form and begin applying for local trust Research and Development (R&D) approval, I was required to have consent in principle from the service at which I hoped to conduct the research project. Unfortunately this stage of the research process was met with a number of delays. My initial intention was to carry out the research in one of the FCAMHS inpatient services where stage one (exploratory interviews with staff) of the series of research projects had taken place. My academic supervisor and I liaised with a consultant clinical psychologist, who was the main point of contact at the unit. The research proposal was taken to the service's own R&D meeting and discussed there. The response from the meeting was that the service wanted to work with the suggested findings from the initial project, before embarking upon further research projects. The members of the multidisciplinary team (MDT) said they would be unable to support the project at that time. My academic supervisor and I reflected upon this response. This particular unit had been the main unit at which stage one of the research into FCAMHS had taken place, and we wondered if it had been unrealistic to expect them to take a lead on the second stage of the project as well.

I contacted one of the other FCAMHS inpatient services. I provided a copy of the research proposal and was informed that this would be discussed in the service's R&D meeting. I was aware that I had not been present at the previous service's R&D meeting, and wondered if being there in person to respond to any questions would be useful. I made this suggestion to the person I was liaising with, and they said they thought it would be more helpful to just have the proposal at this stage. I awaited the

outcome of this meeting. The members of the MDT informed me that although the unit would like to be involved in research, particularly national research, it was not a good time for them to do so. They said the decision was based on various factors, including the arrival of two trainee psychologists and a high level of clinical activity.

I discussed this outcome with my academic supervisor. At this stage I was particularly aware of timing, and the impact the delays were having on my application for ethical approval. We thought about the responses we had received from the two FCAMHS inpatient services and wondered about the reasons for their decisions. Both services had seemingly valid reasons for not wanting to take part in the project at that stage; however we were surprised by the responses, as it was the FCAMHS management who sought out the research project when they approached my academic supervisor. We reflected on the process and wondered whether the nature of the project (an observational study) had impacted upon the respective services' decision.

I was aware that I had approached the services sequentially, awaiting a response from one before approaching another, and wondered whether this had not been the most conducive way of trying to gain consent in principle from a service. I discussed my options with my academic supervisor. We both felt that I did not have the time to approach other services in the same way. I also felt aware of our discussions relating to the project being an observation study. I raised the notion of a change in methodology, under the assumption that a different methodological approach may elicit a different response. I did not want to do this, as I felt that a lot of thought and work had gone into the decisions regarding the methodological approach and design of the study, however at this point felt that my main priority had to be meeting the

requirements of the doctorate course and successfully completing my thesis. I shared this with my academic supervisor and she said that a change in methodology did not feel beneficial. Instead we discussed approaching other inpatient services, not just FCAMHS.

We spoke about the potential implications of a change to the setting and client group. We reflected upon the reasons why the observation design had been chosen. This had, in part, been due to the suggested findings of the exploratory interviews within FCAMHS, but had also been informed by the suggested findings of research conducted in a variety of inpatient settings, including a service for individuals with a diagnosis of personality disorder and a history of offending, a long stay psychiatric ward and a general hospital. We considered that the focus of the research could be an exploration of the method, which could potentially be achieved in any inpatient setting. It was felt that a decision regarding conducting further research at an FCAMHS unit should be made at a later date, when there was more time available to explore some of the apparent ambivalence that had been displayed.

I reflected upon my experience of contacting one service at a time, and decided that the best way to proceed would be to contact a few services at once. I prepared an overview of the project (a one page description of the research), which I decided to send to the different services in order to ascertain a general level of interest. I contacted three further services; a challenging behaviour unit, a secure hospital and an acute inpatient unit. I heard back from all three of the services and chose to pursue the service which had appeared most interested in the research project, the acute inpatient unit.

Once I had received consent in principle from the senior management within the unit I continued with my applications to the appropriate ethics committee and R&D department. I received a favourable opinion from both.

#### **4. Conducting the research**

Before submitting my ethics application, I had preliminary conversations with the ward manager at which the research was due to take place. I was keen to share the thoughts I had regarding the consent and observation procedures, and to incorporate any feedback from the ward manager which appeared pertinent. Upon sharing this, the ward manager said she believed the procedure was workable and was happy with the process of obtaining consent.

Once I had obtained ethical approval, I arranged a series of meetings with the ward manager to discuss the project in further detail and to discuss practical arrangements, such as the day and time of the observation sessions. I noted in my research journal that I was surprised by the ease of these meetings. This experience felt very different from my experience with FCAMHS. Negotiating with the FCAMHS felt very demanding at times, I had to provide a lot of information and respond to many questions. The ward manager at the service at which the research was planned asked relatively few questions. I felt ambivalent about this; I felt pleased that a service had consented and was hopeful that my research project would be able to take place as planned, however the apparent ease of entry left me with a feeling of unease. I began to think about the issue of decision-making and wondered how decisions were made

on the unit. I chose to record some of my thoughts and feelings in relation to entry to the unit.

Hinshelwood and Skogstad (2000) highlighted the importance of initial negotiations with organisations and regarded the consideration of this material as being an important aspect of the initial supervision group meeting. As such, part of the aim of the first supervision session was to consider the material I had made a note of in relation to gaining entry to the service. In the final supervision group meeting, we reflected upon these early conversations and drew parallels between the content of these discussions and the suggested findings from the analysis.

#### **4.1 The observation process and supervision group meetings**

Preparing myself for the observation sessions was an anxiety-provoking experience at times. I began by reading some relevant literature and I attended a seminar session on ‘being an observer’ at a conference entitled ‘observing the unconscious: psychoanalysis and social research’. Hinselwood and Skogstad (2000) describe the importance of adopting an attitude of ‘open interest’ and state the importance of attending to the objective experiences happening, the emotional atmosphere and the observer’s own inner experiences. Prior to beginning the observations, I had been working clinically in a specialist psychodynamic psychotherapy service, under the supervision of a psychodynamic psychotherapist. The importance of keeping in mind the content of conversations and actions of myself and another, whilst attending to transference and countertransference reactions, was a skill I was developing within a clinical context. Whilst I was mindful of the differences between observing a group of

people in an organisational setting and one-to-one work in a clinical context, I felt that these skills would be helpful in preparing me for the role of observer.

Being an observer within the unit evoked a number of strong emotional responses and on occasions these feelings were difficult to manage. At times I felt anxious, felt unwelcome and experienced a sense of hostility from members of the unit. An example of this was when I arrived to conduct supervision session four. As I was waiting to be let into the unit I noticed that the nurse who had come towards the door to let me in, rolled her eyes as she came closer to the door. We made eye contact and I smiled; the nurse did not return the smile. As soon as I entered the unit I became aware of feeling very unwelcome. No-one looked at me and I had to go and find the nurse-in-charge myself. When I had located her she said to me 'we've had a bit of trouble with a patient this morning, it's not a good day'. I felt as though I should not be there, and I did think about whether I should leave or not. I walked over to the chair where I usually sat for the observation sessions and decided to continue. Coping with strong emotional responses was a feature of the observation experience.

Tolerating boredom was a common experience and dealing with the thoughts this engendered was an important part of the observer role. There were also moments of warmth and joy, when I wanted to be part of the group and belong. As part of my role, I endeavoured to pay attention to these emotion reactions and they formed part of my observation notes following the session. I attempted to be as honest and open about these experiences as possible within the supervision session, in order for these responses to form part of the material that was processed within the group meetings.

Being the person responsible for the observation material within the supervision group meetings was a challenging experience at times. Prior to the supervision group commencing I was concerned about doing a good enough job and questioned my ability to adopt the observer stance required by the model. I was also aware that the other group members were taking time out of their work schedule to participate in the group. I was therefore keen that the meetings should be experienced as worthwhile and interesting and my hope was that other group members would be able to learn from the experience as well.

Sharing my observation notes with the other group members felt quite daunting at the beginning; however I soon began to experience the supervision group as a safe space. I believe I was able to adjust to the format of the group meetings quickly, and soon felt comfortable sharing my process notes with the other group members. I was interested in the responses of the group members upon hearing my observation material and I felt that together the group represented individuals who were curious about making sense of the experiences of staff and patients in inpatient services. An aspect of my role was to share my own emotional responses to certain situations; at times this felt quite personally exposing. However, I felt supported in doing this due to the accepting, non judgement stance adopted by the supervision group members.

## **4.2 Data analysis**

The data analysis phase occurred following the completion of the observation sessions, supervision group meetings and transcription of the supervision sessions. I spent time with my academic supervisor discussing my change of role at this stage of the research project. Before this point I had been an integral part of the data collection

process. I had been the person conducting the observations and was immersed in the position the role demanded. I had been a participant of the supervision group, a group whose focus was to process and understand the material I had presented within a psychodynamic framework. I was aware that it was necessary for my role to shift. I felt I was required to approach the data in a curious way, in a way akin to the role of a qualitative researcher.

I believe that a number of key processes helped me negotiate this change of role. My academic supervisor and I made space to discuss this transition within our supervision sessions. I spent time reflecting upon my experience to that point and I shared my expectations regarding analysing the data according to the thematic analysis approach. I re-visited some of the qualitative research literature, in particular the material on thematic analysis (Braun & Clarke, 2006). In addition, I was part of the qualitative support group at the university and found discussions relating to being a qualitative researcher extremely helpful. A further important step in relation to this was the first stage of the analysis process, whereby I was required to read through each transcript whilst listening to the recording of the corresponding supervision group meeting. As I was doing this I was struck by the ‘newness’ of the material I was listening to. Whilst I was a part of each stage of the data collection, I was surprised by the difference each perspective afforded. I became genuinely curious about the data and felt there was a lot to be gained from the qualitative analysis of the material.

When the analysis process began, I felt concerned about getting the analysis ‘right’ and doing justice to the material from the observations of staff and patients on the unit and the supervision group meetings. Supervision with my academic supervisor was



particularly helpful in providing me with the courage to immerse myself in the data and commence coding. Whilst the analysis felt incredibly overwhelming at times, I experienced a great sense of achievement once I had coded all the transcripts and collating the codes into themes was an exciting experience. I felt confident that I had remained close to the data and had given equal attention to all transcripts. I found the use of my reflective diary extremely beneficial at this stage.

### **4.3 Developing the thematic map**

Developing the final thematic map was the stage of the analysis I found the most enjoyable. Throughout the analysis I had made use of a ‘developing themes’ document and I found this extremely useful in moving from coding to searching for themes and generating the initial thematic map of the analysis. I spent time checking the themes worked in relation to the coded extracts and the entire data set. The use of supervision was invaluable at this stage. I presented an initial thematic map to my academic supervisor and shared with her my sense of the map being a good representation of the themes within the data but felt it was ‘a little dull’ and perhaps too repetitive. We discussed this, and through these discussions I was able to refine the specifics of the themes, thus tackling the difficulty I was facing in terms of repetition. We also spoke about the use of ‘in vivo’ quotes to help name the themes. I felt this enabled the map to become more engaging and interesting, something I felt was missing in the initial stages and did not reflect the interest and richness of the data.

#### **4.4. Dissemination of findings**

I am committed to disseminating the suggested findings of the study in a number of different ways. It is my intention to provide feedback to the service at which the observations took place. I am aware the feedback needs to be presented in a way that is collaborative and of use to the staff and the patients on the ward. As part of my research contract, I have planned to meet with my field supervisor following submission of my thesis to consider feedback to the unit.

I also intend to make the suggested findings of this study available to the public through conference presentations and publication in a peer review journal. I have already made arrangements to present at a research presentation conference organised by the university and a special interest meeting for psychologists working with people with psychosis and complex mental health difficulties. I hope both people who have been patients in acute inpatient settings and people who work within such settings will be interested in the suggested findings of my study. I also hope that the methodological approach adopted within the study will appeal to individuals interested in doing qualitatively research differently.

#### **5. The research journey and the supervisory process**

The research journey was both challenging and exciting. I particularly enjoyed watching the project evolve and remained steadfast in my desire to devise a project that was deemed to most appropriately address the research questions. I was aware that the approach adopted within this study was a novel in the way that it integrated psychodynamically-informed observations and qualitative analysis. Overall I found this to be a stimulating process, however at times I felt extremely anxious. Reflecting

upon the research journey as a whole, the most anxiety-provoking time was when the two FCAMHS inpatient services I had approached declined taking part in the project. Whilst I recognised the importance of the units being able to decline the research, I was worried that the project I had spent a long time planning may not come to fruition. I was faced with the notion that I might have to change my project altogether; a potential eventuality I found difficult to cope with.

Research supervision with my academic supervisor was invaluable in supporting me through these times. I did not experience any barriers to supervision and found the supervisory relationship with my academic supervisor to be supportive, enabling and containing. I felt able to talk openly with my supervisor and when presented with challenges, we were able to think creatively about solutions.

The role of my field supervisor was to aid me in setting up the observations, help me prepare for the role of observer and to facilitate the supervision group meetings. My field supervisor had a number of years' experience of working psychoanalytically and had published an observation study. She shared her previous experiences with me and her support and expertise were invaluable in developing my confidence to take on the role of observer and be an active participant within the supervision group meetings.

My academic supervisor, field supervisor and I met at an early stage of the research journey to discuss our respective roles and agree upon a research contract. It was decided that my field supervisor's main role would be in relation to the observations and supervision group meetings and my academic supervisor's role would be to oversee the whole project, keep track of the timeframe and provide guidance

regarding the requirements of a doctoral level thesis and the qualitative research approach. I found this distinction incredibly helpful and having such clarity made it easier for me to attend to my different research tasks at varying stages of the process.

## **6. Reflexivity**

Presenting my emerging analysis at various stages to my academic supervisor, field supervisor, members of the supervision group and participating in the qualitative support group provided an effective way of addressing reflexivity. I endeavoured to feel confident that the suggested finding of the analysis emerged from the data and were not based upon my preconceived ideas or beliefs about the experiences of staff and patients in inpatient settings. Stiles (1993) posits that the expectations a researcher brings to the research, and their internal processes, represent an important part of the investigation, and that these can signify an important source of information in their own right. This appeared to be particularly relevant with regard to my sense of frustration that the initial thematic map did not fully reflect the interest and richness of the data contained in the transcripts. I was encouraged to re-visit the data in order to try and address this concern. My reflective diary was especially useful in allowing me to keep track of my internal process, and thereby remain as open to the data as possible. However, I acknowledge that it would have been impossible for me to prevent my previous experiences and personal beliefs from influencing the research process in some way, and am aware that these factors may have impacted upon my interpretations of emergent themes in the analysis.

## **7. Learning through the research process**

### **7.1 Personal awareness**

Qualitative researchers frequently address subjects that are personally significant and, as such, engage the researcher in a process of self-examination, personal learning and change (Stiles, 1993). I believe my personal awareness has been enhanced in a number of ways. When beginning the research process, I felt I had an interest in working with complexity, the inpatient environment and psychodynamic theory. Carrying out this project has afforded me the opportunity to engage with all of these areas and the research process has confirmed my interest in all aspects.

I have learnt a great deal about the way in which I work. Through conducting this research I realise my need for deadlines in order to achieve and, with an undertaking as large as a doctoral thesis, working to set deadlines was not always part of the process. I reflected upon this at an early stage of my project and, with the help of my academic supervisor, began breaking the research endeavour into smaller projects. This enabled me to plan interim deadlines, an important part of ensuring the research tasks were conducted in a timely fashion. I shared with my supervisor some of my anxieties relating to producing written work that is both interesting and creative and meets the appropriate academic standards. We discussed this and wondered if I had, in the past, been inhibited by the process of writing. With the support of my academic supervisor I feel I have been encouraged to produce written work that is more reflective of my personality and verbal style of communication, whilst remaining aware of the standards required by academic writing.

## **7.2 Learning outcomes**

Conducting this research project has renewed my interest in research in general. I have become very interested in qualitative methodologies and am particularly interested in pursuing the notion of the role of affect in qualitative research. I would value the opportunity to consider further the integration psychodynamic ideas and the qualitative approach to research.

I feel I have gained insight into the complexities associated with carrying out research in inpatient services and have become aware of the challenges faced by clinical psychologists in attempting to balance the demands of research with ongoing clinical commitments. I recognise the importance of regular, reliable and supportive supervision in maintaining motivation and fostering confidence.

I believe I have developed a number of skills throughout the research process. I have learnt a great deal about the psychodynamic approach to observations, the role of the observer and being part of a supervision group. I have developed skills in relation to research design, selection of appropriate methodology, and carrying out thematic analysis. I have also developed an in-depth knowledge of a specific area of research which I would like to build upon in my clinical practice and during future research endeavours.

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**Appendix 1:**  
**Letter of ethical approval**



## National Research Ethics Service

### Derbyshire Research Ethics Committee

3rd Floor  
Laurie House  
Colyear Street  
Derby  
DE1 1LJ

Telephone: 01332 868765  
Facsimile: 01332 868930

20 October 2008

Miss Rebecca Blacker  
Trainee Clinical Psychologist  
University of Leicester/ LPT  
School of Psychology, Clinical Section  
104 Regent Road  
Leicester  
LE1 7LT

Dear Miss Blacker

**Full title of study:** An observational study of an inpatient unit for people with complex mental health difficulties.  
**REC reference number:** 08/H0401/111

Thank you for your letter of 09 October 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice Chair.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

#### Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

#### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority  
*The National Research Ethics Service (NRES) represents the NRES Directorate within the  
National Patient Safety Agency and Research Ethics Committees in England*

WPH 1370

We would also like to draw the following points to your attention:

- As from 3 November 2008 the title Responsible Medical Officer will be replaced with Responsible Consultant and you may wish to change the information sheets, etc to reflect this before commencing your study.
- We noted that there are still one or two typographical errors in the information sheets. We do not consider these to have any ethical implications, but again you may wish to make changes before putting the documents into use.

If you do decide to change any of the documents as a result of the above, please forward revised copies to the REC office with new version number and date and we will acknowledge as a minor amendment.

#### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	AB/139715/1	20 August 2008
Academic Supervisor's CV		20 August 2008
Covering Letter		14 August 2008
Investigator CV		14 August 2008
Letter of invitation to participant	1	14 August 2008
Observation Session Notice	2	14 August 2008
Participant Consent Form: Client	3	02 October 2008
Participant Consent Form: RMO/Doctor/Consultant	2	02 October 2008
Participant Consent Form: Supervision Group	2	14 August 2008
Participant Consent Form: Service Manager Consent for Observation	1	14 August 2008
Participant Consent Form: Staff	3	02 October 2008
Participant Consent Form: Ward Manager	1	14 August 2008
Participant Information Sheet: Client	3	02 October 2008
Participant Information Sheet: Staff	3	02 October 2008
Participant Information Sheet: Supervision Group	2	02 October 2008
Peer Review		15 August 2008
Protocol	9	01 October 2008
Response to Request for Further Information		09 October 2008
RMO Declaration of Capacity to Consent	1	14 August 2008

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

08/H0401/111

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



**Phil Hopkinson**  
Vice Chair

Email: [jenny.hancock@derwentsharedservices.nhs.uk](mailto:jenny.hancock@derwentsharedservices.nhs.uk)

Enclosures:

"After ethical review – guidance for researchers" SL-AR2

Copy to:

Dr Dave Clarke, Leicestershire Partnership NHS Trust

**Appendix 2:**  
**Letter of invitation**

14<sup>th</sup> August 2008

I would like to invite you to take part in a research study. Before you decide whether or not to take part, you need to understand what the research is about and what it could mean for you. Please take your time to read the *Participant Information Sheet* that you will find enclosed with this letter. If you have any questions about the research please contact me by phone or at the address provided.

You do not have to take part in the research if you do not want to.

Thank you for taking the time to read this proposal.

Yours sincerely,

Rebecca Blacker  
Trainee Clinical Psychologist  
University of Leicester

**Appendix 3:**  
**Supervision group participant information sheet**

## **Participant Information Sheet**

I would like to invite you to take part in a research study that I am doing as part of my clinical psychology training. Before you decide whether or not to take part, it is important that you understand what the research is about and what it could mean for you. Please read the following information carefully. If you have any questions about the research please contact me by email, by phone or at the address provided. Please take your time to decide whether or not you want to participate.

### **Title of study**

An observational study of an inpatient unit for people with complex mental health difficulties

### **Principal Researcher**

Rebecca Blacker, Trainee Clinical Psychologist, University of Leicester.

### **Co-Researchers**

Dr Arabella Kurtz, University of Leicester Tel: 0116 223 1650

Dr Anne Goodwin, Nottinghamshire Healthcare NHS Trust. Tel: 01623 785981

### **What is the purpose of the study?**

The first purpose of the study is to consider the ward atmosphere on an acute inpatient unit for people with complex mental health problems. This is to be achieved by using an observation methodology (rather than a questionnaire or interview, for example). The second purpose of the study is to consider the particular observation method used, in order to think about the contribution observation methodologies can make to the consideration of ward atmosphere.

### **Why an observational methodology?**

Much of the recent literature on ward atmosphere relies on the use of questionnaire studies or interviews with members of staff. Compared with a questionnaire study, using an observation methodology allows a more flexible approach, encouraging an in-depth consideration of the subtleties of the ward environment.

### **Why a supervision group?**

This study aims to make use of observations that are informed by the psychodynamic approach. Inherent within this approach is the use of a supervision group. The purpose of this group is to reflect upon the observation material collected and aim to make sense of it according to a psychodynamic framework.

The supervision group will take place during the week following each observation session. The observation and supervision groups will be planned so that an observation will take place one week and a supervision group the next week. This patterned will be followed until the end of the observation/supervision period.

The supervision group will comprise myself, my supervisor from Nottinghamshire NHS Trust and two other clinicians who are experienced in observation methods.

### **Has the study been approved?**



Yes. The School of Psychology at the University of Leicester, my academic and field supervisors, plus the Research and Development Departments at Leicestershire Partnership Trust and Nottinghamshire Healthcare NHS Trust have approved this study.

It has also been reviewed and given a favourable opinion by the Derbyshire Research Ethics Committee (REC), a body appointed by the Strategic Health Authority. It consists of a number of people with various backgrounds, including health care. Their role is to consider the ethical merits of any research and whether the benefits of doing the research outweigh any disadvantages. Research cannot happen without REC approval.

**Do I have to take part?**

No. There is no obligation to take part in the study. Choosing not to take part will not affect you or your role in any way.

**How long will the supervision group sessions last?**

We will meet on six separate occasions. Each supervision group session will last approximately one hour.

**What will happen to me if I decide to take part?**

If you are interested in taking part in the study, you are invited to contact me and/or my supervisor Dr. Anne Goodwin by email, phone or at the address provided. A meeting will be arranged whereby your role in the supervision group will be discussed in more detail. This will also provide you with the opportunity to ask any questions you may have.

If you would like to take part, you will be asked to sign and date a consent form.

If, after you have signed the consent form, you decide that you no longer want to take part in the study you are free to opt-out of the supervision group at any time.

If, throughout the duration of the study, you have any questions you are welcome to contact me or my supervisor by phone, email or at the address provided.

The supervision group sessions will be audio taped with your consent so that they can be typed up and analysed by me at a later date. Once typed up the tapes will be destroyed.

**Will my contribution be confidential?**

Absolutely. Your data, resulting from the transcripts of the supervision group sessions, will be treated in accordance with the Data Protection Act. Information provided by you will be assigned a pseudonym (fictitious name) to protect your identity. Your actual details will be kept separately in a locked cabinet at the University of Leicester. Any information that is kept on the computer will be password protected. Only I will have access to it.

There may be times during the analysis when my research supervisor at the University reads through the transcripts of the supervision group sessions. They won't have access to your information. Your information and transcripts will be kept in a locked place when not being studied. Once the research is over your transcript and accompanying information will be securely kept at the University of Leicester for a period of five years. It will be destroyed after that.

As part of my clinical psychology training it is hoped that my research will be published. It is possible that direct quotes from you may be used in the write-up. All quotes will be kept anonymous.

**What are the benefits of taking part?**

The findings of the study can be used by the Ward Manager and members of the ward to think about what is working well on the ward and areas where changes might be beneficial to the ward environment. In addition, by taking part in the project, you will be contributing to an area of study where ongoing research is required to consider the most useful way to understand factors such as ward atmosphere and the social environment.

**What are the potential risks?**

Being part of a psychodynamic supervision group can be an emotionally demanding experience. As an individual experienced in this type of supervision, it is not expected that this particular supervision group will present any challenge that is outside the realms of commonplace clinical supervision.

I will be available for the duration of my training (up to September 2009) should you need to contact me about taking part. Dr Arabella Kurtz (Senior Clinical Tutor) will also be available should you need to discuss any aspects of the research, especially anything that you are unhappy with.

**What happens if something goes wrong?**

If you have reason to complain about any aspect of the study, the NHS complaints mechanisms are available to you. You may also contact my Academic Supervisor, Dr Arabella Kurtz, at the University on 0116 223 1639.

In the event that something goes wrong and you are harmed during the research because of someone's negligence then you may have grounds for legal action for compensation against Leicestershire Partnership Trust. Please note that you may have to pay legal costs.

**What happens if I change my mind and don't want to participate?**

Your participation is voluntary. If, following the supervision period, you decide you would like your contribution to be withdrawn and you are free to request this prior to data analysis and publication. Your contribution will be removed and destroyed on your request. You do not have to justify your decision.

**What will happen with the results of the study?**

The results will form my thesis that will be submitted as part of my doctorate in clinical psychology. Following this it is hoped that the study will be published in a journal and be presented at a conference.

**I would like to take part. What do I do now?**

I will inform you of the day, date, time and location of the supervision group sessions once a convenient arrangement has been made.

**Contact Details**

Phone: 0116 223 1650

Address: Rebecca Blacker, Trainee Clinical Psychologist, School of Psychology,  
Clinical Section, 104 Regent Road, Leicester, LE1 7L

**Appendix 4:**  
**Supervision group consent form**

**Name of participant:**

**Title:** An observational study of an inpatient setting for people with complex mental health difficulties

**Researcher:** Rebecca Blacker

I agree to voluntarily take part in the above research study. I have read the Participant Information Sheet.

☐

I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

☐

I have not been made to take part in this study and I understand that I am free to withdraw at any time, for any reason, without any penalty.

☐

I have been informed that all information collected about me will be kept anonymous and confidential.

☐

I am aware I can ask questions about the study at any point.

☐

I have been provided with a copy of this consent form and the Participant Information Sheet.

☐

I consent to the supervision group being audio taped with possible use of verbatim quotations in the write-up of the research.

☐

I understand that transcripts collected during the study will be anonymised and may be looked at by supervisors from the University of Leicester and Nottinghamshire NHS Trust. I give permission for these individuals to have access to the transcripts.

☐

Name of participant (print).....Signed.....Date.....

Name of researcher (print).....Signed.....Date.....

Researcher contact details: Rebecca Blacker, School of Psychology, Clinical Section, 104 Regent Road, Leicester, LE1 7LT (Tel: 0116 223 1649)

**Appendix 5:**  
**Staff group participant information sheet**

### **Participant Information Sheet**

I would like to invite you to take part in a research study that I am doing as part of my clinical psychology training. Before you decide whether or not to take part, it is important that you understand what the research is about and what it could mean for you. Please read the following information carefully. If you have any questions about the research please contact me by email, phone or at the address provided. Please take your time to decide whether or not you want to participate.

#### **Title of study**

An observational study in an inpatient unit for people with complex mental health difficulties

#### **Principal Researcher**

Rebecca Blacker, Trainee Clinical Psychologist, University of Leicester.

#### **Co-Researchers**

Dr Arabella Kurtz,	University of Leicester	Tel: 0116 223 1650
Dr Anne Goodwin,	Nottinghamshire Healthcare NHS Trust.	Tel: 01623 785981

#### **What is the purpose of the study?**

The first purpose of the study is to consider the ward atmosphere on an acute inpatient unit for people with complex mental health problems. This is to be achieved by using an observation methodology (rather than a questionnaire or interview, for example). The second purpose of the study is to consider the particular observation method used, in order to think about the contribution observation methodologies can make to the consideration of ward atmosphere.

#### **Why an observational methodology?**

Much of the recent literature on ward atmosphere relies on the use of questionnaire studies or interviews with members of staff. Compared with a questionnaire study, using an observation methodology allows a more flexible approach, encouraging an in-depth consideration of the subtleties of the ward environment.

#### **What is ward atmosphere?**

The term ward atmosphere has previously been defined in many different ways. In general, it is an umbrella term for any social, physical or functional aspects of the ward environment, which may impact on staff and patients.

#### **Has the study been approved?**

Yes. The School of Psychology at the University of Leicester, my academic and field supervisors, plus the Research and Development Departments at Leicestershire Partnership Trust and Nottinghamshire Healthcare NHS Trust have approved this study.

It has also been reviewed and given a favourable opinion by the Derbyshire Research Ethics Committee (REC), a body appointed by the Strategic Health Authority. It consists of a number of people with various backgrounds, including health care. Their role is to consider the ethical merits of any research and whether the benefits of doing the research outweigh any disadvantages. Research cannot happen without REC approval.

**Do I have to take part?**

No. There is no obligation to take part in the study. Choosing not to take part will not affect you or your role in any way.

**What will happen to me if I decide to take part?**

If you are interested in taking part in the study, you are invited to contact me by email, phone or at the address provided if you would like further information about the study. If you would like to arrange a meeting to discuss the study in more depth we will arrange a mutually convenient time and I will come and visit you at the unit.

Once you have had time to think the study, I will ask if you have decided whether or not you would like to take part. If you would like to take part, I will ask you to sign and date a consent form.

If, after you have signed the consent form, you decide that you no longer want to take part in the study you are free to opt-out of the observations at any time.

If, throughout the duration of the study, you have any questions you are welcome to contact me by phone or at the address provided.

During the observation session I will be sitting on the ward at the agreed location. I will not be taking any notes. Following the observation session I will go away and type onto a computer anything I can recall from the observation session.

The content of the observation notes will then be discussed during a supervision group. This group will consist of four people: myself, my supervisor at Nottinghamshire NHS Trust and two other clinicians who are experienced in observation methods. None of the people who are part of this group work on the ward. During the supervision sessions all individuals will be referred to by a pseudonym (fictitious name) to protect your identity. They won't have access to your information.

**How do I find out when and where the observations will take place?**

Before I come to the ward to conduct the observation posters will be displayed around the unit detailing where the observation will take place and on what day, date and time. These posters will be regularly updated so that the correct date and time is displayed.

**How long will the observations last?**

I will visit the unit on six separate occasions. Each observation session will last approximately one hour.

**Will my contribution be confidential?**

Absolutely. Your data, resulting from my notes of the observation session, will be treated in accordance with the Data Protection Act. Information provided by you will be assigned a pseudonym (fictitious name) to protect your identity. Your actual details will be kept separately in a locked cabinet at the University of Leicester. Any information that is kept on the computer will be password protected. Only I will have access to it. The name and location of the ward and unit will be anonymised in order to ensure confidentiality.

There may be times during the analysis when my research supervisor at the University reads through the observation material. They won't have access to your information. Your information and observation notes will be kept in a locked place when not being studied. Once the research is over your transcript and accompanying information will be securely kept at the University of Leicester for a period of five years. It will be destroyed after that.

It is important to note that although all data will be treated in accordance with the Data Protection Act there may be instances when it becomes necessary to break confidentiality. For example, if I observe anything that causes me concern regarding patient care then I have a duty to report this to a line manager. In the unlikely event of this occurring I will discuss my concerns with you as appropriate.

**What are the benefits of taking part?**

The findings of the study can be used by the Ward Manager and members of the ward to think about what is working well on the ward and areas where changes might be beneficial to the ward environment. In addition, by taking part in the project, you will be contributing to an area of study where ongoing research is required to consider the most useful way to understand factors such as ward atmosphere and the social environment.

**What are the potential risks?**

The main aim of this study is to observe the everyday functioning of a ward environment, therefore by taking part you are not be asked to do anything different or in addition to that which you would normally do. In that sense, there are very few risks associated with taking part.

It is recognised, however, that the notion of being observed can be quite anxiety provoking for individuals. This is a natural feeling, which often lessens after the first few minutes. If however you do feel uncomfortable, and decide that you no longer want to take part in the observation, you are free to leave the observation area at any point.

I will be available for the duration of my training (up to September 2009) should you need to contact me about taking part. Dr Arabella Kurtz (Senior Clinical Tutor) will also be available should you need to discuss any aspects of the research, especially anything that you are unhappy with.

**What happens if something goes wrong?**

If you have reason to complain about any aspect of the study, the NHS complaints mechanisms are available to you. You may also contact my Academic Supervisor, Dr Arabella Kurtz, at the University on 0116 223 1639.

In the event that something goes wrong and you are harmed during the research because of someone's negligence then you may have grounds for legal action for compensation against Leicestershire Partnership Trust. Please note that you may have to pay legal costs.

**What happens if I change my mind and don't want to participate?**

Your participation is voluntary. If, following the observation period, you decide you would like your contribution to be withdrawn and you are free to request this prior to data analysis and publication. Your contribution will be removed and destroyed on your request. You do not have to justify your decision.

**What will happen with the results of the study?**

The results will form my thesis that will be submitted as part of my doctorate in clinical psychology. Following this it is hoped that the study will be published in a journal and be presented at a conference.

**I would like to take part. What do I do now?**

You will be informed of the day, date, time and location of the observation by a poster that will be displayed around the unit.

**Contact Details**

Phone: 0116 223 1650

Address: Rebecca Blacker, Trainee Clinical Psychologist, School of Psychology,  
Clinical Section, 104 Regent Road, Leicester, LE1 7LT

***Thank you for taking the time to think about taking part in my study.***



**Appendix 6:**  
**Staff group consent form**



Name of participant:

**Title:** An observational study of an inpatient unit for people with complex mental health difficulties

**Researcher:** Rebecca Blacker

I agree to voluntarily take part in the above research study. I have read the Participant Information Sheet. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

☐

I have not been made to take part in this study and I understand that I am free to withdraw at any time, for any reason, without any penalty.

☐

I have been informed that all information collected about me will be kept anonymous and confidential.

☐

I am aware I can ask questions about the study at any point.

☐

I have been provided with a copy of this consent form and the Participant Information Sheet.

☐

Data protection: I agree to the researcher writing observation notes and I have been informed that these will be anonymised and kept confidential.

☐

I understand that the observation notes collected during the study will be looked at by supervisors from the University of Leicester and Nottinghamshire NHS Trust. I give permission for these individuals to have access to the observation notes.

☐

I understand that if the researcher was to observe any unsafe practice it may be necessary for confidentiality to be broken.

☐

Name of participant (print).....Signed.....Date.....

Name of researcher (print).....Signed.....Date.....

Researcher contact details: Rebecca Blacker, School of Psychology, Clinical Section, 104 Regent Road, Leicester, LE1 7LT (Tel: 0116 223 1649)

**Appendix 7:**  
**Client group participant information sheet**

### **Participant Information Sheet**

I would like to invite you to take part in a research study that I am doing as part of my clinical psychology training. Before you decide whether or not to take part, it is important that you understand what the research is about and what it could mean for you. Please read the following information carefully. If you have any questions about the research please contact me by phone or at the address provided. Please take your time to decide whether or not you want to participate.

#### **Title of study**

An observational study of an inpatient unit for people with complex mental health difficulties

#### **Principal Researcher**

Rebecca Blacker, Trainee Clinical Psychologist, University of Leicester.

#### **Co-Researchers**

Dr Arabella Kurtz,	University of Leicester	Tel: 0116 223 1650
Dr Anne Goodwin,	Nottinghamshire Healthcare NHS Trust.	Tel: 01623 785981

#### **What is the purpose of the study?**

The first purpose of the study is to consider the ward atmosphere on an acute inpatient unit for people with complex mental health problems. This is to be achieved by using an observation methodology (rather than a questionnaire or interview, for example). The second purpose of the study is to consider the particular observation method used, in order to think about the contribution observation methodologies can make to the consideration of ward atmosphere.

#### **Has the study been approved?**

Yes. The School of Psychology at the University of Leicester, my academic and field supervisors, plus the Research and Development Departments at Leicestershire Partnership Trust and Nottinghamshire Healthcare NHS Trust have approved this study.

It has also been reviewed and given a favourable opinion by the Derbyshire Research Ethics Committee (REC), a body appointed by the Strategic Health Authority. It consists of a number of people with various backgrounds, including health care. Their role is to consider the ethical merits of any research and whether the benefits of doing the research outweigh any disadvantages. Research cannot happen without REC approval.

#### **Do I have to take part?**

No. There is no obligation to take part in the study. Choosing not to take part will not affect you in any way.

#### **What will happen to me if I decide to take part?**

If you are interested in taking part in the study, the Ward Manager will ask if you are willing to meet with me to discuss the research in more depth. If you are, I will arrange a meeting with you. This meeting will give us the opportunity to discuss all aspects of the research project and you will be able to ask me any questions you may have.

Following the meeting detailed above, I will meet with you again to ask if you have decided whether or not you would like to take part in the study. If you would like to take part, I will ask you to sign and date a consent form.

If, after you have signed the consent form, you decide that you no longer want to take part in the study you are free to opt-out of the observations at any time.

If, throughout the duration of the study, you have any questions you are welcome to contact me by phone or at the address provided

During the observation session I will be sitting on the ward at the agreed location. I will not be taking any notes. Following the observation session I will go away and type onto a computer anything I can recall from the observation session.

The content of the observation notes will then be discussed during a supervision group. This group will consist of four people: myself, my supervisor at Nottinghamshire NHS Trust and two other clinicians who are experienced in observation methods. None of the people who are part of this group work on the ward. During the supervision sessions all individuals will be referred to by a pseudonym (fictitious name) to protect your identity. They won't have access to your information.

### **How do I find out when and where the observations will take place?**

Before I come to the ward to conduct the observation, posters will be displayed around the unit detailing where the observation will take place and on what day, date and time. These posters will be regularly updated so that the correct date and time is displayed.

### **How long will the observations last?**

I will visit the unit on six separate occasions. Each observation session will last approximately one hour.

### **Will my contribution be confidential?**

Absolutely. Your data, resulting from my notes of the observation session, will be treated in accordance with the Data Protection Act. Information provided by you will be assigned a pseudonym (fictitious name) to protect your identity. Your actual details will be kept separately in a locked cabinet at the University of Leicester. Any information that is kept on the computer will be password protected. Only I will have access to it. The name and location of the ward and unit will be anonymised in order to ensure confidentiality.

There may be times during the analysis when my research supervisor at the University reads through the observation material. They won't have access to your information. Your information and observation notes will be kept in a locked place when not being studied. Once the research is over your transcript and accompanying information will be securely kept at the University of Leicester for a period of five years. It will be destroyed after that.

It is important to note that although all data will be treated in accordance with the Data Protection Act there may be instances when it becomes necessary to break confidentiality. For example, if I observe anything that causes me concern regarding patient care then I have a duty to report this to a line manager. In the unlikely event of this occurring I will discuss my concerns with you as appropriate.

### **What are the benefits of taking part?**

The findings of the study can be used by the Ward Manager and members of the ward to think about what is working well on the ward and areas where changes might be beneficial to the ward environment. In addition, by taking part in the project, you will be contributing to an area of study where ongoing research is required to consider the most useful way to understand factors such as ward atmosphere and the social environment.

**What are the potential risks?**

The main aim of this study is to observe the everyday functioning of a ward environment, therefore by taking part you are not be asked to do anything different or in addition to that which you would normally do. In that sense, there are very few risks associated with taking part.

It is recognised, however, that the notion of being observed can be quite anxiety provoking for individuals. This is a natural feeling, which often lessens after the first few minutes. If however you do feel uncomfortable, and decide that you no longer want to take part in the observation, you are free to leave the observation area at any point.

I will be available for the duration of my training (up to September 2009) should you need to contact me about taking part. Dr Arabella Kurtz (Senior Clinical Tutor) will also be available should you need to discuss any aspects of the research, especially anything that you are unhappy with.

**What happens if something goes wrong?**

If you have reason to complain about any aspect of the study, the NHS complaints mechanisms are available to you. You may also contact my Academic Supervisor, Dr Arabella Kurtz, at the University on 0116 223 1639.

In the event that something goes wrong and you are harmed during the research because of someone's negligence then you may have grounds for legal action for compensation against Leicestershire Partnership Trust. Please note that you may have to pay legal costs.

**What happens if I change my mind and don't want to participate?**

Your participation is voluntary. If, following the observation period, you decide you would like your contribution to be withdrawn and you are free to request this prior to data analysis and publication. Your contribution will be removed and destroyed on your request. You do not have to justify your decision.

**What will happen with the results of the study?**

The results will form my thesis that will be submitted as part of my doctorate in clinical psychology. Following this it is hoped that the study will be published in a journal and be presented at a conference.

**I would like to take part. What do I do now?**

You will be informed of the day, date, time and location of the observation by a poster that will be displayed around the unit.

**Contact Details**

Phone: 0116 223 1650

Address: Rebecca Blacker, Trainee Clinical Psychologist, School of Psychology,  
Clinical Section, 104 Regent Road, Leicester, LE1 7LT

***Thank you for taking the time to think about taking part in my study.***

**Appendix 8:**  
**Client group consent form**

**Name of participant:**

**Title:** An observational study of an inpatient unit for people with complex mental health difficulties

**Researcher:** Rebecca Blacker

I agree to voluntarily take part in the above research study. I have read the Participant Information Sheet. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

☐

I have not been made to take part in this study and I understand that I am free to withdraw at any time, for any reason, without any penalty or loss of benefits.

☐

I have been informed that all information collected about me will be kept anonymous and confidential.

☐

I am aware I can ask questions about the study at any point.

☐

I have been provided with a copy of this consent form and the Participant Information Sheet.

☐

Data protection: I agree to the researcher writing observation notes and I have been informed that these will be anonymised and kept confidential.

☐

I understand that the observation notes collected during the study will be looked at by supervisors from the University of Leicester and Nottinghamshire NHS Trust. I give permission for these individuals to have access to the observation notes.

☐

I understand that if the researcher was to observe any unsafe practice it may be necessary for confidentiality to be broken.

☐

Name of participant (print).....Signed.....Date.....

Name of researcher (print).....Signed.....Date.....

Researcher contact details: Rebecca Blacker, School of Psychology, Clinical Section, 104 Regent Road, Leicester, LE1 7LT (Tel: 0116 223 1649)



**Appendix 9:**  
**Excerpt of observation notes**

*I walked over to the chair I usually sit on. As I sat down I was struck by how close together Debbie and I were. I wondered what impact there might be of having another observer on the ward during my observation session. I looked around the room. The Christmas decorations were as they were during my previous observation session. The only difference I noticed was that there were a number of small bowls on each of the tables with wrapped chocolates in them. The television was switched on, however the volume appeared to be very low. It was not audible from where I was sitting. There was one patient seated on the comfy seats area. She was sitting on the two seater sofa to the left of the semi circle. She appeared to be watching the television.*

*Three members of the nursing staff were gathered around the staff table (Maureen, Kim and Alex, all staff nurses). They were all standing and talking quietly to each other. The staff table was covered with files and pieces of paper. The door to the unit opened. A member of staff I did not recognise walked into the dayroom area, followed closely by a patient called Laura. Kim walked over to meet them. 'I've just walked her over' said the member of staff 'she didn't seem too steady on her feet'. 'Okay. Thanks' said Kim. Laura walked over to the two dining tables, looked around and took a seat at the dining table nearest to where Debbie and myself were seated. She sat on the chair and put her head on her arms on the table 'I feel faint, I feel faint' Laura said in a rather loud voice 'Honestly, I'm not very well'. I felt concerned about Laura and looked over at the staff. No one responded. Laura started to make a noise, which sounded like crying. She still had her head buried into her arms. I looked over at the staff again.*

**Appendix 10:**  
**Excerpt of reflective diary**

*Comments on the observation data:*

*Something about the mess of the ward and the files and papers (could call this physical mess?) that is hard to bear (both from my perspective and the staff's perspective – evidence in the urge to tidy up). Supervision session 2 pp. 21- 22*

- *Compare this with 'emotional mess'. Is this hard to bear? Therefore striving for a 'settled', 'calm' environment?*

*There appears to be a lot of focus on what is happening in the staff room. Is it busy there? There seems to be a lot of movement into and out of the staff room. Is the excitement there? Supervision session 2 p. 34*

- *Compare this to the boredom and disinterest seemingly apparent in the dayroom*

*An issue of groups. Which group do you belong to? Appears to be important to know which group you belong to. Supervision session 3. As an observer I feel I am in a group of my own.*

*'Not very exciting here' Supervision session 4, p45. Maybe the reality is that it's not very exciting? Is this linked with safety? The need to keep things safe?*

**Appendix 11:**  
**Researcher's position**

The current research project was chosen based upon the researcher's previous clinical experience and special interests. The researcher had worked for a number of years in inpatient settings and had found the experience to be both challenging and intriguing. Of particular interest to the researcher was the potential impact of the social environment upon the individuals both working and living within such settings.

As the research endeavour began, the researcher became particularly interested in the concept of pragmatism. Maxcy (2003) stated that the aim of inquiry for pragmatists was not to seek a truth that is independent from human experience, but to achieve a better, richer experience. The author posited this could be through scientific analysis, artistic exploration, social negotiation, or any combination of different approaches that is regarded as affective (Maxcy, 2003). Throughout all phases of the research process the researcher has adopted this position.

**Appendix 12:**  
**Additional supporting quotes**

## **1. Main theme: Fear of engagement**

### **1.1 Sub-theme one: ‘It’s almost like the staff are behind a Perspex screen’:**

#### **difficulty making a connection**

Participant A used an analogy of a Perspex screen (an analogy used previously within the supervision sessions) to illustrate a member of staff’s difficulty connecting with a patient:

*“I was thinking about what you, about Maureen, and I think there was almost a Perspex screen between her and Billy, so she could see it but actually there was no connection” (6, participant A: 521-523).*

Participant A made the following comment in response to hearing a section of the observation material:

*“There is so much ignoring going on, isn’t there” (8, participant A: 197)*

### **1.2 Sub-theme four: The Breakfast Party: rare moments of excitement**

A supervision group member discusses the ‘bursts of excitement’:

*“yeah, there is a kind of running theme of a sort of a very sort of quiet, still, not very much happening, and then these like bursts, almost like bursts of excitement. Be it about breakfast or be it about chocolates or be it about nights out or you know” (8, participant B: 254-257).*

### **1.3 Sub-theme five: Lack of purposeful activity: restlessness in the dayroom**

Several members of the supervision group commented on the movement in the dayroom:



*“It’s like there is lots of movement but nothing changes, there are lots of people, but everything is the same. So even though it’s different people” (3, participant D: 961-963).*

*“People seemed to get up and move around a lot. So there is this kind of table where staff seem to sit, and it feels like there is always at least one person sitting at that table, it felt more often than not there was more than one. But people wouldn’t sit there for very long, you know, maybe five minutes maximum before they had other things to do or other place to be or .... And so it’s just that the configuration would change” (3, participant B: 937-943).*

#### **1.4 Sub-theme six: ‘The off-duty and the link of the boat to dry land’: a desire to be somewhere else, somewhere normal.**

A supervision group member grapples with the notion of normality:

*“It just feels like there is something that is important about not being, having a normality. Making sure you continually refer to outside to keep yourself connected, outside is real, this place is weird (laughs). I don’t know if that is because people get worried about being, you know someone is coming in who is poorly does that mean they believe something that someone says, I don’t know ?? don’t want to talk too much about their delusions because it might start making them more concrete” (9, participant D: 871-878).*

The link between the off-duty and being somewhere else is discussed with the supervision group:

*“Its interesting though isn’t it because it’s an off-duty isn’t it? It’s when you’re off, doing something else, when am I next off, I’ve got to do this, I’ve got to go and make a phone call, I have got to be away from everyone, I have got to go and do a poster, I have got to go and take a urine sample, I have got to go and do this, I have got to be away from this place” (3, participant D: 917-922).*

## **2. Main theme: A state of confusion**

### **2.1 Sub-theme one: Tolerating the uncertainty: the decision-making process is hidden**

A member of the supervision group discusses the decision-making process

*“the fact that actually what we are trying to do when we work with people is to help them tolerate that uncertainty, that middle ground. Rather than kind of splitting things off to cope. And so actually some of that, the difficulty and symptom presentation is mirrored by the environment, of how it is presenting in the environment. Because no one can tolerate that or be open about or discuss or think through some of that complexity and the decision making or the uncertainty, that is not there, its kind of pushed away” (8, participant D; 1054-1062).*

### **2.2 Sub-theme two: “Can I have some water?” is not a simple question: small decisions are highly complex**

A member of the supervision group commented on the movement in the dayroom:

*“Yes it’s making me think about complexities and how a small decision can actually, can actually be so many different factors and it’s actually quite a complex entity itself. And how do you deal with complexity, you know what.*

*But yes what you see on the ward and what you experience is quite sort of calm, almost straight forward, simple you know. The patients sit and watch the TV or make their drinks, and the staff sit and do their paperwork and whatever. It's all very sort of simple really, yet actually what we are talking about is quite complex"* (8, participant B, 1014-1022).

### **2.3 Sub-theme three: 'It feels very much like there is no identity': who's who and what is my role?**

*"It's interesting how people swapped over then (yes) and how erm I just wonder whether that's people just come and go and blend into one (laughs) one kind of blob"* (8, participant D: 230-232).

### **2.4 Sub-theme four: 'The dayroom's like an open-plan office: confusion regarding function and use of space.'**

A member of the supervision group thinks about the communal space as an office:

*"So then it becomes more like rather than a patient communal space where you can talk and interact, it then becomes almost like an office [mmm] where people are working and you should be quiet. So the function of keeping everything quiet, because is it about the staff need to keep it quiet so they can do their work and get on with the paperwork, or is it about a client need to keep every one calm and contained because of the worry of people kicking off"* (8, participant D: 408-414).

### **3. Main theme: Alone and responsible: ‘the responsibility is actually terrifying’**

#### **3.1 Sub-theme two: Importance of maintaining group identity and keeping groups separate**

The observer reflected upon the notion of the separate groups within the dayroom area:

*“It’s kind of, everyone having their spaces it is very tangible actually”* (3, participant B: 246-249).

#### **3.2 Sub-theme three: The ‘I love you incident’: anxiety about the wider perspective**

A discussion between supervision group members regarding the notion of boundaries, responsibility and taking a risk is detailed below:

*“And then it all kind of cut it quite dead again didn’t it. That was quite interesting, the impact of that, and the kind of boundaries, and how the staff are trying to work with those boundaries and not over step the mark and what it does to the interaction”* (4, participant D: 278-282).

*“Because when we think about people in recovery you need some kind of emotional connection, some kind of moving forwards. I would imagine if I was kind of really distressed having something really robotic and mechanical it might get the job done, but that kind of emotional connection might be what I was looking for. And that’s why it felt so nice because she was thinking oh I have made this connection, and then its like no that’s too much. So it was making me wonder about safety, whether its safer to be mechanical and*

*whether staff worry about over stepping the mark or whether, how it all fits”*  
(4, participant D: 361-370).

*“Yes because I wonder, there is that kind of wider societal and kind of organisational stuff of if someone puts in a complaint what happens there. And that must pray on peoples minds about whether or not they do let themselves become ??? have contact with clients at a different level it like is that ok, was that not ok, I’d better not take the risk. I know we were talking last time about risk and difference felt very frightening, and whether that’s about trust as well, how much people can rely on trust that they will get support or they can take the risk or how much to take. And I wonder whether that keeps that kind of erm flatness going rather than change”* (4, participant D: 582-592).

**Appendix 13:**  
**Chronology of research process**

<b>Summary of research activity</b>	<b>Date</b>
Initial research proposal submitted	May 2007
Meeting with university Research Committee panel	June 2007
Ethics submission	September 2008
Began data collection	November 2008
Initiated analysis of data	November 2008
Completed data collection	January 2009
Complete analysis of data	February 2009
Write-up period	December 2008 – May 2009
Dissemination	May/ June 2009