Portfolio Volume 1: Major Research Project

Mental Health Nurses' Experiences of Non-Disclosure within Individual Clinical Supervision

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Abstract

The aim of this research was to explore the experiences of inpatient mental health nurses' use of nondisclosure within their individual clinical supervision. Nondisclosure was defined as the intentional withholding of information for example, personal, professional or relational by a supervisee or supervisor within clinical supervision. As this is the first time the phenomenon of nondisclosure has been looked for within nursing clinical supervision, a qualitative design was utilised in order to gain a rich description. Experiences were collected from 10 participants via semi-structured interviews and a thematic analysis was carried out on the data. The analysis indicated that participants did utilise nondisclosure and five main themes were identified: *expected to be a superhuman*, *you work with them more than your family*, *a poorly defined space*, *relationally unsafe*, and *strategies to stay safe*. These themes operated on an individual level, structural level and cultural level. The findings point to the importance of creating a regular and structured space, that is clearly defined and understood by both supervisee and supervisor, and one that feels predictable and safe. This finding was is in line with existing research in therapeutic supervision. Previously unreported findings included the internalised belief that nurses need to be 'superhuman' and the important interactions of the team in an environment that requires cooperation to be effective. These interacted with the other findings to create an environment that facilitated nondisclosure.

Chapter one - Introduction

An important focus

Nurses have been described as the backbone of any health system (WHO, 2020) whose roles over the last few decades have grown to encompass more and more responsibilities (Fowler & Cutliffe, 2011). Nursing numbers within the NHS continue to fall however, which impacts on all areas of the healthcare system (NHS, 2019a). This problem was only compounded by the global pandemic which led to high rates of burnout among nurses (Galanis et al., 2020). Clinical supervision can be a place for learning, growth, support and restoration (Proctor, 2011) and to maximise its effectiveness barriers such as nondisclosure need to be explored and understood.

Epistemological position

This research has been viewed through the lens of a critical realist. This position has been adopted as critical realism aims to provide a position that retains a concept of truth whilst recognising that human experience always shapes how we understand and experience truth (Braun & Clarke, 2022). The researcher is therefore assuming that the data collected will be able to inform an understanding of the 'real world' however, it will not necessarily be able to provide a direct reflection, and so interpretation will need to be conducted (Willig, 2013). How nurses make meaning of their experiences of nondisclosure can be considered to be socially constructed, with the potential for multiple truths derived from context, beliefs and values. However, the phenomenon of nondisclosure itself has a material basis and retains a concept of truth (Joffe, 2011).

A further reason why this position has been adopted is that as a programme, the clinical psychology doctorate at the University of Hertfordshire leans towards viewing knowledge through a social constructionist lens. Nursing, with its routes traditionally within the medical model may view knowledge more through a realist lens. Utilising a critical realist position therefore provides a potential bridging context through which the traditional research of the institution and the need for links with clinical practice can be maintained.

A comment on terminology

Nondisclosure will be discussed in detail in the systematic literature review, however for ease, this research defines nondisclosure as the intentional withholding of information for example, personal, professional or relational by a supervisee or supervisor within clinical supervision, that has the potential to result in a negative clinical outcome for those involved. This form of nondisclosure is therefore defined by the supervisee in their choice of response. This definition was subsequently used in the shaping of the interview schedule It is important to note that not all nondisclosure should be considered to be a negative. In some instances, it may be a sign of supervisees navigating the power dynamic within the space or it may be due to the content not impacting on clinical work (Mehr, Ladany & Caskie, 2010). Ultimately this research is looking at nondisclosure within a supervisory space not a therapy space, where unlike personal therapy, the ultimate goal is to improve patient care through professional development (Yegdich, 1999; Hyrkäs, et al., 1999).

The researcher acknowledges that the term nondisclosure can hold different meanings across different contexts and therefore might be considered imperfect and controversial. A search for the term in a medical database like PubMed, for example, will show nondisclosure frequently used to refer to openly discussing medical conditions which

come with social stigma (e.g HIV), whereas a search through the psychological literature will mainly locate nondisclosure within the withholding of information by a client in a therapeutic space. The definition used in this research is based on the existing literature into nondisclosure within clinical supervision (Hess et al., 2008; Mehr et al., 2010; Sweeney & Creaner, 2014; Singh-Pillay & Cartwright, 2018; Cook et al, 2020). This definition is being used so as to be comparable with existing literature whilst the researcher acknowledges that there is not a single, universally agreed, definition; this aligns with the epistemological position of a critical realist.

There is no single agreed definition for clinical supervision, however its core fundamentals can be described as a process of professional learning and skills development through the use of reflection, which is held regularly with another professional, and separate to managerial supervision (HCPC, 2021). It has also been described as an 'ethical and professional expectation' (BPS, 2017). The researcher acknowledges these are psychological definitions of clinical supervision, but as will be discussed later, an accepted nursing definition for supervision is an ongoing endeavour. Unless stated otherwise, when the term 'supervision' is used it is referring specifically to clinical supervision among nurses.

Participants in this research are all registered mental health nurses, for the purpose of this research they will be referred to simply as nurses.

An aspiring psychologist amongst nurses – a fox in the hen house?

It is important to acknowledge that this research has involved the discipline of psychology analysing the supervision practices of the nursing discipline. This could be misinterpreted as psychology evaluating or judging nursing; indeed, a discourse already exists within nursing around the negative consequences of supervision being imposed by other professionals (Royal College of Nursing, 2019). It is crucial therefore, that the purpose

of this research is understood to be primarily the search for the nondisclosure phenomenon

which has already been highly researched by psychologists (Mehr et al., 2010; Sweeney &

Creaner, 2014; Huntman & Ellis, 2019). As an addition, the findings of this research will

hopefully be of interest to the discipline of nursing, for example with clinical governance

and in line with the recommendations of the Mid Staffordshire Report (Francis, 2013).

Although this phenomenon could be effectively looked at from a purely nursing

perspective, there are advantages for both disciplines in having a jointly held perspective

with clinical psychology. Psychological theory can offer an understanding of certain

underlying constructs that may inform nondisclosure within clinical supervision; for

example, relational safety. Relational safety within supervision, refers to the development

through co-creation of a context where both supervisor and supervisee are able to raise

questions, challenge points of view, ponder issues, confront opinions, articulate ideas, and

express concerns (Hernández & McDowell, 2010). The concept of relational safety also

provides a framework to look at power difference and intersectionality within the

supervisory space and may allow for hypothesising if the current study finds similar

challenging supervision experiences to those reported in previous literature.

As a Trainee Clinical Psychologist, the researcher is able to bring an outsider stance

to the research. There are advantages to such a stance, such as; being viewed as an

independent, non-judgemental outsider (Bonner & Tolhurst, 2002) which may lead to

participants feeling more comfortable and less scrutinised when discussing potentially

sensitive topics. There are however disadvantages of the outsider stance including

challenges caused by not understanding subtle cultural nuances (Bonner & Tolhurst, 2002).

It was therefore important that the present research included a nurse consultation team as

well as a nurse on the supervisory team, as this provides an opportunity to present an insider view. In her review of the literature, Kerstetter (2012) describes the 'space in between' highlighting that rarely do researchers solely occupy an outsider or insider stance. Indeed, although not a nurse, the lead researcher has worked closely alongside nurses for several years in a range of settings. This both/and approach should allow for a richer interpretation of the data.

Finally, adding to the literature in this field will provide clinical psychologists with a more detailed account of how the phenomenon of nondisclosure influences nursing supervision. From a research perspective, this sheds light on similarities and differences across disciplines and from a practitioner perspective, it will support clinical psychologists who deliver supervision and training in how best to deliver supervision, to nurses.

Rationale for the current study

The rationale for this research can therefore be broken down into three parts. Firstly, to see whether the phenomenon of nondisclosure is present in other disciplines who utilise clinical supervision. This would expand research into the field and develop our understanding of nondisclosure. There are a number of possible disciplines, each equally suitable, however it was outside the scope of this doctoral thesis to look at multiple professions simultaneously. Nursing was chosen over other options by the lead researcher due to a personal resonance with the discipline originating from personal and professional experience. Additionally, within the NHS, the nursing progression represents a large body in terms of numbers and so choosing this discipline could potentially be more impactful on the day-to-day role of the mental health service provision.

Secondly, clinical supervision is embedded into the practice of clinical psychologists, so much so that clinical psychologists are often asked to supervise those from other disciplines, both individually and in groups, as well as, deliver training on supervision. It is therefore important for

clinical psychologists to have an awareness and understanding of nondisclosure and how it might

impact on their facilitating or training of supervision, which this research can inform.

Thirdly, with an increasing drive to embed clinical supervision within nursing (NHS England,

2021) this research may be of interest to colleagues in the nursing discipline. This was one reason

why the research included a nurse consultation team and a senior nurse on the supervisory team to

continuously check that the research remained meaningful to nursing.

Defining Clinical Supervision in Nursing

It can be helpful when discussing a topic to begin by defining it. In the case of clinical

supervision in nursing, this has continued to be a challenge. Since its inception within the

NHS in the early 1990s, multiple definitions have been offered but no clear consensus

reached (Hyrkäs, et al., 1999; Yegdich, 1999; Davey et al., 2006; Grant & Townend, 2007;

Buss & Gonge, 2009; Milne & Watkins Jr., 2014; Driscoll et al., 2019; NHS Education for

Scotland, 2021).

In addition, over the years new meanings have been added to meet different

professional and educational aims which have had the effect of further congesting the

meaning of the term, leading Buss and Gonge (2009) to observe that the term 'clinical

supervision' may be the only common denominator. This notable lack of definition is likely

to be one of the main reasons why effective clinical supervision has tended to remain an

aspiration rather than a reality (Grant & Townend, 2007).

The original definition put forward by the Department of Health (DoH) in 1993

described clinical supervision as a 'formal process of professional support and learning

which enables individual practitioners to develop knowledge and competence, assume

responsibility for their own practice and enhance consumer protection and safety of care in

complex situations' although this definition has been added to by others over the years

(Driscoll et al., 2019). For example, supervision has been described as a place for

consultation, mentorship, job management (Hyrkäs, et al., 1999), clinical teaching of specific

therapeutic skills (Yegdich, 1999) and the practice of two professionals with a declared

interest examining a piece of work (Butterworth, 1997). Davey et al. (2006) observe that

although there is not a single definition there are common themes and Driscoll et al. (2019)

conclude that supervision is concerned with those subjects the supervisee chooses to reflect

on in line with their continued professional development.

One main difficulty with a lack of clear definition is differentiating clinical supervision

from managerial supervision and individual therapy. Managerial supervision differs from

clinical supervision as it is hierarchical in nature, and concerned more with operational and

management issues. It has been argued that within this hierarchy, supervisors might

manipulate supervisees to meet the goals of the organisation though administrative

principles (Yegdich, 1999). Clinical supervision, however, is considered more democratic

placing an emphasis on relationships with the supervisee-client and the relationship within

supervision (Faugier, 1997; Davey et al., 2006). Although a main component of clinical

supervision is the development of skills through the use of personal and professional

reflection (Faugier, 1997; Davey et al., 2006) unlike personal therapy, the ultimate goal is to

improve patient care through professional development (Yegdich, 1999; Hyrkäs, et al.,

1999).

Other challenges have arisen caused by the tendency to interpret models of

supervision at a local level to meet specific needs which in turn makes generalisability

difficult (Yegdich, 1999). It is however also possible that the opposite is true; a global

definition might be hampered by the broad scope of domains nurses practice in.

In the near 30 years since clinical supervision was introduced into nursing within the

NHS, a single definition has yet to be identified, however commonly recognised themes are

becoming more widely accepted. This lack of definition however may act as a barrier to it

being rolled out consistently and why it is still considered a voluntary exercise.

The following sections will give an overview of the literature looking at clinical

supervision within nursing, specifically: its history, different models, agreed structure,

evaluations of its effectiveness, barriers to its implementation and experiences of those

accessing it.

History

Early History.

Early evidence of modern clinical supervision in nursing dates back to America in the

1930s, where it was noted that nurses had a need for clinical supervision to be able to

reflect on their practice (Fowler & Cutliffe, 2011). At the time, supervisory practices were

informed by the supervision being conducted in the industry and education sectors, as well

as supervision within psychoanalysis (Yegdich, 1999).

Fowler and Cutliffe (2011) provide an excellent account of the early supervision

history of nursing in the UK; this review will take from their work to provide a brief

summary. In the UK, during the 1970s, nursing began changing operations from a

hierarchical model in which senior nurses identify tasks before allocating them to junior

nurses, to a more holistic approach whereby a single nurse plans and delivers care to a

group of patients (Fowler & Cutliffe, 2011). Clinical responsibility began to move away from

the senior nurse or consultant and instead the individual nurse was accountable. This

approach also meant that the apprenticeship approach was replaced with an educational

one resulting in the structures of supervised practice and quality assurance being weakened

(Fowler & Cutliffe, 2011).

Other changes that occurred during the 1970s and 80s included the reduction in

overlapping time between shifts in a drive to be cost effective. The overlap period had until

that point been used to conduct many elements commonly seen in supervision such as

training and support. The significant developments in community-based care also meant

those entering inpatient setting were more acutely unwell, whilst pressures on beds meant

patient turnover was much higher. All this led to a situation whereby the intensity of the

work increased whilst the support systems decreased (Fowler & Cutliffe, 2011).

In the 1990s Butterworth and Faugier (1992) were among the early pioneers in

advocating for nurse supervision, offering models for the its provision and mechanisms

through which it could be drawn into practice. Clinical supervision for all nurses was

subsequently endorsed by the DoH in their 1993 Vision for the Future government paper

(Davey et al., 2006). It was the first time that clinical supervision had been defined and its

structure outlined. It described several components including the improvement in standards

of patient care, enhancement of understanding of practice and further developments of

skills and knowledge (Fowler & Cutliffe, 2011).

High profile legal inquiries at the time, such as the Allitt inquiry in 1994 which looked

into the unlawful killing of children by nurse Beverley Allitt, also led to an increased focus on

nursing supervision. However, Yegdich (1999) highlights that inquiry recommendations did

not refer to clinical supervision, focusing rather on managerial supervision. Cultural shifts to more risk-adverse practice also occurred as a result of inquiries; these will be discussed in more detail in the evaluation section.

Policy.

In 1996 the UKCC (now NMC) gave a position statement on clinical supervision endorsing its use and providing principles for its implementation (Sloan, 2011). Among others these included, allowing every practitioner access to supervision, having agreed ground rules, providing training for supervisors and having a method of evaluation (Sloan, 2011). Although this statement was an important step in cementing supervision into nursing practice, Driscoll et al. (2019) note that clinical supervision is not a mandatory requirement for UK nurses, and that the NMC does not have a policy or standards for organisations or nurses to follow in relation to clinical supervision. The exception to this is midwives, who have had statutory supervision outlined since the 1902 Midwives Act (Department of Health, 2000). Additionally, Driscoll et al. (2019) comment that there is no agreed or accredited training for new clinical supervisors, and it is unclear what constitutes ongoing support for supervisors.

With the Release of Agenda for Change in 2004, there was increasing interest in the role of the organisation in supporting the development of nurses through the use of approaches like clinical supervision and preceptorship (Davey et al., 2006). The importance of this organisational focus was highlighted by Grant and Townend (2007) who remarked that nursing supervision had often been viewed simply as an interaction between supervisor and supervisee and did not take into account the broader organisational and cultural context that shape the supervisory space. They expressed the importance of viewing nurses

within the moral, cultural and professional climate of needing to demonstrate competence and accountability.

Following the implementation of the Health & Social Care Act 2012 major changes were made to how NHS care was commissioned with the aim of improving efficiency, effectiveness and accountability (Health & Social Care Act, 2012). Following the act, the NHS standard contract was released in 2013 and has been updated annually.

A quick word search for 'supervision' within The Health & Social Care Act 2012 and another nursing policy document: Leading Change, Adding Value A framework for nursing, midwifery and care staff 2016, identifies one reference in the Health & Social Care Act pertaining to the provision of supervision for social workers and guidance for midwifery supervision in the Leading Change document. This is similar to the Principles for Preceptorship booklet released by the NMC in 2020 which only discusses supervision for midwives. Although hardly a rigorous methodology, the findings are interesting and asks the question how talked about is supervision at a strategic level and how much is it considered part of the solution. The NHS standard contract does mention the provision of clinical supervision making sure all staff receive "proper and sufficient continues professional and personal development, clinical supervision, training and instruction" however, it does not give any further specifics or guidance for non-midwives (NHS, 2013; NHS, 2016; NHS, 2019b).

The regulator for health and social care in England (CQC) has produced guidance for the implementation of effective clinical supervision (CQC, 2013). Under regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staff must receive "support, training, professional development, supervision and appraisals that are necessary

for them to carry out their role and responsibilities" (CQC, 2022a). The guidance and

regulation do not specify the length or frequency of supervision, which potentially could

lead to a wide range of interpretations.

Trusts now have supervision policies and although there are differences between

them, most define clinical supervision (with some separating it from managerial

supervision), give guidance on its use and training, as well as, details on the frequency and

duration. Some trusts also use a supervision record to have a written account of supervision

discussions and actions. Davey et al. (2006) discuss the policy-practice divide and reflect on

the level of supervision nurses are actually receiving. It is also unclear how clinical

supervision is evaluated, beyond a record of its having happened, and what this evaluation

would look like; this will be discussed further in the evaluation section.

Training and Retention.

Nursing numbers have gradually fallen in recent decades, with Davey et al. (2006)

noting that the NHS had overlooked approaches to support the retention of nurses, as

historically there had always been a supply of new recruits. In 2000, The Last Straw report

looked into the shortages in nursing, highlighting that without improvements to nurse

workloads and working conditions, retention would be increasingly difficult (The King's

Fund, 2020a). In 2019, although central collection of data had stopped in 2010, it was

estimated that 93% of trusts were experiencing an acute nursing shortage Taylor et al.

(2019), with the Interim NHS People Plan (2019a) estimating that there was a shortfall of

40,000 nurses nationwide. Additionally, the current workforce profile for nurses is aging and

in 10 years almost a third of nurses will be eligible for retirement (Taylor et al., 2019). There

is some optimism in that a recent study found that clinical supervision and preceptorship did

improve retention by improving skills, engagement and satisfaction (Aparício & Nicholson, 2020).

Nurse training changed in the new millennium with the nursing qualification being increased to a graduate-level in 2009, reflecting the growing demands and responsibilities placed upon nurses such as becoming prescribers. Subsequent research found that the greater the proportion of nurses with degree-level education, the better patient outcomes; however, it was unclear why this was the case (Barrett, 2016). In 2010, the Preceptorship Framework was released which aimed to ensure high-quality preceptorship for up to two years post-qualification (DoH, 2010). Preceptorship, or support for newly qualified staff, had been suggested as a practice since the Project 2000 review in 1986 (Lord, 2002). The Preceptorship Framework highlighted the need for guided reflection through supervision and suggested around 18 hours across the preceptorship (DoH, 2010). Although strongly recommended, preceptorship is not mandated with NHS providers being "obliged" to provide a period of preceptorship (Royal College of Nursing, 2021).

A new focus seems to be being directed at clinical supervision within nursing, and this may have been in part as a result of the unprecedented pressures placed on nurses during the Covid-19 pandemic. In 2021, NHS Scotland released their Clinical Supervision: Nursing and Midwifery Workforce Position Statement. The aim of the statement was to develop a national framework for clinical supervision by differentiating the different types of supervision and providing practical interpretations of the different components of supervision (NHS Education for Scotland, 2021). Likewise in England, as part of its Long-Term Plan, the NHS launched the Professional Nurse Advocate (PNA) programme, a masters level programme training nurses to deliver restorative clinical supervision, develop cultures of

learning, and monitor and improve care. The programme aims to train 5000 nurses and is

currently being evaluated alongside its implementation (NHS England, 2021). The most

recent NHS Standard Contract makes specific and detailed reference to the PNA programme

and that all registered nurses should have access to restorative supervision (NHS Standard

Contract, 2022/23).

Clinical supervision has been established within nursing in the NHS for around 30

years. However, despite it being widely recognised that nurses benefit from supervision

throughout their career (Driscoll et al., 2019), it continues to not be consistently

implemented. It appears that nursing's history of, and relationship with clinical supervision

is a complex one.

Models

There have been a number of models put forward for nursing clinical supervision;

this section will summarise several of them. Within the UK the most widely used is Proctor's

model (Buus & Gonge, 2009; Sirola-Karvinen & Hyrkäs, 2011; Sloan, 2011; Franklin, 2013;

Driscoll et al., 2019) which has been used in both clinical and research settings.

Proctor's model incorporates three elements to supervision: *normative*, *formative*

and *restorative*. The normative element addresses accountability and focuses on monitoring

and maintaining the supervisee's clinical practice. The formative element addresses learning

and the continued development of skills and abilities, whilst the restorative element is

responsive to the emotional needs of the supervisee whilst engaging in demanding clinical

work (Driscoll et al., 2019). The model is described as a supervision alliance model and

emphasises that clinical supervision involves more than two stakeholders, all of whom

should be respected; however, the key figures are the supervisee and the supervisor

(Proctor, 2011). The development of a good working relationship is therefore important and can be supported through the use of contracts and agreements (Proctor, 2011).

Another model of supervision is the resilience-based clinical supervision (RBCS) model (Stacey et al., 2017). It evolved from findings that the transition from being a student to being newly registered was a stressful period for nurses and that nurses who left the profession cited their reasons as lack of support, poor work environment and the emotional impact of the role (Stacey et al., 2017). Resilience is the ability to resist adversity and respond in a positive manner. RCBS draws upon the theoretical underpinnings of compassion-focused therapy that behaviour is motivated by three emotional regulatory systems: a desire to protect oneself, to compete for achievement and to soothe and reach contentment. Each system can be beneficial but it is the ability to recognise which system will be the most beneficial in any given situation to provide an effective response is what is developed in RBCS. This is completed through a combination of teaching, mindfulness and reframing (Stacey et al., 2017).

The new PNA programme being rolled out by NHS England utilises the advocating and educating for quality improvement (A-EQUIP) model. A-EQUIP incorporates the three elements of Proctor's model and adds a fourth element: quality improvement. A key part of the model is its use of restorative supervision to address emotional needs and developing clinical leadership. Its overall aim is to mitigate workplace stress and improve overall emotional wellbeing by promoting reflection of personal emotions and practice (NHS England, 2021).

Franklin (2013) reviewed the literature of models of clinical supervision for nursing students in Australia. Although the literature highlighted that quality clinical supervision was

"the pivotal cornerstone for successful clinical placements", Franklin commented that the large number of models made it difficult to ascertain which was the best approach for student nurses. Three main models included the preceptor model, facilitator model and dedicated education unit. The preceptor model is slightly different to the UK which operates for newly registered nurses, in the Australian model clinical supervision is 1:1 where a student is assigned to a registered nurse to work alongside. Franklin (2013) noted that a commonly reported theme was that effectiveness was often linked to the attributes, skills and knowledge of the supervising registered nurse and their ability to create a positive learning environment. The facilitator model is where a supervisor directly and indirectly supervises a group of students. The facilitation model was reported to be a better approach for the development of critical thinking, linking theory to practice and improved clinical competence. However, it often relied on external supervisors who may not be aware of the clinical environment or who had difficulty managing other commitments The dedicated education unit is a combination of the preceptor and facilitator models with the addition that the university and health service were partnered with a designated member of staff acting as liaison. The literature strongly supported the use of this model of supervision as it fostered critical thinking through reflective practice, as well as offering greater opportunity to perform clinical skills and procedures, however it was costly to set up (Franklin, 2013).

Franklin's (2013) review of the literature highlighted that there was little empirical evidence that evaluated the effectiveness of current supervision models. This may have been an outcome of what Hyrkäs et al. (1999) observed among researchers; an ongoing debate as to whether clinical supervision should be guided by theory. In their literature review, Hyrkäs and colleagues discuss that the development of a theory had frequently been seen as unnecessary and impossible due to the difference in professional groups. As

well as the question of who would set the criteria: the supervisor, supervisee, employer or

administration. A counter argument was that supervision without a theoretical framework

had no prospects or goal, and that most supervisors did use a framework although they may

not have been aware of it. Ultimately a flaw with the argument was that theory was being

debated by researchers and not clinicians with the practical lens (Hyrkäs et al., 1999).

Stevenson (2011) offers an interesting alternative to existing clinical supervision

models by adopting a postmodernist stance. He challenges the modernist assumptions of

traditional clinical supervision, such as: the existence of real mental health diagnoses within

people that can be treated by professionals, where an expert supervisor can spot problems

missed by supervisees and provide treatment solutions, and that the ability to practice

grows with time and so it is appropriate to have a hierarchy of supervision of senior nurses

supervising junior nurses. Instead, he favours a social constructionist view, that we

construct our world and so there can therefore be multiple realities, interpretations and no

single truths. Stevenson discusses Egalitarian consultation meetings (ECMs) listing three

main ways they differ from traditional supervision. Firstly, not having an imposed structure

of content as this limits creativity if the focus is on discovering the *real* problem, issues with

the supervisee's approach and the correct intervention. Second, that it should be separate

to managerial supervision to avoid a hierarchical structure and concerns that the supervisor

is auditing the supervisee. Lastly, that the space is democratic so that the idea of the

omnipotent supervisor is dismissed. As supervision is often the first casualty of a busy ward,

made more so by possible negative connotations associated with it, such as being

judgemental and punitive, ECMs might offer a helpful alternative (Stevenson, 2011).

Nursing within the UK has typically used Proctor's model, there are numerous other models, although empirical evidence supporting these models is not as available.

Structure

Suggested Structures.

Nursing clinical supervision utilises a number of different structures. Fowler and Cutcliffe (2011) identified three principles which appear to be the most common across these structures: a meeting with at least two people, which is structured and organised and where reflection is used to focus on practice.

At the beginning of the supervision process, the supervisor and supervisee should discuss and agree roles and responsibilities as well as clarify the purpose and function of the space (Driscoll et al., 2019). The creation of this 'contract' sets out ground rules and expectations around topics such as confidentiality, commitment and format, it also acts to separate itself from other more informal spaces (Department of Health, 2000) and be in line with organisational guidelines and professional ethics (Proctor, 2011). This initial creation process should be co-produced with the supervisee writing up the rules so it can act as a platform for learning and be both safe and risk taking. This initial time given to setting up the space serves two key purposes: a practical and a relational. The practical relates to identifying learning styles and resources, whereas the relational aims to establish trust, safety and a working alliance (Proctor, 2011).

Both parties need to enter the supervision space with an awareness of the expectations of them. For the supervisor this includes working in a way that is not hierarchical i.e. to understand they are part of a relationship between two professionals not

a pedagogic relationship between teacher and pupil. This also means that they can role-

model vulnerability on occasion to normalise this feeling, as well as support wellbeing. The

skills that supervisors are expected to bring include: rapport building, clarifying and

negotiating, challenging and empathy. Supervisees need to be mindful of certain attitudes

they bring with them so as to maximise reflection and learning, this may include scepticism

of the equality within the space. Skills supervisees are expected to bring include: reflection,

communication, preparation and case presentation and the giving and receiving of feedback

(Proctor, 2011).

In terms of logistical steps, a validation study of the Manchester Clinical Supervision

Scale, identified that supervision needed to be of sufficient length and frequency to be

effective. It suggested hourly sessions that occurred monthly or bi-monthly (Sloan, 2011).

Support for Supervisors.

As mentioned earlier, training for supervisors has no agreed structure (Driscoll et al.,

2019) which Yegdich (1999) argued was of high importance, as although supervising

students was well established and common practice, the supervising of qualified staff was

not. DoH (2000) agreed that supervisor training was essential and could be facilitated in a

number of ways such as academic or skills-based, be conducted internally or externally and

be a single session or modular. They also highlighted the importance of including

supervisors in the development of the training and not simply imposing it upon them.

Proctor (2011) comments that one of the biggest challenges for new supervisors is

managing the formative, normative and restorative elements, for example in being able to

challenge authoritatively whilst remaining respectful. Additionally, without an awareness of

the range of possible topics, supervisors can slip into routine patterns and might miss

certain perspectives (Proctor, 2011). Without teaching it is likely that new supervisors will

fall back on the ways that they themselves were/are supervised which could replicate

ineffective practice.

Implementation.

A common quandary within the early nursing supervision literature was how to

separate the personal and professional functions of supervision (Jones, 2006). It was argued

that the boundaries between professional supervision and personal therapy needed to be

respected and not distorted, as otherwise supervision might end up offering more than it

could deliver (Yegdich, 1999).

Grant and Townsend (2007) stress the importance of viewing clinical supervision

within the climate of needing to demonstrate professional accountability. They discuss the

paradox that a need for accountability has in fact undermined public trust in professionals,

as it created a sense of doubt and suspicion "because professionals need to be audited

'every which way' they must be fundamentally untrustworthy". In such a climate, they

argue, risk-adverse organisations may view the reflective practice element of supervision

with suspicion and not give it priority. Instead, supervision may be a platform to control and

discipline staff. Grant and Townsend (2007) argue that creativity and risk are interlinked and

so supervision that incorporates risk and experiment within wider recovery-based and

expert led care, will improve overall outcomes for supervisee and clients.

Evaluation.

Since its inception within nursing, much research has been conducted to evaluate

the effectiveness of clinical supervision. A fully comprehensive analysis of nursing

supervision is beyond the scope of this thesis; however, a summary of key literature will be

described.

An evaluation of the early research literature was conducted by Hyrkäs et al. (1999).

Reviewing 11 papers, the authors identified eight factors that effected the reliability of the

studies including: participant selection and sample size, different interventions, lack of

cohesion due to varying focuses of the studies, and representativeness and comparability.

They observed that the varying approaches to examining effectiveness had made the

process difficult, highlighting the complexity of the topic to evaluate. Another confounding

variable into supervision effectiveness, is its nature of being a long-term process that can

often coincide with life events which occur outside of the working environment but that

may influence results. The authors conclude that evaluations into the effectiveness of

supervision need to be reliable, although they ponder what is meant by *effectiveness*; is it

the reported experiences of supervisees or the cost-benefit ratios linked to staff sickness

and absence that form part of an administration process.

Davey et al. (2006) conducted a large-scale national study, commissioned by the DoH

to look at the use of clinical supervision among newly registered nurses across four domains

(adult, child, learning disability and mental health); the model of supervision used was

Proctor's model. Their findings showed that of the 1918 nurses included in the study 38%

were receiving supervision and 25% had never had supervision in their current job. Of those

that had supervision the majority of nurses felt their needs were met in terms of assistance

with setting objectives, however fewer nurses felt their needs were met in terms of the

teaching of new clinical skills and reflecting on practice. The majority of nurses, in terms of

normative elements, thought their supervision was sufficient or more than needed. It

appears from Davey and colleague's findings that arguably the closest element of clinical

supervision to managerial supervision within Proctor's model, normative, was the only

element that was implemented to a reported satisfactory rate. This suggests that

supervisors were more familiar and comfortable with a hierarchical approach. The authors

conclude that the low numbers accessing supervision are indicative of a gap between DoH

policy and nursing practice in terms of supervision quality. In their review of the literature,

Butterworth et al. (2008) observed similar findings to Davey et al. (2006) reporting that

engagement in supervision varied widely across the UK from 18-85.9%. The authors discuss

research that reports nurse resistance to engaging in supervision, citing reasons such as:

feeling threatened, viewing it as a 'paper exercise', concerns with confidentiality and a

worry it would increase stress. Cottrell (2002) describes four types of resistance to

supervision: Suspicion, resistance, tokenism and mutiny, concluding that implementation of

supervision is often unsuccessful when key stakeholders are not involved in the planning

and set up, similar to what Proctor (2011) described. Other, organisational level issues also

impacted the accessibility of supervision including financial resources and lack of regional

guidelines on its implementation, despite trust directors supporting its application (Rice et

al., 2007). Further barriers will be discussed in a later section.

Another area of evaluation has looked at the supervisory relationship. In their review

of the literature, Jones (2006) indicated a knowledge gap into the impacts of the

interactions between supervisor and supervisee and what roles power and influence play in

the relationship. Jones expressed concern with the assumption that all nurses possess an

innate ability to reflect on their practice and that this skill feels safe and comfortable. A

similar gap was identified by Sloan (2011) who reported several identified characteristics of

a 'good supervisor' based on the perceptions of supervisees. These included: having

relevant skills and knowledge, an ability to form supportive relationships and good listening skills. The context was also identified as important as when supervisors served as both clinical supervisor and line manager tensions arose due to the incompatibilities between the roles (Sloan, 2011). Earlier it was highlighted that there is no agreed supervisor training for nurses within the UK (Driscoll et al. 2019). Bos et al. (2015) looked at the experiences of district nurse supervisors who supervised student nurses. Supervisors reported feeling abandoned by academic institutions with poor communication of what was expected of them. In some cases, this led to supervisors feeling ambivalent to the process, expressing uncertainty as to how to supervise and a felt sense that it was not part of their ordinary work but in addition to. This research further highlights the need for supervisors to be supported to enable them to support their supervisees.

As discussed earlier, Proctor's model is the most widely used model for supervision in nursing practice and research within England, however it has been criticised for a number of limitations. Buus & Gonge (2009) note that the model does not consider clinical outcomes or situational or organisational factors. The model's structure has also been described as vague and doesn't provide supervisors with guidance on what to offer when working within the three elements; this gap makes quality checks difficult (Sloan & Watson, 2002). Evaluation of the restorative element of the model has also had inconsistent results, with some studies reporting nurses viewing it as the most important element, whilst others reported no significant results (Butterworth et al., 2007). Similarly, Davey et al. (2006) noted that only a minority of nurses who did not have discussions about their relationships with other staff wanted the opportunity to do so. This might be linked to what other research has reported in terms of nurse's unfamiliarity with the nature of reflecting and feeling safe within the space.

In terms of specific tools to aid in evaluating supervision, the Manchester Clinical Supervision Scale (Winstanley, 2000) is the first validated measure specifically designed to assess the impact of clinical supervision (DoH, 2000). It is a 36-item measure that consists of seven subscales: trust/rapport, supervisor advice/support, improved care/skills, importance/value of supervision, finding time, personal issues and reflection (Edwards et al. 2006). Since its inception, the measure has been used in over 90 studies in 12 counties (Winstanley & White, 2011) and was later revised into a 26-item measure (Winstanley & White, 2014).

Clinical supervision takes time to establish, requires ongoing endorsement and comes with a financial cost. For it to therefore be continuingly supported by trusts, it needs to have a robust body of literature demonstrating its benefit (Jones, 2006). There is indeed a large and growing body of literature evaluating supervision among nurses, and although some studies offer promising results others can only draw tentative conclusions (Buus & Gonge, 2009). There is also little evidence for the impact on client outcomes (Carson, 2007). Hyrkäs et al. (1999) describe the problem in evaluating supervision as epistemological in nature. Organisations may often wish quantitative outcomes of change which are external, observable and can be measured. However, often the changes in supervision might be qualitative and internal, for example in the growth supervisees experience through new meaning making. Similarly, Buus and Gonge (2009) note the difficulty in standardising and measuring a supervision intervention that is informed to a large degree by the personality of the supervisor. Finally, Butterworth et al. (2007) observe that there is little evidence to support the view that clinical supervision is a negative experience, however it does not always produce universally positive effects. This might therefore offer a useful conclusion into the current evaluations of nursing clinical supervision.

Barriers to Supervision

Meaning.

The challenges with finding a universally agreed definition for clinical supervision within nursing has been discussed earlier. This absence has been described as the most serious obstacle to developing the field of supervision (Buus & Gonge, 2009), although others argue that the lack of definition should not be seen as a barrier but as an opportunity (Jones, 2022). The growing popularity of clinical supervision has also led to the development of an abundance of guiding frameworks, however with little research supporting their utility, the expectation of the process can be seen as burdensome and distract from the core value of the supervision (Sloan, 2011).

Another impact of this lack of consensus is the blending together of managerial and clinical supervision, which amongst other things, results in a hierarchical structure that is the opposite of the aims of clinical supervision. Having to feedback to management whilst feeling a sense of being watched, meant nurses had a negative experience of the supervision process (Sloan, 2011). This hierarchy within supervision has been suggested to induce an absence of ownership from all parties, with tensions emerging between managers and staff, and resistance from staff to engage in the process (Duncan-Grant 2000).

Supervisors/ supervisee perceptions.

It has been suggested that many nurses may resist the implementation of supervision but limited small-scale research did find that very few nurses felt they did not need supervision (Davey et al. 2006).

Research has shown that some supervisors view clinical supervision as anxiety provoking and burdensome. This highlights that encouraging nurses to engage in supervision before its ideas and ideals are properly explained, understood and assimilated, may lead to supervision being less effective (Jones, 2006).

For supervisees, engaging in supervision on a regular basis can be challenging to fit around busy practice (Jones, 2006) and this is made more complex if permission needs to granted by a manager (Driscoll et al. 2019). A solution to this is to use group supervision, however this does not come without its own set of challenges. Due to work pressures, the spaces are often poorly planned, have inconsistent attendance (Driscoll et al. 2019) and can easily become an unproductive 'moaning session' (Fowler, 2011).

As discussed earlier, nurses who believe the space to be punitive and hold a belief that supervision is a managerial tool to find fault in their practice, are less likely to engage (DoH, 2000). These beliefs help explain, why in busy environments, supervision is often the first casualty when things need to be cancelled (Stevenson, 2011). Therefore, for supervision to have the best chances of a positive result, staff need to attend with a prepared mind in an environment that actively engages with clinical supervision. Clinical environments that are stressful, anxiety-provoking and defensive are unlikely to enable supervisees to engage effectively and meaningfully in supervision (Gonge & Buus, 2014).

Organisational.

An argument has been made that a key barrier to implementation of supervision is time and resource and this rests with trusts (Davey et al., 2006). Inconsistent support from senior managers and executive boards can lead to nurses feeling unaided; at these times a 'supervision champion' or advocate can play an important role in implementation (DoH,

2000); this is part of the aims of the new PNA programme. Whilst Butterworth et al. (2008) note that organisational culture is consistently reported as an important determinant of implementation, Sloan (2011) concludes that a lack of acknowledgement of these wider organisational contexts within which supervision takes place, means there is little understanding of how these contexts impact upon supervision.

Culture.

In systemically hierarchical work environments such as nursing, excellent working alliances between more and less experienced workers are rare (Proctor, 2011). This is not due to the individual workers inability to form alliances, rather it is the effect of the culture informing role behaviour appropriate to hierarchy which can also appear to punish more cooperative ways of relating (Proctor, 2011).

As discussed earlier, current societal concerns with managing risk in services such as the NHS, leads paradoxically to the undermining of faith in professionals; can anyone who requires auditing be trusted? (Grant & Townsend, 2007). This mistrust can lead organisations to become risk-adverse which can directly impact clinical supervision whose flattened hierarchy and space for vulnerability from both sides can come with a felt sense of risk. Instead, more familiar and hierarchical forms of managerial supervision can be re-established as the norm (Grant & Townsend, 2007).

Context example – inpatient setting

Cleary and Horsfall (2011) conducted an ethnographic study of an acute inpatient mental health ward in Australia, their aim was to understand the contextual and cultural realities of clinical supervision within that environment. The authors observed that

although participants understood the purpose of clinical supervision and were aware of its many advantages, they preferred more informal ad hoc methods of support. An example, was boundary transgressions made by junior nurses who were able to be taken aside in the moment and given live supervision rather than waiting for a later date. A preference of ad hoc supervision might also have arisen due to the difficulty nurses may feel in acknowledging that they are stressed or not coping, with attending formal supervision being viewed as an admission of this.

The authors comment that this ad hoc style led participants to believe they were engaging in clinical supervision, which may have been further enhanced by the knowledge that supervision was a requirement coupled with the held belief that only the people who work alongside you can understand. Ad hoc support was also likely more naturalistic, accessible and created less stress (caused by time away from other responsibilities) than more formal types of supervision. The authors note that although in the moment ad hoc supervision is beneficial, longer term it reinforces cautious attitudes towards supervision and embeds the belief that it has limited value in-practice.

Other logistical concerns were also raised, for example with 1:1 formal supervision being arranged towards the end of the shift meaning that supervisees were tired and unable to effectively use the space. Likewise, that supervision arranged outside of working hours should mean 'time in lieu' was granted but this was not always the case. Time and staffing issues were a continuous problem and so often the reality meant policy could not be implemented as intended. Group supervision was utilised but similar to Driscoll et al.'s (2019) findings, challenges arose with getting nurses working across several different shift

patterns (e.g., earlies/lates/nights) to regularly attend, which resulted in issues not being resolved.

Cleary and Horsfall conclude that despite considerable discussion, there is little published examples of effective implementation of clinical supervision within inpatient settings. Without this, there isn't likely to be large scale investment which may be what is needed to challenge culture and logistical concerns.

Although based in Australia, the findings of this study are likely transferable to inpatient settings within the NHS.

Nurse Experience

Highlighted earlier are the challenges of defining supervision and the resulting confusion for nurses in understanding the purpose of the space. Cleary and Horsfall (2011) highlighted that this can lead nurses to mistake certain forms of ad hoc support as clinical supervision whilst Davey et al. (2006) comment that problems with not separating it from managerial supervision can lead to perceptions of an invasive management tool used for performance monitoring, assessing coping abilities and discipline.

Jones (2006) notes that many preconceived notions about supervision can be justified, as by its nature supervision may be an anxiety provoking exercise. Therefore, this needs to be managed appropriately to navigate defences that are activated by the supervisee, which they argue, is hard to do in a professional space, this links with earlier arguments about the personal and professional divide (Yegdich, 1999). Jones (2006) argues that supervision with an understanding of human complexities can help supervisees sustain themselves, their colleagues and patients. The need to understand defences was also

discussed by Yegdich (1998) who commented on the social defences nurses might employ to avoid any related pain, anxiety and uncertainty in their interactions with patients, especially following the shift from team to more independent working.

In their discussions concerning the impacts of low-risk environments, Grant and Townsend (2007) notes that the experiences of supervision might shift from the promotion of professional growth and self-determination to one of maintaining low-risk. Supervisees may see their role as to only receive knowledge from their supervisors in a single direction without broader discussions. This 'do to' approach can breed dependency and have the potential to be abusive (Grant & Townsend, 2007).

Whilst conducting a piece of research on the impact of clinical supervision on nurse's experiences of wellbeing, Bégat et al. (2005) noted the ease of differentiating nurses who were accessing clinical supervision in terms of positive outcomes on their wellbeing. Nurses were better able to care with empathy and compassion, were more motivated and their rate of absence was lower. Edwards et al. (2006) in their review however, summarise that much of the literature discussing the link between clinical supervision and burnout is contradictory with some studies showing a reduction whilst others showing no change, the authors also highlight methodological issues such as small sample sizes.

The picture of nursing experiences of clinical supervision is unclear in terms of positives and negatives. It is possible that the experiences of what goes on outside the supervision space, (e.g., an organisation that advocates a supervision culture, provides clear understanding and training for supervisors) may play as large a role on the overall experience for nurses, as what goes on within the supervision space.

Nondisclosure & Nursing Supervision

The researcher found no evidence in the literature that nondisclosure has been looked at within nursing supervision, this may not be too surprising as even within the therapeutic literature, the body of research is comparatively small. From reviewing the literature on nondisclosure within the therapeutic supervision, and the present review on nursing supervision, some tentative assumptions can be made.

A systematic review of the nondisclosure literature is provided in chapter two, but for ease, the findings point to the importance of several factors that help mitigate the chance of nondisclosure occurring. These include: an understanding at all levels of what supervision is, suitable training for supervisors to manage their own and their supervisee's anxieties, a healthy supervisory relationship, and a good set up with a shared understanding and acknowledgement of power. With this in mind, it is possible to see where the phenomenon of nondisclosure and nursing supervision may intersect.

In terms of a good understanding, the lack of a clear definition for clinical supervision is problematic, additionally, Butterworth et al. (2008) and DoH (2000) findings demonstrate the negative preconceptions nurses feel towards supervision. Whilst Davey et al. (2006) findings talk to the difficulties of setting up an effective supervision space due to limited time and resources which impacted on who can consistently access supervision. This can be further complicated by organisational and regional inconsistencies with guidelines and funding (Rice et al., 2007). Sloan (2011) highlights the importance of training for nurse supervisors whilst Driscoll et al. (2019) comments on the lack of agreed and accredited training for them. Resulting in what Bos et al. (2015) found in their interviews with supervisors: feelings of uncertainty, abandonment and ambivalence. In terms of the

supervisory relationship, Jones (2006) highlights a knowledge gap on the impacts of the

supervisory relationship within nursing supervision, whilst Proctor (2011) comments that

due to hierarchical work environments, alliances between more and less experienced

workers are rare. It can be inferred then that between supervisees who hold negative

preconceptions about supervision and supervisors who feel uncertain and ambivalent, a

healthy supervisory relationship will be difficult to form.

This suggests that nondisclosure is likely to occur within nursing supervision,

however it is also possible for other variables to be present and responsible due to cultural

differences in how supervision may be viewed, valued and utilised.

Summary

This section has aimed to provide an overview of nursing supervision, in doing so it

has described its origins, structures, challenges and current directions. The author

acknowledges that some of the cited research is relatively older, however this is a reflection

of the available found research. Supervision within nursing is clearly complex and although

recognised as an important part of practice, after almost 30 years of use within the NHS,

there remains confusion around what it is and how it can be applied (Butterworth, 2022). It

is therefore important that research continues, to broaden our understanding and inform

effective supervision practices.

Nondisclosure in particular is a phenomenon that should be considered within nursing

supervision. The next section will discuss what is known about this phenomenon.

Chapter two – systematic literature review: What is Known About Nondisclosure in

Clinical Supervision?

Nondisclosure is a phenomenon that can be defined as the act of intentionally withholding information. It has been a topic of conversation for several decades and its occurrence has been studied in both therapy by clients and in supervision by therapists. Within therapy for example, nondisclosure has been linked to feelings of shame and low mood (Hook & Andrews, 2005). Clinical supervision is often seen as a space for professional development where a less experienced clinician can benefit from the knowledge and experience of their supervisor. As supervisors rarely observe their supervisee continuously, there is an expectation and assumption that supervisees will be honest and transparent in their reporting of clinical work to enable the supervision to be helpful (Jakob et al., 2014; Cook et al., 2019; Hutman & Ellis, 2020) nondisclosure therefore can be seen as at odds with this setup.

Nursing as a discipline recognises the value and advocates the practice of clinical supervision, however engagement levels with supervision can vary considerably (Butterworth et al., 2008) and despite the support of directors, can struggle to be implemented consistently (Rice et al., 2007). Several reasons have been offered to explain these challenges, including staff and organisation attitudes to supervision (Gonge & Buus, 2014) and continuous organisational change (BéGat et al., 2005). Whether nondisclosure may be interlinked with these has so far not been considered and a useful first step will be to better understand the phenomenon.

This systematic review of the literature will therefore aim to identify and collate available knowledge, so as to present a clear picture of our current understanding of

nondisclosure within clinical supervision as well as any potentially new directions for future research. For this review, clinical supervision is seen as an individual act, separate to a group format.

Methodology

To help guide this systematic literature review, a protocol was developed which detailed each step and acted as a reference point throughout the process; a copy of this can be found in appendix three.

Identifying a research question and bibliographic databases.

The first step was to identify a research question that was linked to the thesis topic and could point to gaps in the literature. To do this, four bibliographic databases were chosen: PubMed which houses articles from the biomedical and life sciences literature; Scopus, the largest abstract and citation database of peer-reviewed literature in the fields of science, medicine and social sciences; CINAHL Plus, the world's most comprehensive source of full text for nursing & allied health journals; and Psyarticles a database for journals in behavioural science and related fields. It was felt that between them, these four databases would provide a broad enough base to help identify and refine a research question. Scoping searches were conducted within each database to get an overview of available literature, and preliminary search terms were identified. From the findings, it was decided to focus the review on nondisclosure within supervision. Once a question had been confirmed, a search on the PROSPERO database was carried out to check for any pre-existing systematic literature reviews asking the same question; none were identified.

Inclusion and exclusion criteria.

The PICOSS tool (figure 1) was used to help identify inclusion criteria, this has been tabulated below. If a paper contained each of the following, it was included in the review.

Population	Healthcare professionals accessing individual clinical supervision
Intervention	Direct reference to and discussions of nondisclosure within the supervisory space, i.e. focus is not on disclosure more generally
Comparator	none
Outcomes	Reports of impacts of nondisclosure within Clinical supervision
Study Design	Quantitative or Qualitative
Setting	Clinical/trainee settings

Figure 1

The exclusion criteria were also identified from the scoping searches. These included: any research that used a case study methodology, the main reason for this was reduced research rigour and limited generalisability; any research that looked at group supervision, given additional factors, such as group dynamics, would make direct links between the two forms of supervision difficult; any literature reviews or editorials, so that the focus of this review was on original studies. Although not a direct exclusion criterion, due to the databases chosen, no grey literature was included in this review. Although a research area for several decades, the quantity of literature on the topic of nondisclosure is not vast, therefore no limits were placed on date of publication.

Defining search terms.

From the relevance of the results, it was decided to remove the PubMed and CINAHL Plus databases as they often returned with very broad and numerous results, for example tens or hundreds of thousands of papers, or nothing at all. Of those results that did match the inclusion criteria, they were also identified by the other two databases.

Search terms were defined by the nature of the research question, the scoping searches and abstract key words from identified papers. There were initially broad but were defined more specifically with each subsequent search, keywords from existing papers also informed terms. As combining all search terms produced no returns, different combinations of the search terms were used, with papers that showed potential being syphoned off into a saved search folder within the bibliographic database. A reference search of some articles was also conducted to further identify additional papers. This was repeated several times with increasingly complex combinations until a pool of papers was gathered. An example list of these combinations can be found in appendix four.

The final search terms were:

"Clinical Supervision"
Clinical and Supervision
Non-disclosure OR nondisclosure
Disclosure
"Mental health nursing"
"Clinical Supervision"
Nursing
Sharing OR openness OR transparency

Screening and selection.

Once the pool of papers had been identified, a more thorough screening of titles and abstracts was performed. Papers that did not meet the inclusion criteria or duplicates were removed, the full text of one paper was not available and so an interlibrary loan request was made to gain access from The British Library. A final 13 papers were identified and used within the review.

Below is a flowchart (figure 2) outlining the paper selection process:
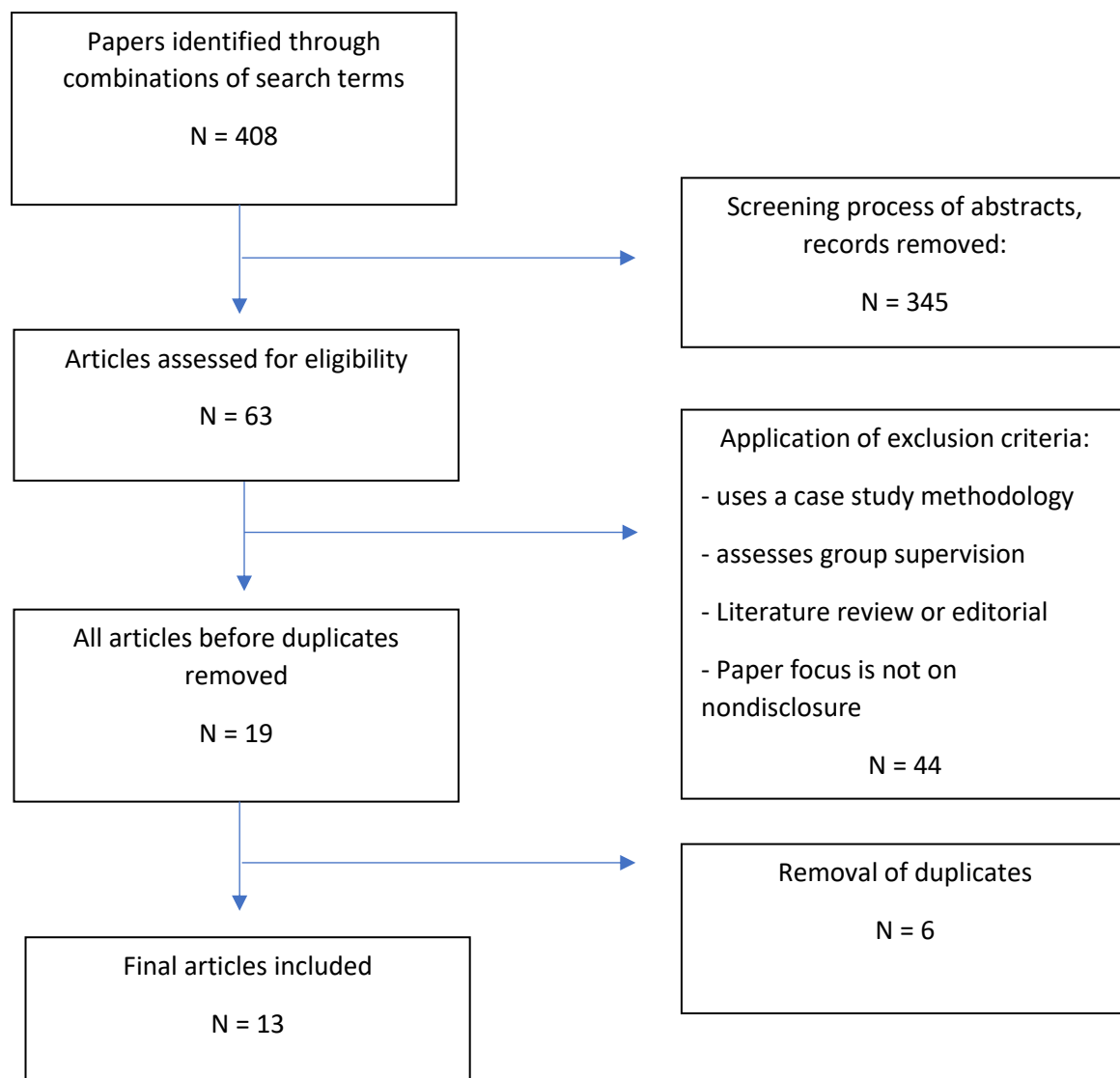
Figure 2

List of papers included.

Number	Date	Author	Title
1	2019	Ryan M. Cook, Laura E. Welfare & Jyotsana Sharma	Exploring supervisees' in-session experiences of utilizing intentional nondisclosure
2	2018	W. Bradley McKibben, Ryan M. Cook & Melissa J. Fickling	Feminist supervision and supervisee nondisclosure: The mediating role of the supervisory relationship
3	1996	Nicholas Ladany, Clara E. Hill, Maureen M. Corbett and Elizabeth A. Nutt	Nature, Extent, and Importance of What Psychotherapy Trainees Do Not Disclose to Their Supervisors
4	1996	David B. Yourman & Barry A. Farber	Nondisclosure and distortion In psychotherapy supervision
5	2014	Marion Jakob, Florian Weck, Volkmar Höfling, Samantha Richtberg & Martin Bohus	Nondisclosure during psychotherapy supervision: Validation of the German version of the Supervisory Questionnaire (SQ)
6	2008	Shirley A. Hess , Sarah Knox , Jill M. Schultz , Clara E. Hill , Lea Sloan , Susan Brandt , Frances Kelley & Mary Ann Hoffman	Predoctoral interns' nondisclosure in supervision

7	2019	Heidi Hutman and Michael V. Ellis	Supervisee Nondisclosure in Clinical Supervision: Cultural and Relational Considerations
8	2020	Ryan M. Cook, Connie T. Jones, and Laura E. Welfare	Supervisor Cultural Humility Predicts Intentional Nondisclosure by Post-Master's Counsellors
9	2021	Neeshi Singh-Pillay & Duncan Cartwright	The Unsaid II: In-depth accounts of nondisclosures in clinical supervision from the supervisor's perspective
10	2018	Neeshi Singh-Pillay & Duncan Cartwright	The unsaid: In-depth accounts of nondisclosures in supervision from the trainees' perspective
11	2018	Andrew S. Gibson, Michael V. Ellis, and Myrna L. Friedlander	Toward a Nuanced Understanding of Nondisclosure in Psychotherapy Supervision
12	2010	Kristin e. Mehr*, nicholas ladany & grace i.l. Caskie	Trainee nondisclosure in supervision: What are they not telling you?
13	2014	Jennifer Sweeney & Mary Creaner	What's not being said? Recollections of nondisclosure in clinical supervision while in training

Figure 3

Data extraction

For each of the 13 papers, a data extraction table was completed to capture key information. The data captured included: lead author, year of publication, journal, study design, where the study was conducted, inclusion/exclusion criteria, participant type and numbers (including drop outs) participant demographics, intervention or comparator, type of analysis, outcomes, conclusions and any, study sponsorship. An example extraction table can be found in appendix five. All data extraction tables were then combined into a single spreadsheet for comparison and analysis.

Quality Assessment

Qualitative Papers.

To assess the quality of the qualitative papers the Critical Appraisal Skills Programme, CASP, Qualitative Checklist (CASP, 2018) was utilised. This tool was chosen as, although there is little consensus on what constitutes as quality in qualitative research, the CASP has been endorsed by the Cochrane Qualitative and Implementation Methods Group (Long, French & Brooks, 2020).

The CASP Qualitative Checklist consists of 10 questions with the first two being screening questions. Each question has three possible answers *Yes*, *No* or *Can't tell*. The tool was developed by a group of experts and trialled with health care professionals before the final checklist was compiled (CASP, 2018). For the appraisal, *Yes* was used if the paper made clear reference, *no* was used if no mention was made and *can't tell* was used if the paper's account was too brief or unclear.

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Paper 1	Yes	Yes	Yes	Yes	Yes	Yes	Can't' tell	Yes	Yes	Valuable
Paper 6	Yes	Yes	Yes	Yes	Yes	Yes	Can't' tell	Yes	Yes	Valuable
Paper 9	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Paper 10	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Paper 13	Yes	Yes	Yes	Can't' tell	Yes	Yes	Yes	Yes	Can't' tell	Valuable

Figure 4

The above table summarises the findings for the five qualitative papers included in

the review. All papers met the screening criteria and so the full checklist was implemented.

Each of the papers looked to understand participant's in-depth experiences, or understand

the factors that led to nondisclosure, or look at the meaning of participant's lived

experience.

All of the research designs were appropriate to the aims of the research: two of the papers (papers 9 & 10) used an interpretative phenomenological analysis (IPA) approach, two (papers 6 & 13) used a consensual qualitative research (CQR) approach and paper one used interviews informed by interpersonal process recall (IPR) which is used to help supervisees recall their unspoken experiences in supervision. All the studies, except paper 13, gave a summary of why they had chosen their particular methodology.

All but paper 13, reported the use of purposive sampling as their method for recruiting participants. Although a criticism of this methodology is that it is prone to researcher bias and limits generalisability, it is also recognised to be useful when looking for a specific population which these papers were. Paper 13 did not include much detail around their recruitment strategy. Each paper listed demographic information for their sample and although what was included varied, all reported: age, gender and ethnicity. None of the papers gave a rationale for any participants they did not include and only one reported its inclusion criteria.

All the papers described their data collection process, this took the form of audio-recorded interviews between 60-90 minutes followed by a process of transcription. Papers 9 & 10 also included a copy of their interview schedule for clarity.

Each paper spoke to the relationship between researcher and participant in its own way, for example reflecting individually on their own experiences and what biases this might bring or by discussing biases as a research team. Most papers also named strategies that were utilised to manage potential bias, for example, having another researcher act as a checking process or by keeping a reflective diary.

Discussions around ethics varied across the papers. Paper 13 for example, included a separate section providing a detailed account of their considerations, whereas paper one mentioned gaining ethical approval but provided no further detail. The other papers make reference to consent forms, information sheets and confidentiality but go into little detail beyond that.

Similar to ethics, the level of descriptive detail of the analysis process varied across the papers, from minor to very detailed. Each paper does provide a comprehensive overview of the themes and subthemes identified, as well as, the inclusion of quotes to support their conclusions. None of the papers reported any contradictory findings. Each paper provides an overview of its findings, although it is not as clear in some. Most also link these findings back to the original question and makes links to existing literature. Finally, all the papers include a section on recommendations, and all but paper 10, comment on their limitations.

In terms of value, each paper offers further insights into the phenomenon of nondisclosure and make recommendations, for example, by attending to the supervisory relationship and including a comprehensive role orientation. Each paper also points to areas of future research to develop the growing field of nondisclosure literature. A main limitation across all the papers however, is generalisability given relatively small and specific populations. Using trainee therapists of whom most were white and female meant that applying any findings to qualified populations, other disciplines or those or identify as a different gender or from the global majority becomes difficult. Having said that, the insights the papers do offer have the potential to be applied tentatively or act as a foundation for future research within these wider demographics.

Quantitative papers.

As each of the quantitative papers used questionnaires as their methodology, a quality tool that was specifically designed to assess surveys, was sought. The Critical Appraisal of a Survey tool was developed by the Centre for Evidence-Based Management (CEBMa) in 2014 after being adapted from Crombie's text on critical appraisal (Crombie, 1996).

The tool consists of 12 questions with possible answers being 'yes', 'no' or 'can't tell'. Similar to the qualitative appraisal tool, *Yes* was used if the paper made clear reference, *no* was used if no mention was made and *can't tell* was used if the paper's account was too brief or unclear. Initially, a slight adjustment was made to the twelfth question, instead of '*can the results be applied to your organization?*' it instead asked, '*can the results be generalised to other populations?*' However, it was decided to remove question 12 as its answer could be covered by the fifth question: '*Was the sample of subjects representative with regard to the population to which the findings will be referred?*'

	Did the study address a clearly focused question / issue?	Is the research method (study design) appropriate for answering the research question?	Is the method of selection of the subjects clearly described?	Could the way the sample was obtained introduce (selection)bias?	Was the sample of subjects representative with regard to the population to which the findings will be referred?	Was the sample size based on pre-study	Was a satisfactory response rate achieved?	Are the measurements (questionnaires) likely to be valid and reliable?	Was the statistical significance assessed?	Are confidence intervals given for the main results?	Could there be confounding factors that haven't been accounted for?
Paper 2	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
Paper 3	Yes	Yes	Yes	Can't tell	Can't tell	No	Yes	Yes	Yes	No	Yes
Paper 4	Yes	Yes	Yes	Yes	Can't tell	No	Yes	Yes	Yes	No	Yes
Paper 5	Yes	Yes	Yes	Can't tell	Yes	No	Yes	Yes	Yes	No	Yes
Paper 7	Yes	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Yes
Paper 8	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	No	Yes
Paper 11	Yes	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Yes
Paper 12	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	No	Yes

Figure 5

The above table summarises the findings from the tool. Each of the papers had a

clearly defined question which focused around a desire to look at the frequency and extent

of nondisclosure, or make comparisons and predictions, whilst paper five looked to evaluate an existing questionnaire. It was therefore felt that a quantitative methodology was best suited to answer these questions.

Each of the papers clearly described their recruitment process which, as they used the trainee population, for the most part involved contacting course directors, or colleagues in academic institutions, either by email or telephone. The questionnaires themselves, were either posted out or accessed online. This method of selection does have the potential to introduce bias as it involves the motivations and willingness of individual directors to advertise on their programmes and the extent of this can vary. Three of the studies (papers 3, 7 & 11) also used a monetary incentive which could lead to an increase in motivation. The reporting of attrition rates varied across the articles, for example paper 12 makes no mention of lost numbers, whereas paper five provides a graphical breakdown. Aside from paper 12, all others reported stages at which participant data was removed from the research and the reasons for this, this included missed questions or eligibility, e.g. no longer accessing supervision.

Participant demographic information was provided by each paper, the level of data captured varied but all included age and gender with some also including ethnicity, occupation, sexuality, marital status and length of time with supervisor. Averaging across all the papers, samples were comprised primarily of white (79%) females (81%) with an average age of 31 years. In terms of similarity to the composition of therapy trainees in western academic institutions, this is a representative sample. However, as the papers are looking to talk to the phenomenon of nondisclosure in supervision more broadly, this sample is unlikely to be representative of qualified therapists or clinicians in other

disciplines. It doesn't make the findings insignificant however, as they can offer tentative comments on supervision practices more broadly.

Five of the eight papers (2, 7, 8, 11 & 12) made reference to a priori power analysis to determine required sample size. The papers planned to observe a small to medium effect with power set at 0.8 and 0.9.

Only half the papers reported response rates (Paper 3 - 50%; paper 4 – 35.2%; paper 5 - 68.6%; paper 8 -10.5%). Paper eight commented that although the response rate was small it was in line with other mail questionnaire studies. Although the other papers didn't comment on their response rates beyond reporting them, these would be considered satisfactory. Papers two, seven & 11 note that it was not possible to obtain information about response rates due to their recruitment methodology and not knowing how many individuals were reached via emails and postings from course directors. Paper 12 does not make reference to response rates.

All papers evidenced the research behind their questionnaires, for example its theoretical underpinnings, previous uses and Cronbach alpha internal consistency scores. Paper 4, which developed The Supervisory Questionnaire (SQ) for its study, comments on it being based on a review of the literature and previous questionnaires. For these reasons it appears all the measures used across the studies were likely to be valid and reliable.

Statistical significance was assessed in all papers, the papers provided varying detail but all used a form of statistical analysis including chi square, t-test and multiple regression. Only three (2, 7 & 11) of the eight papers reported confidence intervals however.

Each of the papers has the potential for additional confounding variables, one that affects all of them is participant bias in terms of the motivation to talk about nondisclosure especially if the disclosures are referring to a current supervisor. Worries for example about confidentiality might deter some people from participating. This confounding variable, however, is present in all research into nondisclosure. Other confounding variables highlighted include, the timing of the interviews and the impact of reduced recall, or only focusing on a single supervision session and missing potential longitudinal information, or only being able to look at a single facet of supervision.

Summary.

This quality assessment has aimed to provide a detailed review of the 13 papers included in this systematic literature review. To account for the different methodologies, two different tools were utilised, the CASP -Qualitative and the Critical Appraisal of a Survey Tool. Both tools detailed that the research papers demonstrated research vigour and provided new knowledge to the phenomenon of nondisclosure, however, mostly due to the type of participant being trainee therapists, the findings cannot easily be generalised to wider populations. The insights they do give however, remain valuable.

Data Analysis

Similar to the quality assessment, the papers were divided by methodology (quantitative and qualitative), with the qualitative papers initially being examined. The rationale for this approach was first for ease as the papers were already divided and second, to allow for the data analysis to begin on a smaller number of papers to develop the technique.

The qualitative papers each identified a number of superordinate and subordinate themes, and these were grouped together into four categories: the content of nondisclosure, the reasons for nondisclosure, the consequences of nondisclosure and what helped facilitate disclosure. Following this, the data from the quantitative papers was analysed and it became clear that this data complemented the qualitative and mapped easily onto the four categories. One additional category was added: the frequency of nondisclosure.

The content of nondisclosure.

Most papers gave examples of different themes of what was not discussed, these included: personal matters, clinical issues and issues with the supervisory relationship. Hess et al. (2008) note that the content of nondisclosures made by supervisees who reported a positive supervisory relationship, mainly involved clinical issues, such as mistakes, whereas for those who reported a negative relationship, most nondisclosures related to the supervisory relationship. Interestingly, Sweeney and Creaner (2014) found conflicting results to Hess and highlighted the complexity of this being a multi-layered phenomenon where issues are often intertwined and not easily separated out.

The frequency of nondisclosure.

Across the papers, although all found evidence of nondisclosure, the frequency of reported nondisclosure was inconsistent. Mehr, Ladany and Caskie (2010) for example, found 84.3% of their sample withheld information in a single supervision session with an average of 2.68 nondisclosures. Whereas, Ladany, Hill, Corbett and Nutt (1996) recorded that 97.2% of their sample withheld information. Hutman and Ellis (2019) however, highlight

several studies, including their own, which reported comparatively low levels of nondisclosure, though they did not provide figures for these.

This inconsistency might be due to the relatively small body of research in this area, coupled with the varying methodologies used and constructs explored by each paper.

Reasons for nondisclosure.

The papers offered a number of potential reasons for supervisee nondisclosure. The setup and style of the supervision, induced reported nondisclosure in a number of supervisees. The setup related to a lack of understanding of how to use the supervisory space effectively, what was appropriate to disclose and concerns around confidentiality (Cook, Welfare & Sharma, 2019). Wider, organisational level issues also impacted on the setup, for example, with supervisees editing their discussions due to feeling rushed and worrying about other imminent meetings (Cook et al., 2019). The style, related to the supervisor's approach to supervision, with dogmatic and authoritative (Singh-Pillay & Cartwright, 2018), non-facilitative (Sweeney & Creaner, 2014), restrictive (Cook, et al., 2019), less interpersonally sensitive (Ladany et al., 1996), and those that did not discuss issues of power directly related to demographic differences between supervisor and supervisee (Hess et al., 2008; Cook et al., 2019; Cook, Jones & Welfare, 2020) leading to increased incidents of nondisclosure. Ladany et al. (1996) found that 90% of supervisees in their sample linked at least one nondisclosure to a negative reaction to their supervisor. Similarly, Yourman and Farber (1996) reported that 59% of their sample rarely or never felt comfortable to disclose negative feelings towards their supervisor and almost 50% moderately or frequently told their supervisor what they thought they wanted them to hear. If supervisees had negative experiences of having previously attempted to disclose

with these supervisors, they were less likely to try again (Hess et al., 2008; Sweeney &

Creaner, 2014) with some concluding it was not worth it (Cook et al., 2019). Research has

shown that supervision-related nondisclosure typically occurs more frequently than client-

related nondisclosure (Gibson, Ellis & Friedlander, 2018; Huntman & Ellis, 2019). Yourman &

Farber (1996) interestingly describe the potential positives of interpersonal relationship

problems between supervisor and supervisee being the main source of nondisclosure.

Firstly, that as the difficulty does not lie between supervisee and client, it is unlikely to be

distorting the therapy process and negatively impacting client outcomes. Secondly, as these

types of difficulties happen live within the space, they may be more readily apparent and

more accessible to intervention in the moment.

Power differentials were highlighted as a possible reason for nondisclosure, with the

supervisor being perceived by the supervisee as all-knowing and omnipotent (Singh-Pillay &

Cartwright, 2018; Singh-Pillay & Cartwright, 2021) and the gatekeeper to career

development (Hess, et al., 2008). This can illicit fear in supervisees, who may worry about a

bad evaluation or being judged by their supervisor both personally and professionally

(Ladany et al., 1996; Mehr et al., 2010; Jakob et al., 2014; Huntman & Ellis, 2019), resulting

in supervisees utilising nondisclosure to appear in a certain way so as to be regarded in a

positive light (Hess, et al., 2008; Mehr et al., 2010; Singh-Pillay & Cartwright, 2018; Cook, et

al., 2019). Similarly, wider societal influences on for example age, ethnicity and gender can

also play into the power differential within the supervisory space (Cook et al., 2019).

However, some studies found that demographic variables (such as age, gender or race)

were not significantly related to any of the variables of nondisclosure (Ladany et al., 1996;

Yourman & Farber, 1996; Jakob et al., 2014; Huntman & Ellis, 2019). In their study, Ladany

and their colleagues only found that experience (defined by number of months working)

was related to negative reactions to their supervisor, with more experience linked to a higher negative reaction.

Supervisee's own anxieties, doubt confusion and other negative emotions can also be a source of nondisclosure (Hess et al., 2008; Sweeney & Creaner, 2014) with greater levels of anxiety linked with greater amounts of nondisclosure (Mehr et al., 2010). Even when supervisors make attempts to help mitigate this, the setting and evaluation process work to heighten difficult emotions in supervisees (Hess et al., 2008). Other interpersonal concerns within the supervisory relationship including feeling uncomfortable, feeling unsafe and having a lack of trust in the supervisor can all play a role in nondisclosure (Cook et al., 2019; Sweeney & Creaner, 2014). It has been suggested that this form of nondisclosure might be a type of self-defence employed by the supervisee in attempts to stay safe (Singh-Pillay & Cartwright, 2021) and is a passive approach i.e. not bringing topics up (Ladany et al., 1996). To navigate these spaces, supervisees may use impression management to appear more favourable when discussing their concerns. In this way, disclosures that would put them in a critical light are limited, this also talks to the power differences within the space and that conversations around these topics are often one-sided and ego threatening (Ladany et al., 1996).

Two other interesting possible explanations for nondisclosure include acts of resistance and role-modelling. In an attempt to counter perceived negative power differentials, supervisees withhold information to assert some control of the supervisory relationship (Sweeney & Creaner, 2014). Possibly as an attempt to appear favourably in the eyes of their supervisor, supervisees may also role model their perceived supervisor's nondisclosure, and withhold information themselves (Singh-Pillay & Cartwright, 2018). This

highlights the possibly unconscious role supervisors may play in disabling disclosure in the supervisory space.

Consequences of nondisclosure.

In the traditional supervision set up, supervisors will more frequently rely on their supervisee's reported accounts as opposed to direct observation of their clinical work. This approach therefore requires that supervisees provide an honest and accurate account, to enable the supervisor to support supervisee development and effectively hold risk (Mehr et al., 2010; Huntman & Ellis, 2019). When this doesn't happen, the consequences impact all three parts of the supervisory triad.

For the supervisee, ongoing unaddressed feelings of self-doubt and uncertainty can affect their development and self-efficacy (Hess et al., 2008), this could possibly also impact their confidence in carrying out the role requirements of a qualified clinician. Ladany et al. (1996) highlight that an important role of supervision is to allow supervisees to practice confronting sources of conflict so as to better be able to support clients to do the same. By not disclosing negative reactions to their supervisor, supervisees are not practicing this skill.

Similarly, nondisclosure can negatively impact on learning and knowledge, especially if supervisees devalue supervision and instead rely on their own knowledge (Singh-Pillay & Cartwright, 2018). If supervisees move away from established approaches for intervention, they could begin working outside of their own competencies which could have consequences and risk implications for clients they are working with (Singh-Pillay & Cartwright, 2021). Alternatively, if supervisees do not challenge supervisor suggestions, clients may receive inappropriate interventions (Ladany et al., 1996).

Nondisclosure on the part of the supervisee can also impact on the supervisor. On a personal level this could result in feeling defensive, disheartened and questioning the efficacy of supervision. On a professional level this can have serious and damaging consequences as the supervisor holds clinical responsibility. For example, (Ladany et al., 1996) in their sample of 108 supervisees, found that 44% of nondisclosures were about clinical mistakes and that 66% of all nondisclosures were discussed with someone other than the supervisor; the majority of these being a friend or peer. These nondisclosures were perceived as significantly more important to supervisee functioning than nondisclosures told to no one.

It is also important to note the potential harm caused by unconscious biases and microaggressions performed by both supervisor and supervisee within the supervisory relationship. These could have negative consequences for the supervisor, supervisee and clients.

What helped facilitate disclosure.

Providing a safe, supportive, comfortable and inclusive space (Sweeney & Creaner, 2014; Singh-Pillay & Cartwright, 2018), which has a structure with shared goals and agreements (Mehr et al., 2010; Huntman & Ellis, 2019; Cook et al., 2020), where supervisors focus on relationships and the working alliance (Mehr at al., 2010; Gibson et al., 2019), utilise curiosity to encourage disclosure (Sweeney & Creaner, 2014), normalise mistakes as part of the learning process (Yourman & Farber, 1996), discuss power and evaluation (Mehr et al., 2010), provide space to process personal issues (Sweeney & Creaner, 2014), acknowledge and process conflict within the supervisory space (Hess et al., 2008), work to mitigate anticipated negative experiences (Singh-Pillay & Cartwright, 2018) and where both

parties balance their cultural knowledge with an acknowledgment of the limits of their

cultural knowledge (Cook et al., 2020), all help reduce the likelihood of nondisclosure.

McKibben, Cook and Fickling (2018) highlight the benefits of using a feminist

supervision style. With such a style, the supervisor acknowledges and attempts to address

and appropriately balance hierarchy and power differentials, thereby forging a collaborative

and empowering relationship. Testing their conceptual model showed that higher ratings of

a feminist supervisory approach, predicted fewer instances of supervisee nondisclosure.

Similarly, supervisees who rated their supervisors' approach as more feminist, also rated a

stronger supervisory relationship.

Huntman and Ellis (2019) discuss the importance of two constructs that help inform

supervisee nondisclosure; supervisory working alliance (SWA) and supervisee's perception

of supervisor's multicultural competence. SWA is defined as the shared emotional bond

between supervisor and supervisee, as well as, agreed task and goals for supervision.

Multicultural competence is the possession of attitudes, knowledge, and skills needed to

work effectively with diversity. In their study, Huntman and Ellis found that SWA and

perceived multicultural competence were strongly related, with a stronger SWA associated

with higher levels of perceived supervisor multicultural competence, which in turn appeared

to be linked with reduced frequencies of nondisclosure. Gibson et al. (2018) support the

importance of the SWA in determining supervisee disclose. Although they note that SWA is

more strongly related to supervisor-related nondisclosure than client-related nondisclosure,

or in other words the quality of the SWA did not impact on the frequency of client-related

disclosure as much as it did supervisor-related nondisclosure.

Cook et al. (2020) introduce another construct, cultural humility. Cultural humility is a supervisor's openness and humble desire to learn with their supervisees about differing cultural backgrounds and varying viewpoints. Their research established a statistical link between supervisee's positive perception of their supervisor's cultural humility, and their willingness to disclose.

These studies highlight the importance of proactively addressing issues of power and hierarchy to facilitate a good working alliance and to open up spaces to discuss multicultural competence. Although their study did not explicitly look at this, exploring supervisee multicultural competence after a strong SWA has been created, will likely also be beneficial. This is supported by Cook et al. (2020) who highlight that supervisors have an ethical responsibility to provide multiculturally competent supervision, and that this should include discussions of difference within the supervisory dyad.

Although some supervisees felt that facilitating discussions around nondisclosure was the responsibility of the supervisor and that the initial steps should come from them (Hess et al., 2008), supervisees being more open to supervision and reducing their own level of egotism also helped the process (Sweeney & Creaner, 2014). McKibben, Cook and Fickling (2018) highlight that competent implementation of a feminist supervisory approach rests on the supervisor being self and other-aware. Finally, Mehr et al. (2010) point to the importance of supervisors empowering supervisees within the space; building their sense of confidence and efficacy.

Supervisor perspective.

Singh-Pillay and Cartwright (2021) was the only paper reviewed that looked at nondisclosure in supervision from a supervisor perspective. The study found a number of

interesting observations and highlighted considerable mirroring with the reported experiences of supervisees.

Supervisors reported receiving no formal training and no consultation, mentoring or guidance from the associated academic institutions; the implied expectation being that supervisors should be 'all knowing'. Supervisors therefore relied on their own experiences as a supervisor and supervisee but were unaware of any literature on supervision styles, could not identify their own approach, or effectively manage supervisee nondisclosure.

Some supervisors reported feeling ill-equipped and doubted their ability to supervise effectively. Others felt that supervision was imposed upon them, leading them to feel out of their depth, overwhelmed and powerless. For some, this resulted in supervisors viewing supervision as an obligation and becoming disinterested.

Power differentials seemed to be partially as a result of expectations of others (e.g. academic institutions and supervisees). Supervisors felt they needed to project an overly positive impression of the workplace and themselves as professionals, as well as withhold any deficits in their own knowledge, so as to appear as authoritative, in control and 'invulnerable'. This at times resulted in the purposeful use of nondisclosure, although other reasons also included a belief that it was not helpful to, for example, discuss personal issues, or due to wanting to facilitate supervisee learning, i.e. not give all the answers.

For supervisors, disclosure was prompted when it was considered to support supervisee learning, if it was in the patient's best interest, where it may improve supervisory alliance.

Conclusion

The papers in this review spanned a period of 24 years and provided a comprehensive picture of the developing knowledge of nondisclosure. The papers included both qualitative and quantitative methodologies and the data analysis section showed that findings complemented each other for the most part. The quality assessment of the papers concluded that sufficient research rigor was maintained across the papers.

This review highlighted that the phenomenon of nondisclosure is complex and still not fully understood. Although most often broken down into three main types; personal nondisclosure, clinical nondisclosure or supervisory nondisclosure, interactions between these three types can make a clear understanding difficult. Similarly, the frequency of the phenomenon is inconsistently recorded. Although all papers in this review identified incidents of nondisclosure, differences across type, demographics, methodology, time frame and construct explored, all impacted on reported nondisclosure; further evidencing the complex nature of the phenomenon.

There are several findings from the review that bare important consideration, these will be discussed further.

Systemic considerations – organisation culture, training and setup.

There appears to be a number of considerations that should be held in mind before supervisor and supervisee meet for the first time:

- How supervision is understood within the wider organisation and whether it is valued and prioritised as an important part of clinical work.

- In what ways are supervisors provided with sufficient training to enable them to understand the expectations of the role and to feel confident, competent and engaged.

- How the supervisory space is set up and whether it includes a shared understanding of its function, with rules and goals identified and co-constructed.

Without these important elements, supervisors may feel unsupported by their institutions, be left feeling undervalued and may resent their role. Similarly, supervisees may struggle to understand and effectively utilise the space, leading to a devaluing of the process.

Risk.

Underpinning all clinical work and informing effective practice, risk management is an integral part of a clinician's role. Highlighted in this review are the resulting risk implications of nondisclosure for the client, supervisee and supervisor. Although there are many individual factors that will also impact on risk, exploring incidents of and working to reduce nondisclosure should be considered an important action within any supervisory space.

Limitations.

There were a number of limitations across the papers that impact their generalisability. The relatively small number of papers coupled with the differences in methodologies, approaches and constructs being explored, meant the sample could not be considered homogenous. Similarly, the ranges in participant numbers and demographics make it difficult to draw direct comparisons. Linked with this are the participants

themselves who were all therapist trainees and therefore not representative or other

disciples or qualified clinicians; it should be noted though, that the samples collected by

each study were likely reflective of the trainee therapist cohort. Finally, in terms of

generalisability, all but two of the studies were based in white western nations, with the

other two being based in South Africa. This therefore does not reflect how the phenomenon

may present at a global level.

Although across the papers, the impact of demographic differences was not always

directly related to nondisclosure, this inconsistency was likely caused by two main reasons.

Firstly, the papers were not specifically looking at the impacts of diversity and

nondisclosure. Secondly, the demographic makeup of the participant samples was unlikely

to provide any meaningful data due to the comparatively small numbers of members of the

global majority being included. This highlights an important gap in the existing literature as

within large institutions such as the NHS, whose workforce is increasingly diversifying,

understanding how difference is understood and spoken about in supervision will be critical

to growth and wellbeing.

Summary

This review set out to understand what is known about nondisclosure within clinical

supervision. To do this it identified 13 papers and through synthesis brought together

findings into five main categories: the content of nondisclosure, the frequency of

nondisclosure, the reasons for nondisclosure, the consequences of nondisclosure and what

helped facilitate disclosure. In addition, four key components were identified as being

helpful in reducing nondisclosure; these are listed below.

Four key components to supervision:

1. Having a clearly defined space where all parties are aware of the goals and expectations of the space. This could take the form of a supervision contract. This space should also be understood to be an important part of patient care and supervisee development.

2. Having a focus on relational aspects and working alliances. Initially this will support the development of the space, but should be routinely revisited to process any conflict.

3. Having an understanding that supervision can be a space for shared learning. Mistakes can be normalised and learnt from and disclosure can come from both parties.

4. Having open discussions of power and difference, where knowledge can be shared and competence cultivated.

An important observation from this systematic review of the literature is that it did not identify any research that looked at the phenomenon of nondisclosure within nursing clinical supervision, only supervision among therapists.

It is likely that the themes identified in this review will translate in some way to nursing supervision, however as nursing has a different history of and relationship to supervision, there are likely a number of additional factors that remain unknown. Similarly, as it has been suggested that negative attitudes towards clinical supervision among nurses may be a cause for the low overall uptake, therefore researching this through the lens of nondisclosure may provide valuable insights. This observation indicates a gap in existing knowledge and provides a rationale for the current research.

Chapter three - Methodology

Design

From the earliest conceptions of the study, it was decided the inclusion of a consultation team comprised of nurses was imperative to ensure research quality and integrity. An advert was placed in the researcher's local trust's newsletter. As this was in the early design stage, the methodology had not been fully developed and ethical approval had not been sought, therefore for expediency the local trust was chosen due to the researcher having readily available access to the local comms, alongside it being a major employer of mental health nurses in the region. The chosen trust eventually became one of those used for participant recruitment. One nurse contacted the researcher and after a discussion around the aims of the research agreed to support the research and contacted two colleagues who also expressed interest and agreed to join after an initial discussion. The team met at different stages of the study to plan; these meetings were facilitated using online communication. Outside of these times the researcher used the consultation team to discuss reflections and ideas.

Previous studies investigating nondisclosure have utilised both qualitative and quantitative methodologies. This project utilised a qualitative methodology, the rationale for this was with the aim of providing a more in depth understanding of the phenomenon as it occurs within nursing clinical supervision. As research into nondisclosure within supervision comprises a small body of literature and research into nondisclosure among nursing supervision in particular being in its infancy, it was felt by the researcher and consultation team that a deep exploration would offer more valuable findings, both for developing current understanding and informing future research.

Using semi-structured interviews, data was collected on participant experiences and opinions of nondisclosure and clinical supervision. Data from the interviews was then analysed using Thematic Analysis (TA). When themes were identified these were then given back to participants with the aim of member checking to improve the overall quality of the research. During member checking, data is returned to participants to check whether it captures their experiences (Birt, Scott, Cavers, Campbell & Walter, 2016).

Research of this type is subjective and findings are often influenced by assumptions and biases of those interpreting the data. Subjectivity has been argued to be an important and key aspect of TA as long as it is accompanied by the process of reflexivity (Braun & Clarke, 2022). Reflexivity involves continuously reflecting on assumptions, expectations, choices and actions throughout the research process (Braun & Clarke, 2022). To accomplish this, the researcher kept a reflective journal throughout the research, extracts of which can be found in appendix twenty-two. The researcher also utilised regular supervision with the research team and the nurse consultation team to reflect on topics such as progress and barriers.

Research question

The overall aim of the research is to understand the experiences of nondisclosure among inpatient mental health nurses who access clinical supervision. This was broken down into several sub-aims which, alongside the nurse consultation team, informed the interview schedule. These sub-aims were:

- To explore whether nurses describe experiences of the phenomenon of nondisclosure within clinical supervision.

- If they do describe experiencing nondisclosure: what factors do they feel precipitate its onset, cause it to perpetuate within the space, how does it impact them, and what factors do they feel may facilitate disclosure?

- Are there common trends with what is already known within the therapy nondisclosure literature?

Why thematic analysis.

TA is best suited to understanding a group's conceptualization of a given phenomenon (Joffe, 2011) and can offer a flexible approach that has the potential to provide rich, detailed and complex accounts of data (Braun & Clarke, 2006). The method also aligns with the researcher's epistemological stance of a critical realist. As a critical realist the researcher holds the view that a separate reality does exist, however it is contextualised and our experiences and practices shape how we know and understand this reality (Braun & Clarke, 2022). In other words, the researcher holds the view that the constructs of supervision and nondisclosure are knowable however, the researcher's own experience, those of the supervisory and consultations teams and those of the participants will shape how this is understood.

TA was also chosen as it allows for a mix of both inductive and deductive approaches which this research has included. The existing literature into nondisclosure informed part of the analysis, as certain key areas such as the supervisory relationship was paid particular attention to amongst the data in a deductive fashion. However, as this was the first time the research had been conducted with a nursing population, potentially new themes could emerge in a more data driven inductive approach.

Additionally, TA can facilitate the move beyond the content level, which looks solely at explicit meaning within the data, and towards analysis at a semantic level which involves interpretation. Through interpretation, theorising of the broader meanings of patterns and the resulting implications can occur in line with existing literature (Braun & Clarke, 2006).

Finally, TA was chosen as it offers the choice of a broad shallow analysis or a narrower in-depth analysis (Braun & Clarke, 2006). There are merits to both; as this is an under-researched area, a broader analysis might be preferable as it has the potential to capture lots of data, although as the research is looking at the phenomenon of nondisclosure for the first time among nurses, a detailed analysis would allow for the discovery of richer detail and nuance.

There are disadvantages to TA, one of which is linked to its flexibility as an approach which has the potential to lead to inconsistency and a lack of coherence (Nowell, et al., 2017). In contrast to other qualitative methods, TA also does not allow the researcher to make claims about language use or the functionality of talk (Braun & Clarke, 2006). Also as a qualitative method requiring interviews, participants cannot remain anonymous which given the topic under exploration might lead potential participants being hesitant to take part.

There are other interpretative designs which could have been utilised for this research and two were considered, grounded theory (GT) and interpretive phenomenological analysis (IPA), both were discarded in favour of TA. For GT this was due to the goal not being to create a theory, that it's methodology was clearly defined offering limited flexibility comparable to TA and that the method of recruitment was likely unfeasible given the challenges recruiting from the population. IPA was not chosen as its epistemological position did not fit with the researchers; it does not allow for a deductive approach which

this study utilised (e.g. previous literature informing interview questions) and the small

numbers may have limited transferability as it was possible all participants might come from

a single ward.

Participants

Ten mental health nurses were recruited for the research. Eight of the participants

identified as female and two as male. The participants ranged in age from 24-66 with a

mean age of 37 and a median age of 32. Four of the participants identified as White British,

two as Black African, one as White Irish, one as British Pakistani and one as British Asian and

one as Chinese. One participant considered themselves to have a disability. Six of the

participants occupied band 6 positions and four occupied band 5 positions. Time registered

ranged from 5 months to 7 years. Seven of the participants currently worked in inpatient

settings and three had worked within inpatient settings within the last six months.

Recruitment.

As the research followed a qualitative methodology, homogeneity of the participants

was an important consideration. Nurses practice across a wide range of health care settings

and therefore to maintain homogeneity one specific subgroup of nurses was chosen;

inpatient mental health nurses. Inpatient mental health nurses have a number of contextual

factors such as working with acutely unwell individuals whose risk may be higher, utilising a

shift-working pattern and operating within an environment that can be highly

unpredictable. This group was chosen as the researcher is familiar with inpatient wards and

is aware of the significant impact caused by the demands of working within such a setting.

The type of person who would be drawn to the research, or who might be reluctant to contribute, for a range of reasons, and how this could impact on the data was considered. It is likely a number of people with a relationship with nondisclosure were not able to contribute and their voices not heard due to the challenges and possible anxieties of discussing the topic. Although a variable that could not be controlled it was an important consideration during the analysis phase.

Recruitment was carried out in the East of England using Purposeful sampling. Study information was sent out through each of the trust's newsletters via the comms team. The local collaborator in each trust also disseminated study information (participant information sheet, expression of interest, advert poster; see appendix) to senior nurses and nurse managers. Finally, word of mouth recruiting was also carried out using the nurse consultation team.

Recruitment became a significant challenge to the research, which will be discussed in detail in the discussion section. Initially it was planned for more participants to be recruited but this became unrealistic due to time restraints. To aid recruitment, several amendments were submitted to allow for preceptees to be included in the research and for social media to be used as a recruitment tool. The Professional Nurse Advocate programme was also contacted and they agreed to advertise to colleagues who worked in the trusts that were approved. A presentation was also given to preceptee nurses in two of the three trusts, managers in one inpatient setting and a psychology team in one setting (appendix sixteen).

Finally, with the agreement of one trust, the consultation team and the researcher went onto an inpatient ward. The consultation team took the place of the nurse on shift so

that they could attend the interview. This method allowed for five nurses to be recruited,

the other five were recruited through subsequent word of mouth.

Inclusion and exclusion criteria.

Inclusion criteria.

- Mental Health nurses

- Bands 5/6

- Currently working or experience within the last three years of working, within

  inpatient settings

- Accessing individual Clinical Supervision

- Permanent staff

- Preceptee nurses

Exclusion criteria.

- Community based nurses. Due to having different pressures in terms of cases, time

  and environment.

- Band 7 nurses. Due to the differences in type/frequency/function of supervision.

- Dual-trained nurses were not excluded but the focus was on their experiences of

  supervision as a mental health nurse.

Ethics

The research obtained approval from HRA (appendix eight) and the University

(appendix seven). Due to the nature of the study, REC approval was not required.

Participant emotional wellbeing.

It was assumed that nurses who had been cleared by occupational health to work in an inpatient setting would be emotionally well enough to take part in the study. Discussing difficult experiences of supervision has the potential to cause distress. Participants were reminded that they only needed to talk about what they felt able and willing to talk about. Participants were informed that that they could take breaks and their rights to withdraw. All participants were also provided with a list of support networks that they could access.

Study involvement also presented a time burden for participants (approximately 60 minutes). The trusts had agreed for the interviews to take place in work hours so that participants could get paid. The nurse consultation team also recommended that interviews should be conducted at weekends when the wards are generally quieter.

Confidentiality.

Potential participants were required to complete an expression of interest form. Only once the form was received was personal data held. All data collected was anonymised, using pseudonyms and kept confidential in compliance with the Data Protection Act 1998 and GDPR. All physical documents containing personal identifiable information were stored in a locked cabinet that was only accessible by the researcher. All electronic documents were stored on the University of Herefordshire Secure Cloud only accessible by the researcher.

All face-to-face recordings were stored on an encrypted Dictaphone and all remote recordings were stored on a secure cloud server. Personal identifiable information was removed from the transcript and the recordings deleted on completion of a quality check on the transcripts.

A third-party transcription service was used. Before any data was sent to them, a non-disclosure/confidentiality agreement was signed.

Informed consent.

Informed consent was discussed and taken from all participants prior to the interview commencing. The discussion was formed around the consent form which was then signed by the participant.

Participants were informed that all material was kept confidential, unless serious concerns about their wellbeing were raised. This was in line with statutory and professional responsibilities.

Face to face interviews in the context of COVID-19.

As this research was conducted during the global pandemic, all local protocols around COVID-19 safety were followed, for example the wearing of medical grade masks, adhering to room occupancy and using cleaning wipes. A specific university risk assessment was also completed.

Other sources of stress.

Due to the recruitment method, it was anticipated that participants may feel a pressure to engage with the research from their managers. This was mitigated by, where possible, meeting with managers to discuss the research and reiterating that it was a voluntary process. The nurse consultation team also supported this by talking to potential participants peer-to-peer, also reiterating the voluntary nature and facilitate a more informal 'chat'.

Additionally, nurses work very long hours and finding time to fit the research around their shifts may also be a source of stress, to mitigate this the researcher was flexible with

interview times and participants were able to cancel planned interviews last minute if ward

demands meant they were unable to attend.

Client consultation

The research incorporated a consultation team of three mental health nurses with

experience of inpatient settings. The consultation team were recruited through an advert in

the trust's comms letters and an information telephone call to discuss the role. The team

was consulted at each stage of the research; they helped design the interview schedule,

supported recruitment for the interviews and consulted on the emerging themes.

Procedure and Data collection

Following receipt of ethical approval and university sponsorship, data collection

commenced. The procedure is summarised below in figure six.

The interview schedule was developed through a review of the existing

nondisclosure and supervision literature, in collaboration with the nurse consultation team,

and in consultation with the research supervision team. The interview schedule was then

used in a pilot interview with a separate nurse volunteer who gave their feedback on the

questions and overall experience of the interview; this interview was not recorded or used

in the research.

Upon completion, a summary of the research findings was sent to the three

collaborating trusts and written in a format that was suitable for academic journal
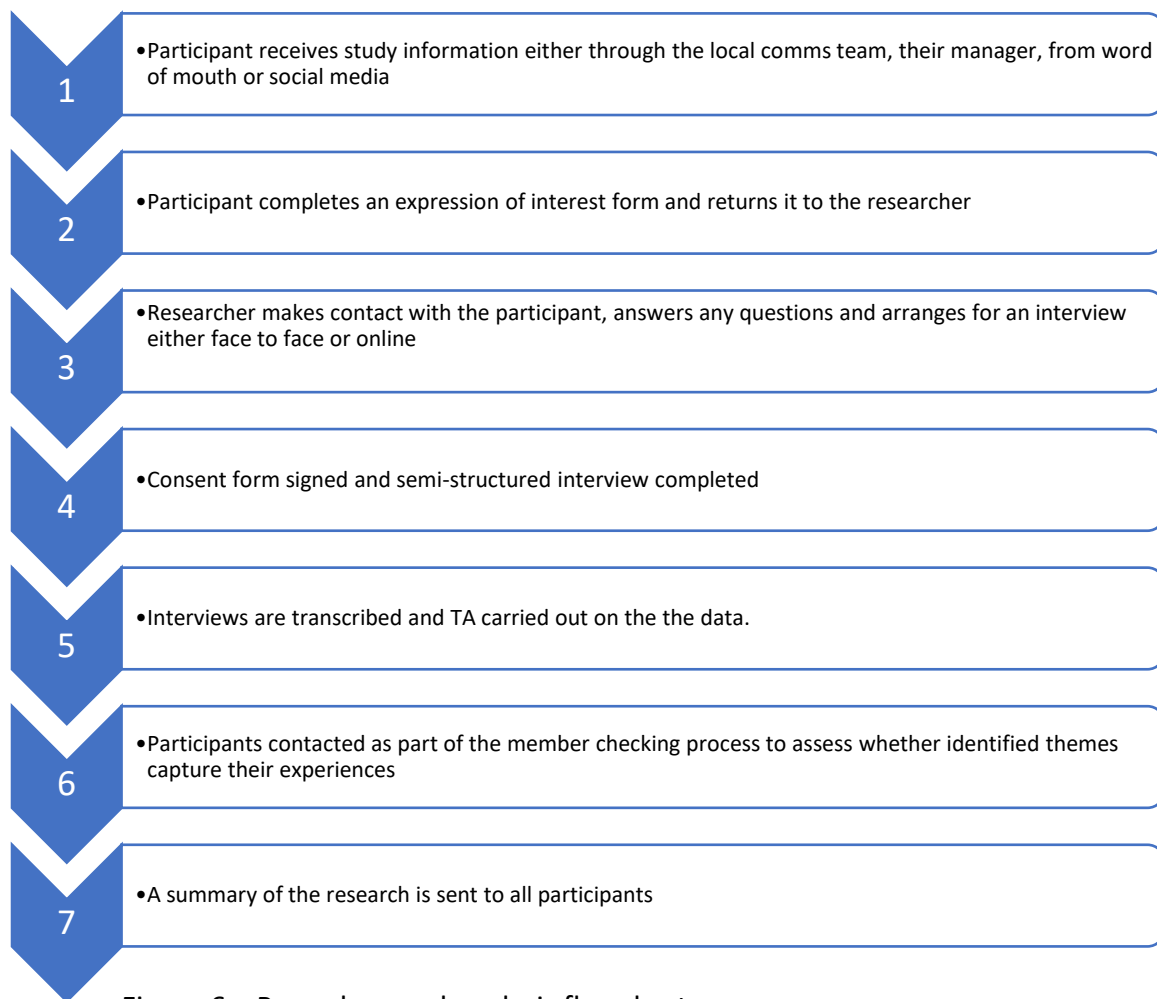
publication.

1 •Participant receives study information either through the local comms team, their manager, from word of mouth or social media

2 •Participant completes an expression of interest form and returns it to the researcher

3 •Researcher makes contact with the participant, answers any questions and arranges for an interview either face to face or online

4 •Consent form signed and semi-structured interview completed

5 •Interviews are transcribed and TA carried out on the the data.

6 •Participants contacted as part of the member checking process to assess whether identified themes capture their experiences

7 •A summary of the research is sent to all participants

Figure 6 – Procedure and analysis flowchart.

Data analysis

Thematic analysis was used to analyse the data collected from the semi-structured interviews. TA is comprised of six main phases; these are outlined below. Braun and Clarke (2022) note the importance in understanding there is not a single way to *do* TA and that the process is not necessarily linear. This is because reflexivity on behalf of the researcher forms a large part of the process, and so phases can be revisited and new meanings made.

- Phase 1: familiarisation with the dataset – immersion in the data by reading and re-reading transcripts and listening to audio recordings. Beginning to make brief notes of initial ideas.

- Phase 2: coding – systematically working through the dataset (e.g., line by line) identifying segments that appear relevant and meaningful to the research question, and giving them a coding label. These are then compiled together.

- Phase 3: generating initial themes – clustering codes to start developing a shared meaning across the whole dataset.

- Phase 4: developing and reviewing themes – checking the initial themes to ensure clarity with the initial codes and consistency across the dataset. Radical revision may occur if themes are brought together or separated out. Consideration given to the relationship between the themes and existing knowledge.

- Phase 5: refining, defining and naming themes – 'fine tuning' the analysis by ensuring that each theme is distinguishable from the others, a brief synopsis of each theme is written.

- Phase 6: writing up – Although in TA writing can start from phase three onwards, the final write-up involves pulling everything together.

The analysis' member checking process took place between phases five and six.

Quality, validity and Self reflexivity

To assess the quality of the current research, Tracy's Eight "Big-Tent" Criteria (2010) were used. The research is a worthy topic; at a time of high nurse shortages across the NHS as well as an increased focus on restorative supervision and staff support following the global pandemic, understanding any potential negative impacts on the supervisory process is important. The research is rigorous with a detailed method for data collection and analysis which is based within theoretical constructs, and the use of a nurse consultation group to allow for both insider and outsider perspectives. The researcher aimed to be

sincere and utilised self-reflexivity to look at possible value-driven biases. To improve

credibility, thick-descriptions and quotes were used, multiple voices were also heard.

Although the sample size limits broad generalisability, its findings will hopefully be

transferable to other similar settings. As this is the first time this research has been

conducted with nurses, its findings can contribute and widen the understanding of the

phenomenon of nondisclosure within supervision. Ethics were considered throughout the

research from the recruitment of participants, culturally specific considerations for example

ward environments and the final sharing of the outcomes.

Chapter four - Analysis

Summary of findings

As TA is a reflexive process (Braun & Clarke, 2022), for this section the first person

will be used in places as a way to better convey my connection with the analytic process.

When reading this interpretation, it will be helpful to hold in mind that surrounding

and woven throughout each of these themes was the interaction of three components in

the supervision process: the supervisee, the supervisor and the environment, which all
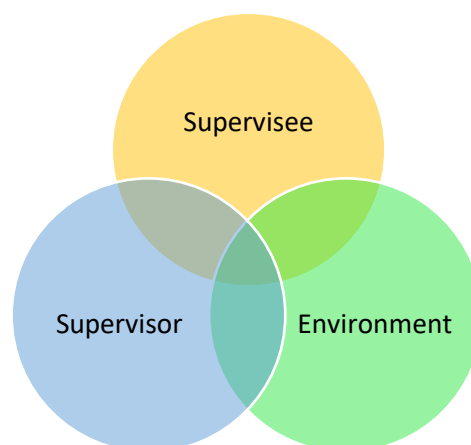
impacted on nondisclosure.

Figure 7 – Ven diagram of interacting components.

Two of these components, the supervisee and supervisor, have been identified previously in the literature and were identified in this analysis through a deductive process, whereas the environment has not been described in detail previously and so was developed inductively.

My first conceptualisation of themes for this analysis contained each of the three components as individual themes, a thematic map of this can be found in appendix twenty-one, however it became increasingly clear that there was considerable overlap, and as themes, these three were not entirely discrete. Therefore, the themes were evolved through a process of reflection and refinement to 'let things go' and 'make room for new interpretation' (Braun & Clarke, 2022) and a second conceptualisation produced.

Both conceptualisations offered an interpretation of the data and in discussions with the supervisory team, it was felt the first one offered a shallower exploration but potentially more practical application i.e. it pointed to three discrete areas that could be targeted for change. The second however, offered a deeper exploration that was perhaps more abstract as the areas were no longer discrete and could work independently or in conjunction. It was assumed that the first conceptualisation might be more preferable for an operational implementation of the findings. Therefore, I decided to share each with the nurse consultation team and gain their feedback on which they thought would be most impactful. The consultation team fed back that although both offered a useful insight, they preferred the second conceptualisation as they felt it conveyed the felt emotion more clearly and that it was running closely with training that they had received on leadership. They did however, feel that the visualised thematic map was very helpful for the first conceptualisation and so a map was created for the second one, see figure nine.

Separate to these discussions, there was also a process of reflection as to why I was perhaps trying to 'fix' this aspect of supervision by looking for practical application and assuming this would also be what nurses would wish for, even though this was not my research question. Research supervision was used to reflect on my personal values and my epistemological position as a researcher, specifically what it meant for me to 'fix' and whether this needed to be an observable and quantifiable change.

Following this period of consultation and reflection, the second conceptualisation was felt to be a better fit for the data and so was used for this analysis.

Braun and Clarke (2022) note that the write up stage is not an addition, but instead is embedded in the analytic process which continues to *produce* the analysis. Indeed, whilst writing this section, the identified themes went through further evolutions and moved from a collection of seven to five themes. These are outlined in the table below. Several of the themes had subthemes which have also been summarised.

The first two themes describe more broader cultural narratives, themes three and four the supervision space and the fifth the supervisees reactions.

Theme 1	Expected to be a superhuman	
Theme 2	You work with them more than your family	- Putting the team first - I'm not a grass
Theme 3	A poorly defined space	- I didn't know that was part of supervision - An invalidating experience
Theme 4	Relationally unsafe	- Impression management - It would do more harm than good - But you always wonder don't you - Everyone's different, you know
Theme 5	Strategies to stay safe	

Figure 8

The thematic map shown below visualises the idea that the themes are working across a number of layers, with the two widest circles representing broader narratives, within which the middle circles represent the supervision space, and the smallest circle the in-the-moment responses made by the supervisee. Each circle is not necessarily the result of the preceding one, but it occurs within it.
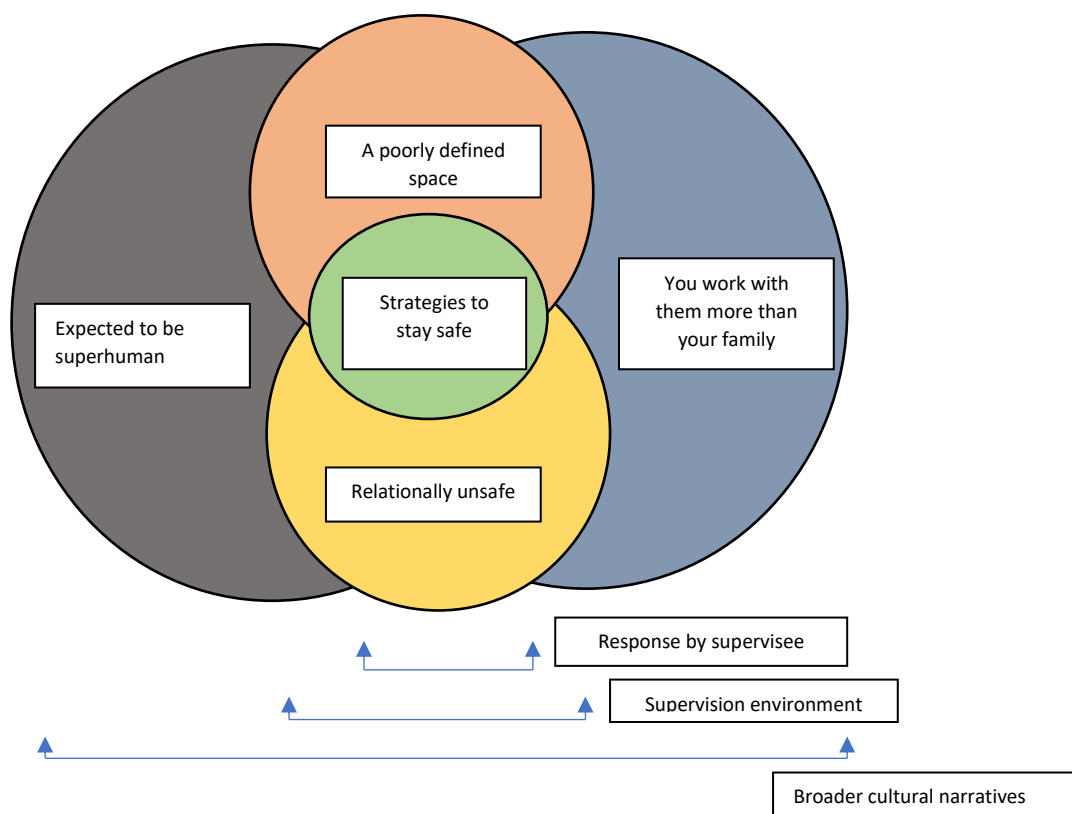
Figure 9

Theme one - Needing to be Superhuman

This subtheme spoke to the internalised belief held by participants. Interestingly this was described more strongly by the band 6 nurses, which may be the result of being in-between the junior nurses and ward manager; needing to manage the demands of the ward, whilst meeting both the immediate needs of their band 5 colleagues and the expectations of management. Vanessa, Zainab and Sarah describe the impact of this expectation:

but, as you go higher, I think it becomes more difficult to open … to … to open up fully about what you're really going through, and sometimes I think you just … want to put on this brave face, and just carry on really … and you're not really expressing and letting out … what you are feeling. I suppose as you go higher, they expect you … they expect you to handle it, isn't

it? You're supposed to … you're expected to … to be this strong person … you're expected … to do the job effectively otherwise you know … who knows, you think maybe I'm apologising for not being able to do my job well, you know … so, you take on a lot really… as you know, from a Band 6 role, I'd say that … you know, taking on a lot and not opening up as much as you should … should really … you know, when things are not going the way they should be, so … you sort of bear it and go on, I think

when I had the first supervision after a year… I didn't question why haven't you given me supervision for a year which is what … I don't know why I … I mean, I can't explain. I mean I should have really … it's a question I should have asked really, isn't it? Maybe, being a Band 6, trying to make sure to appear like you got it … everything's OK, I've got it all together, you know … suffering in silence kind of thing, you know

I think there's also like an expectation when you're a Band 6. Like a lot of things … I feel like are just thrown at you and you … you just have to sort of get on with it because they feel like you're … you're the charge nurse

God … yeah, it sounds bad … looking back, I'd probably say I didn't feel comfortable talking about a lot to be honest… like kind of basics of work stuff really because again, as I've said I felt like I had a lot of pressure on me to kind of … to carry sort of the load of the ward and keep my chin up sort of thing so, I didn't … I didn't really feel comfortable saying if things were hard … I was someone that … I was asked like continuously to do extra bank shifts and stuff like that … so, I felt like there was a lot of pressure from management and … yeah, to just sort of keep going

The ability to be able to 'carry on' appears to be a cultural belief held by the nurses. It is also possible that this is reinforced by a narrative held more broadly in society, evidenced perhaps by the popularity of the 'clap for heroes' at the height of the pandemic.

The perceived expectation to be 'the strong one' to 'carry the load' and to 'suffer in silence' may imply that disclosing difficulties might feel forbidden, Zainab talks to this when she describes 'apologising for not doing my job well'.

Theme two - You work with them more than your family

This theme talks to the unique role the team plays within the inpatient environment, which is likely different for other disciplines and in other contexts. An interesting observation was that almost all examples of nondisclosure spoken about during the interviews were linked to relational challenges within the staff team.

Subtheme one - putting the team first.

This subtheme spoke to participants holding the team and their supervisor in mind which impacted on their ability to be fully present in supervision and also to prioritise attendance over other ward demands. This drive to put other's needs before their own, might be linked to how participants view their role as a nurse, i.e., as a provider of care, and the importance of working as a team when supporting severely unwell and potentially challenges patients.

I can't always focus 100% on the supervision because my … yeah … like my mind was on the supervision, but then also thinking of what's going on outside the ward, I'm like "I hope they're OK"

I finish at 8 o'clock … they're starting the shift, they … they're the nurse in charge, they can't be spending that first sort of half an hour, 40 minutes with me because it is that crucial … and that's the most riskiest time as well on the ward

I do understand it is an acute ward and it is not always the case, and how … my supervisor can be extremely busy. Because my manager – she would WANT to meet every month – but it's just sometimes just not possible.

I think I am mindful of the time especially, I remember once I had supervision … and I think it was allocated for an hour or half an hour but it was sort of running a bit over, and I knew it was medication time and the other nurses would struggle, so I was sort of hurrying off a little bit

Linked with this was participants worries that speaking up might be an unwanted additional source of stress in an already pressured environment. Resulting in participants choosing not to disclose in order to protect others. This belief may have originated internally within individual nurses, but its prevalence suggested it was also a ward cultural belief.

When the ward environment is so stressful already, you didn't want to be pushy … and add like this extra stress on top of everything else you're doing already

Another concern held in mind by the participants was the impact their supervision would have on the ward. Gina, Tammy and Danielle describe the impacts of the ward pressure on how they prioritised their disclosure.

we'd often only have two nurses, so it would be you and … you know, maybe your supervisor …and so, I'd just … I think I … I wouldn't have wanted to as I said sort of disturb … disturb the day if you were busy

because then when the ward is busy, it's difficult to have those … yeah … to have like a long, in-depth conversation regarding supervision … yeah… because sometimes it's like … difficult … if it's social stuff, it's difficult to like call your supervisor and say "Can I talk to you?" when there's so much other things that need doing that take priority on the ward

I felt that she's under pressure for time, I'd probably just say "Yeah, everything's fine" and not say the important things that I'm feeling. and watching her getting distracted by the ward, and watching her that she's stuck for time, and then I'd be like "You know what? Things are fine, don't worry about me, take priority of the ward.

Subtheme two - I'm not a Grass.

This theme spoke to a held belief that raising concerns about their colleagues would lead to the issue being escalated which might negatively impact on their colleague and potentially disrupt the team dynamic. Bill, Tracy, Gina and Vanesa talk about their worries with this topic:

I don't like to … speak … when, you know, the supervision is … what I think, that what I meant to say …is going to affect someone in a negative way … like a complaint … or say, you know, this … staff, you know, is … not good.

in terms of supervision I think I am pretty much comfortable talking about anything. I think staff … staff issues, I think is always going to be the tough one. I think obviously … because you work with these people … you work with everyone … you work with them more than you would with your family at home … and I think sometimes it can be quite difficult sort of saying "I'm really … I don't like how this person's done this, this, this and this" … because, I think sometimes you don't want to get … it carry on in a sort of … go into something a bit

more … not serious – it's not the right word to use – but sort of … tumble you into something

a bit bigger

you don't want to interrupt the staff's balance, you know, the happiness of the staff … you

don't want to … you don't want to … you know, cause something for … for no reason maybe

… I mean I never … I never had these issues, so I never had to … but I can … you know, if

something was going on and I just … I probably just wouldn't talk about it … because you just

don't want to upset the dynamic of the unit.

I don't want to feel like I am … I am grassing my colleague, you know, so those are … those

are difficult issues that you need to talk about it. It's like the elephant in the room – we both

know – but it's quite difficult to … sort of bad mouth a colleague who's on the same level

This theme may talk to a blame culture within the ward environment which might

negatively impact the ability to be candid about peer performance. The idea that discussing

these issues will automatically lead to a negative outcome suggests a lack of safety. It also

suggests a level of fragility within the team, that the team would be unable to cope with any

disruption such as being a person down or conflict between staff. Highlighting the pressure

that staff feel they are under to keep everything contained.

Theme three - A Poorly Defined Space

This theme talks to the challenges brought about by a lack of a definition for

supervision within the setting and the resulting impact on the supervisee's experience.

Subtheme one - I didn't know that was part of supervision.

This subtheme relates to the lack of a shared understanding of what supervision is

for and what it should look like. This uncertainty appeared present within the supervisee's

understanding, the supervisor's construction and wider environmental conceptualisations of what constitutes supervision. Interestingly almost all participants described a problem narrative; supervision was there to identify problems, fix issues and learn from mistakes.

Participants gave a range of ideas for the purpose of supervision, as highlighted in these comments from Bill, Vanessa and Geoffrey:

supervision is more … more or less like a … you know, get together, see … see what's the problem in this area and … and then trying to, you know, help each other

I think … the … the purpose of it is just to sort of vent really, and just talk about what's … what sort of issues I have on the ward

the important thing is to do … is to have supervisions … so, the format really is … I don't think it's very … very important

This final point is interesting as it suggests a lack of awareness of importance of supervision for practice and could suggest a more 'tick box' approach. Alternately it might highlight a need for flexibility in the ways that supervision is conducted given the nature of the ward.

Not fully understanding the function of supervision also meant that needs that could have been met by the space, where instead taken elsewhere; overtime this might lead to a mystifying of the space. Bill, Emily and Geoffrey speak to this:

we always talk, you know, between us … between … you know, Band Six's and Seven's, doctors, so in a … in a way that … that supervision is quite regular, but it's in a kind of … informal way

we do that … yeah, so that's like discussions we have at hand-overs daily, and we'll always discuss different things there… we can do that like with the hand-overs … we have huddles … safety huddles as well at hand-overs … we have safety huddles so we can ask what's this, what's that?

we usually don't go into detail with the patients…but we do these discussions we will do hand-overs and it is …with the whole team … that's when we will discuss how best we can actually manage the service user on the ward

At times, it seems supervision became quick drop-ins to discuss clinical concerns, for example:

Yeah. What I'm saying here is that sometimes, during a month, we've not actually had time to sit down and do a supervision …but we always talk about it and … in the times we meet, we always have time to meet to talk about issues, and to just say "OK. This is our supervision."

I can … just to knock on her door … if I see she's not on the phone and she's free, and there's an issue I need addressing on the … you know, relating to work, I just have that informal discussion.

Tracy spoke highly of this more ad hoc approach:

I think that's … also acknowledges and it also validates it as well if I can go to my supervisor and say "Can I please just have ten minutes … can I please just discuss this, this, this with you?" … and sort of like … "Yeah, that's fine" … and like "OK this is what we can do sort of about that" … so, the problem solving aspect maybe that sort of also helps … um … and also if I'm saying … "Right, no … I'll see you in five minutes and have a quick chat with you" … and

it is being acknowledged … it's not saying "Oh, just wait til the end of the day, or wait til next week, I'll schedule it in" … it's like "OK" … in that moment in time … to sort of understand that I need that sort of 5/10 minutes

The potential problem of a space that isn't fully understood by those using it, is that it can lead to needs not being met. Sarah talks to her experiences of this as it seems there was pressure from outside the ward to undertake supervision but that within the ward this became another task to find time for, perhaps more a burden than a helpful exercise.

I felt like as a priority it was like a tick box sort of thing – like they knew that they had to get it done – so, like they tried to squeeze it in wherever they could basically

Subtheme two - an Invalidating Experience.

The final comment links to the second subtheme which talks to the experience of the process of supervision. Participant accounts talk to the challenges of setting up a predictable and consistent space within the inpatient environment. Participants reported a wide range of different experiences of supervision, for example, Bill and Tammy described different approaches between their supervisors:

she was brilliant. She was always respectful. She was always open, you know, it was asking questions, and sort of what I want from her, you know …and then I got another supervisor… that I never … I never met with her. I don't know why.

whatever we talked about, he typed up really nicely saying like this is what we're going to do … like … and then he emailed it to me, so that was good … but then after I finished, my supervisor changed, and he didn't do that.

Further inconsistencies were noticeable when looking at the experiences of Gina and

Sarah:

They were quite good … we would often let the … there was a big book and you would look

in the book and you would plan your next … so, if your supervisor couldn't do it, then it would

go up to the manager, and then the manager would do it instead.

so, my supervisor would sit there with a notepad, and kind of just freestyle it.

Gina's experience seems to be one where a structure is established with supervision

being planned proactively, and a contingency in place if her supervisor was not available,

whereas Sarah's supervisor's style seems to be developed in the moment.

Participants also shared their thoughts in response to these approaches, for example

Bill spoke quite positively of his supervisor's style and similar to Geoffrey's earlier comment,

suggested a narrative that within the ward environment, flexibility with what is considered

supervision might be preferable.

he's very … informal… you know, he like "Oh yeah, yeah … we have to do supervision …this …

tonight" … and then he asked me two or three questions, blah-blah-blah … and I answer and

he's "Oh yeah, yeah, we'll fill out the form later on"…you probably think that it's not

respectful because it's quite informal … I told you it was informal, yeah, a couple of questions

and that's it, you know … but, no it works with us.

Sarah on the other hand described a different reaction in response to her

supervisor's style, suggesting perhaps an underlying message that supervision was not

important.

I was someone that I never received like supervision notes or anything like that … so, I kind of … yeah … I didn't take it probably as seriously as I would have done had there been like an agenda and my notes given to me and stuff like that

It is hard make sense of what caused such a large inconsistency between supervisors among participants in this study, but it is possible that this could be related to the training supervisors had received and wider cultural narratives on the ward around the importance of supervision.

Further variability among participant experiences seemed linked to the ward environment itself. An example of this is logistical considerations, which Tammy spoke to when talking about the shift pattern.

… and then like my allocated supervisors were … were either working different shifts to me, like … because they do day and night shifts …like I could be doing the day shift, but then they're doing night shifts, so it was difficult to like find like a time to do it.

Tammy went on to describe that when time is found for supervision the nature of the ward meant that often it was difficult to facilitate effectively:

I do remember times when we were in supervision, people have like knocked on the door and kind of go "Oh I'm sorry we need you to come out and deal with this" because there was an emergency situation on the ward

Perhaps unsurprisingly, this meant that the frequency and duration of supervision also varied considerably. This is shown below in the comments from Danielle, Bill, Geoffrey, Gina and Sarah.

Not often. Not often. I probably … I worked there for three … three years and I maybe had two supervisions.

very, very, very bad. You know, it's not … not regularly at all… probably about two years ago we try to have it every month … monthly

Every four weeks

but yeah it was … it was always different it changed every time really. I wasn't really sure how long the supervision would last for … like it would change each time.

When it came to supervision for the participants, it appears that there were lots of uncertainties from not knowing when they would have it, what they would get it, and how long it would last. These appear to be amplified when it was perceived that the supervisor did not have the time, knowledge or power to mitigate them. For example, participants often described a sense that they and their needs were not seen as a priority, for example in the accounts from Danielle and Sarah:

and allocate it, you know … "Danielle, I'm meeting you on 12 March at 9 o'clock" … have a set time, not "maybe, if we have time, I'll meet you" … because then it's just pushing me to the side

I felt a bit devalued … I thought "Oh, I'm not even worth like scheduling a room to go into, but doing it quite cramped … in a tiny little room"

I felt it was probably a bit disrespectful that I was never sent the supervision notes …so, I couldn't kind of … you know, I wouldn't be able to reflect on the supervision in my own time, or just have it for my records, so I felt a bit like it wasn't taken very seriously

All these highlighted needs were practical and so potentially relatively straightforward to remedy. Zainab and Bill however, both describe the reactions from their supervisor due to the pressures of the ward. Zainab refers to the challenges of working conflicting shifts and Bill talks to how supervision was not seen, as a priority.

she was always like "Oh … you know I'm going home. I've finished my shift now." Or … or … or when I have to … stay, after the shift

because I wanted to meet with her, and then she was like "Oh no, I'm too busy. I have to organise the shift" … or … whatever …

Not being heard was also a narrative shared by participants, for example Tracy shared her experiences:

because, sometimes, I don't want to be talking to somebody and it feels like I'm talking to a brick wall, and they're like saying … "G, don't be getting stressed about this … don't be getting stressed about that"

what I probably would have liked if … if I had said, you know … "Things … things are like especially bad at the moment" … I feel probably would have liked my supervisor to be like "How are you looking after yourself? Like, are you doing any self-care? What could … what could we do to sort of relieve the pressure a bit?" … but, instead, it was almost like "Yeah. Things are pretty bad. Can you do a bank shift tomorrow?"

and they expect us to sort of just carry on and … because we have been doing it for so long, and they just think we can do it. So, sometimes I think it can be quite difficult speaking about that because the management always see it from the manager's perspective

It appears that not being heard was an invalidating experience for these participants when their supervisor had not picked up on their needs in the moment. This suggests that supervisors might have been out of touch with what was happening for the nurses on the wards, possibly creating an 'us and them' narrative. There is also the psychological impact of not being listened to when you are trying to disclose.

Over time this appears to have led to a sense of resignation that things will not change resulting in a sense of powerlessness. Danielle, Zainab and Vanessa described this belief both in terms of their supervisor's approach and the ward environment.

Many times… I often spoke about that a lot … that I … I was being criticised for you know some of the things I do … I … I … yeah, that bothered me a lot. I took it to supervision a lot …it was heard … it was listened to … but nothing really changed. I'll be honest – nothing changed.

I think the few occasions we have spoken to like our supervisors about it, but like I said, there wasn't anything significant and you can't help the nature of the ward, because it is quite … a really busy ward … but I think we just feel there's like sometimes a lack of support … and then we just feel … there's not even a point in discussing it

I would have wanted one but you know because I didn't want to go and say "When is my supervision?" I just sort of waited … waited until I … in the end it just became the norm that I'm not having one, and then I just learned to live with it.

Theme four – Relationally Unsafe

This theme relates to the relationship between the supervisor and supervisee.

  Subtheme one - impression Management.

  This subtheme describes how participants may have wished to present themselves in a positive light in front of their supervisor. It highlights the power differentials that were felt in the supervision space and possibly a sense of implied consequences of getting something wrong. Tammy, Emily, Zainab and Gina provide insight into the personal narratives that were being held by the supervisee as they were entering into the space:

…so probably a bit awkward … I'll be like in my mind "Shall I talk to him? Shall I not?"… like or if I want to talk to him, HOW am I going to talk to him?

I have to ask questions, and I feel like "Oh I should know this now. You've told me once, I should remember this," and things like that…you can feel like you can't say how you feel

you don't want to … to appear incompetent and, you know not being able to handle the pressure, so I suppose you put a little pressure on yourself as you … as you progress

due to the sort of type of person that they were, I wouldn't ever over-step or anything like that in what I was saying. They were … no, they were a nice person but we didn't have the same humour or things like that so I would never … I'd be taken too seriously if I said something

I don't know if I would be able … I don't think I would be able to raise it to them … just being in my position as a newly qualified with a sort of senior Band 6 nurse … I don't know if I would have had the confidence to … to raise that. So, I probably would not … I probably wouldn't

Subtheme two - It would do More Harm than Good.

Participants spoke to their belief that talking about topics linked to the supervisory

relationship would at best not be heard and at worst negatively impact on them. This is

eloquently described by Sarah, Tracy and Danielle. These accounts might also talk to events

that occurred outside of the supervisory space that were impacting on what was going on

inside, however these were not felt able to be spoken of.

I don't know if she would have been able to hear the feedback. I feel that she probably would

have... been a bit defensive maybe because that's how she appeared on occasion ... and on

similar occasions.

sometimes if you sort of raise sort of issues, with that particular supervisor, I don't think I

physically could have ... I think it would be like talking to a brick wall. I don't think it would

get anywhere. I think it would probably do more harm than good.

that wouldn't have been possible ... I mean she ... she did things to annoy me all the time to

be honest, but I'd never bring it up with her ... I really wanted to get a promotion so I

probably would have worried that it would have jeopardised that but also... yeah ... I don't

know like ... and it would have impacted on my supervision in future

I probably covered up in all of them. Just to get ... you know... I didn't want to cause any

trouble for myself, so I just, you know, covered up a bit.

Subtheme three - but then you never know do you.

This theme relates to how confidential participants felt the supervision space was. It

highlights both the lived experience of the participants but also their beliefs. Bill, Sarah and

Vanessa shared their experiences:

it won't happen, you know, in the next hour, but maybe in a couple of months, someone will

say "Oh yeah, yeah, by the way, he was saying this about you

that's the thing because just knowing what they were like and being in their office before …

in like their little office, you'd hear them gossiping, and it wasn't necessarily very

professional … and I'd just think "Oh my God … I'm definitely … you know, I can't … I can't … I

don't feel able to open up in supervision"

I don't know, maybe it's just being a bit … you know, thinking that … you know, maybe when

she …when she talks to this person, she's going to be talking about what I discussed… I don't

know it's just human nature, isn't it … "Oh are they really talking … talking about … are they

discussing what I talked about … with her …?"

Subtheme four - Everyone's different you know.

This subtheme speaks to the personal and professional differences between

supervisee and supervisor which made participants hesitant to bring up certain topics if they

felt there was little common ground. Tracy, Tammy and Gina describe their experience of

navigating these more complex interactions. As this subtheme talks more specifically to the

supervisory relationship, it is likely that it influences the other subthemes which are

consequences of feeling relationally unsafe.

but I think in terms of that sort of relationship, I don't think it was sort of … not … it wasn't

really there … um … not anything sort of bad … there was nothing bad about that person … it

was just I think different personal differences and I think even how we look at certain

problems, and things I potentially would like to discuss may not be a priority for that person,

it may be sort of brushed over … I don't know … do you know what I mean?

I think you do that anyway … I … I would say every time, but I think that was just … I think that was probably just due to the … the nature of the type of person that my supervisor was rather than … I think if I had … yeah … I think if I had something I had to say, I would say it …

Well, obviously, we're all humans and there are some people you get on better with than … than others … so if it's a colleague who's … who's like … I get on with … yeah … I tend to be able to talk to them better

Theme five – Strategies to stay safe

Participants described several different strategies they used to help navigate difficult supervision spaces. These strategies may likely be the result of feeling relationally unsafe within a poorly defined environment where a culture of managing other's expectations is perpetuated. Vanessa, Tracy and Emily for example, described several different techniques utilised in the moment such as gauging, minimising or avoiding entirely:

are they … are they lending a listening ear? Are they being compassionate? You know, that sort of response that you get from them … sort of either lets you open up or you just end up saying "You know, I'm not going to go there."

I'd probably say … the tip of the iceberg if I want to talk about something … if I say like the tip of … I'd probably sort of make it PG if that makes sense … I really sort of dampen it down sort of … I don't know … I think it … it's just that once you've said something, it's like you can't … it's like once you've said it, you can't go back and put it in

would I raise it? (Pause) … probably not at the moment … I'd get on with it … just get on with it and think "Right. OK. Just try and maybe avoid … or something like that. Just keep out of …" … yeah …

A pattern emerged for some participants which involved sticking to topics which were 'safer' such as development and training. It is possible these topics were considered safer because there is less relational risk taking and the focus is on positives. It is possible these topics are therefore also safer for the supervisor.

we just talk about what's going on, and how I'm feeling … what's … how I'm finding it, and the things I want to achieve, and things like that, and have I achieved them, and how can they help, and things like that

professional development, personal … yeah … off the top of my head, that's the main sort of things they would … they would talk about.

I think more … trust … topics that are more comfortable to talk about are just general stuff like training and development

Finally, participants also described finding strength outside of supervision in the form of peer or familial support. Zainab, Sarah, Vanessa and Emily talk to this:

I'll probably … most times, I'd probably be like quietly and carefully "Oh yeah, yeah, yeah" … you know, and then say to … and then you vent to your colleague, and you know sort of … you know, let it out there, and just carry on.

in supervision because there's never any outcome or changes. So we all just support each other and … um … I think it makes it easier … it's not just you going through something that generally all the nurses are feeling this way

Not really … me and my colleagues were just kind of like … have a little laugh after and just be "Yeah, I see you've had your supervision!" And just go (gives a thumbs up) … sort of thing

… it was just …yeah … it didn't really feel … it wasn't so much a useful space, and I think we were all feeling a little bit disillusioned with it

no. I don't think so.… probably mention it to my husband when I get home… he doesn't work in this field, so …he doesn't get it at all. no, I don't think so, not unless I was really … you know … no … because you know like … because thinking back to my other role as well … I'm thinking of that as well but … yeah … no, I don't think I would at the moment.

Member checking

A summary of these themes was sent out to the study participants via their preferred email. Unfortunately, despite the participants being aware that they would be contacted again for this part of the analysis, only one responded. This is likely due to the same issues that made recruitment for this research incredibly difficult and will be talked to further in the discussion section. The one participant did comment that they "resonate with all the themes" and that it was "interesting to know that others are feeling the same". Although it is difficult to draw conclusions from one person, this feed back does suggest that the themes were representative of some experiences.

Chapter five - Discussion

Overview of results

This research aimed to understand mental health nurses' experiences of nondisclosure within their individual clinical supervision. Five themes were identified which operated at different levels. On the broader cultural level, two themes spoke first to a belief that nurses felt they were expected to be superhuman, and second, the challenges brought about by the necessity to work closely with colleagues leaving little room for navigating

conflict. Two further themes operated at the supervision level and described inconsistent set ups and invalidating experiences that felt relationally unsafe. The final theme operated on the individual supervisee level and spoke to in-the-moment responses made to cope and adapt with the situations they found themselves in.

Summary of additional findings

Although this research's focus was on nondisclosure, it became difficult at times to separate this particular phenomenon from experiences of supervision overall. Important observations from participant comments gave rise to additional findings such as, the high rates of variability of the supervisory space both in terms of the supervisor, content and environment. This finding highlights a 'perfect storm' of interactions which made supervision as intended seemingly not possible and therefore further consideration around how supervision can operate within such an environment will be beneficial. This will ultimately feedback into addressing any potential negatives as a result of nondisclosure, as the existing literature highlights the importance of a space that has a good set up and is facilitated by a trained supervisor to address power differences and supervisee anxiety.

Another finding was that every participant acknowledged the importance of supervision and no one said that they would have preferred not to have it. Each participant described what they would have liked to have seen from their supervision experiences, although outside of the scope of the nondisclosure research question, it felt important for these voices to be heard. Therefore, an extract of comments can be found in appendix twenty-three, but in summary participants wished for: a good structure with consistency, to be held in mind and prioritised, for there to be trust and for the space to hold meaning. All of these aspects have been shown to be important in other studies that have looked at

nondisclosure, although not with nurses (Sweeney & Creaner, 2014; Singh-Pillay &

Cartwright, 2018; Mehr et al., 2010; Huntman & Ellis, 2019; Cook et al., 2020)

Linking the findings to the literature

A problematic narrative.

Participants described a felt sense of needing to carry on regardless of the impact on

themselves, and that they needed to be superhuman. This narrative of nurses as

superheroes has become popular across the UK and other countries around the worse since

the start of the global pandemic, although this representation of nurses in such a way is not

new (McAllister et al., 2020).

Although this public perception and resulting communal actions such as 'clap for

heroes' is meant as a show of gratitude, it is argued to also have additional unintended

consequences. Stokes-Parish et al. (2020) note that seeing nurses as something other than

human (e.g. angels) leads to a failure to acknowledge their suffering resulting in

disempowerment and the silencing of nurses. It also places added pressure on exhausted

nurses (Rees, 2022) whose needs often become misunderstood resulting in nurses being

ignored and exploited (McAllister et al., 2020).

The superhero narrative also centres the need for nurses to deal with problems at an

individual level, which can lead those left traumatised by organisational failures to feel

personally responsible (Traynor, 2018). Nurses are routinely encouraged to 'roll with the

punches' and develop their resilience skills to better manage adversity. The implication that

it is their responsibility to cope, can perpetuate the inequalities of the status quo within the

healthcare organisation (Traynor, 2018). Maben and Bridges (2020) argue that it is "not

acceptable" that nurses are made to feel at fault for not being 'resilient enough' as resilience is not an individual responsibility but an organisational one. This need to look beyond individuals, aligns with Grant and Townend's (2007) perspective on the importance of viewing nurses within their moral, cultural and professional contexts with regards the need to demonstrate competence and accountability.

This also points to a paradox; within a supervision space that requires one to be open, how do nurses enable vulnerability when they are expected to be invulnerable.

Working with family.

An interesting observation of the data was that although participants held their team in mind during supervision, always putting them first and not wishing to get them into trouble, the content of most nondisclosure was related to relations within the team.

The notion of a blame culture might offer some explanation as to this pattern of thinking and behaviour. A blame culture is described as being seen in operation where organisations seek to blame individuals when harm is caused to patients (Wolvaardt, 2019) and is evident in many areas of health care (Wand, 2017). In a survey of 164 mental health clinicians, 71% agreed that following an adverse event they are left feeling responsible for inaccurate assessment and management of risk (Wand et al., 2015). The authors concluded that a blame culture imposes "a poisonous and paralysing power" that leads to clinicians being viewed with suspicion.

Cooke (2012) describes a shift in focus during the 1990s away from institutional failings to the failings of the individual, which gave rise to the 'bad apple' narrative within nursing. This was further cemented with high-profile court cases such as the Allitt enquiry.

Reviewing the literature, Cooke (2012) highlighted that nurses are often disciplined by managers for 'attitude problems' and are more likely than other groups to be suspended. Also, that disciplinary action can have devastating psychological and professional consequences on nurses, with the outcomes for post-suspension being poor with a third of nurses choosing to retire or resign.

In recent years within the NHS, there has been a growing focus on shifting away from a blame culture to a 'just and learning' culture (Trueland, 2019). Tools such as the Just Culture Guide (NHS, 2018) support managers in delivering a supportive, constructive and fair evaluation of staff involvement in incidents.

Moving beyond the blame culture narrative however might be helpful, as participants examples did not always describe a clinical issue where patient safety was the chief concern, indeed participants explicitly mentioned that if it did, then they would have informed their supervisor. These nondisclosures referred more to relational dynamics within the team for example in ways of working and interacting.

Although these relational differences are not necessarily any cause for concern, participants appeared to think they would be interpreted as such. This highlights the challenge of reflecting on difficulties in relationships without feeling that the relationship is being undermined or weakened by such an act; *how do I talk badly about family?* Or put another way: in an unpredictable and potentially risky environment that requires nurses to look out for one another, how does a supervisee balance the tension between discussing difficulties about a colleague alongside their need for possible support from that colleague.

The concept of shame offers a link between superhero beliefs and looking out for one's team. Humans have evolved a strong desire to create positive feelings about

themselves in the minds of others (Gilbert, 2010). Shame therefore, can be defined as a

negative affective state as a result of negative evaluations of the self as bad, undesirable or

worthless (Kolts, 2016). This can take the form of internal shame where negative personal

judgements are held, such as the need to be invulnerable, and external which is the

perception that others will hold a negative evaluation, for example how the team might

hold a grass in mind. When experiencing feelings of shame the internalised threat system

can activate and defences utilised as a means of coping. These can take the form of

avoidance, staying on-guard, being self-critical and keeping things to oneself (Gilbert, 2010)

all of which can lead to nondisclosure.

Macdonald & Morely (2001) looked at the relationship between shame and

nondisclosure within a therapy setting. Finding support for the idea of internal and external

shame. Negative self-assessment on behalf of participants led to a judgement that parts of

themselves were unacceptable to be spoken about, similarly where it was perceived

disclosures would be judged as unacceptable by others, nondisclosure occurred. Research

that has focused on the role of shame and disclosure in clinical supervision among

psychotherapy trainees, has similarly found a link often related to the supervisory

relationship. The notion of in-the-moment discussion with someone who may be the cause

of the negative shameful feelings being particularly difficult (Yourman, 2003).

The supervision.

Participants described a wide-ranging experience of their supervision and few could

give examples of a predictable and consistent space with an established process.

This is counter to existing literature and policy on supervision which emphasises the

importance of organisation and structure where roles and responsibilities are clearly

defined and where a contract and rules are in place to differentiate it from other more

informal spaces (DoH, 2000; Fowler & Cutcliffe, 2011; Driscoll et al., 2019).

The findings of this study are similar to Davey et al. (2006) who observed that few

nurses felt their needs were met in terms of the teaching of new clinical skills (beyond

booking onto training) and reflecting on practice. It adds support to the author's comments

of a theory-practice divide, between policy commitments and real world delivery.

Similarly when looking at Proctor's model, which is considered the most widely used

model of clinical supervision within the UK, it was not always clear how consistently its three

elements (normative, formative and restorative) were being implemented. This is not too

surprising as Proctor herself describes the model as relational in nature, with the

supervisory relationship forming a foundation on which to explore the three elements. It is

difficult to see how a sufficient supervisory relationship could be established when

supervisions were so sporadic. Indeed, a study utilising the Manchester Clinical Supervision

Scale, identified that supervision needed to be of sufficient length and frequency to be

effective. It suggested hourly sessions that occurred monthly or bi-monthly (Sloan, 2011).

A common complaint from participants was that of logistics, for example, being on

different shifts to their supervisor and either not seeing them or having little to no time if

they did. This talks to a wider systemic issue and one that Fowler and Cutliffe (2011)

comment on in their history of nursing supervision: the overlap of shifts, where supervision

activities took place, being reduced to save costs. Stevenson's (2011) comment that

supervision is often the first casualty of a busy ward also seems relevant.

The findings suggest a disparity between what policy makers expect and what is achievable on the ground level. Aristotle's proverb 'Well begun is half done' might be a helpful consideration to hold in mind.

The relationship.

Participants described a relationship with their supervisors that did not always appear conducive with a context of safety. Concerns around confidentiality and how their supervisor might react became barriers to disclosing. These findings align with those described by Butterworth et al. (2008) who reported nurses' resistance to participating in supervision was due to worries around confidentiality, causing additional stress and feeling threatened.

Mason (1993) comments that uncertainty rather than certainty is the predominant aspect of the living world. McKinney (2020) describes uncertainty as a way of being which effects everyone, although contextual factors mean it can feel greater for some groups at different times. Local factors such as the ward environment, as well as global factors such as the pandemic, may have a silencing effect on clinicians who may have a fear of showing vulnerability (McKinney, 2020). Mason (1993) introduced the concept of safe uncertainty as a position that can be taken up for example by supervisor and supervisee, it is a position that is not fixed, but one that is centred in respect and collaboration. From this position, relational risk-taking which looks to shift a relationship between people can take place. This relational risk aims to open up different conversations and make room for new ways of being (Mason, 1993). Although Mason made clear that he didn't consider his ideas as a solution or tool, this concept might be helpful in understanding what might be occurring in the participant's supervision and offer possible ways to approach things differently. Risk-

taking within a position of safe-uncertainty can lead to a felt sense of relational safety. This is where questions can be raised, viewpoints challenged, opinions confronted and ideas expressed in a mutual and collaborative space, that develops over time (Hernández & McDowell, 2010). This idea is supported by Grant and Townsend (2007) who argue that creativity and risk are interlinked and so supervision that incorporates risk and experiment within wider recovery-based and expert led care, will improve overall outcomes for supervisees and clients.

Also suggested by the data was the varying styles of the supervisor which garnered a mixed reaction from participants. Driscoll et al. (2019) notes that there is no agreed or accredited training for new clinical supervisors, and it is unclear what constitutes ongoing support for supervisors. Research by Jones (2006) also found that supervisors can find supervision anxiety provoking and burdensome, whilst others have described supervisor's reports of feeling ill-equipped, out of their depth, overwhelmed and powerless (Singh-Pillay & Cartwright, 2021). Although views of supervisors were not collected in this research, by the lack of a reported standardised approach, it is plausible that supervisors fell back on their own experiences of supervision as a guide for facilitation. It is argued that a problem with this strategy is that supervision without a theoretical framework had no goals or prospects (Hyrkäs et al., 1999). This also suggests a diminished supervisory working alliance the absence of which is linked to increased levels of nondisclosure (Huntman & Ellis, 2019).

A worrying narrative that emerged from the data was one of resignation that things would not improve. This is important in understanding why nurses might choose not to disclose, as well as issues of nurse wellbeing and self-efficacy, especially given the high rates of burnout and nurses leaving the profession.

Strengths and Limitations

Strengths.

This research has for the first time looked at nondisclosure within nursing supervision. In doing so it completes the overall aim of adding to the evidence base on how it operates within the discipline.

The inclusion of a nurse consultation team adds to the quality and validity of the methodology and findings. The consultation team informed all stages of the research including designing the interview questions, supporting recruitment and interpreting findings. In this way, the research benefitted from the knowledge and experience brought by a multidisciplinary approach and centred the voices of nurses throughout.

The use of a qualitative methodology allowed for a deeper exploration of nurse's narratives, and in doing so made their voices heard and emotions expressed. Given the growing acknowledgement of staff wellbeing and the importance of effective supervision for nurses, these accounts will be valuable in current and future planning.

Limitations.

A lack of generalisability is an often-quoted problem with any qualitative research. Braun and Clarke (2022) discuss the problematic nature of this critique, as it assumes that research *should* be generalisable and that there is a universal conceptualisation of generalisability. Their epistemological position leans more towards viewing knowledge though a social constructionist lens. As a critical realist, the researcher believes it is important to acknowledge the experiences of the participant whilst also looking for ways that their generosity in sharing can help others. Therefore, it might be more productive to

consider the *transferability* of the data. The richly contextualised reporting of data in this research, aims to allow the reader to make a judgement as to what extent they can safely transfer the analysis to their own context (Braun & Clarke, 2022).

The recruitment of participants was incredibly difficult for this research. The initial recruiting methods of advertising through the participating NHS Trust communications teams and disseminating study information by senior nurses and the local collaborator, were unsuccessful in identifying any potential participants. Several amendments were submitted to allow for the inclusion of preceptee nurses and the use of social media platforms. The researcher attended preceptee training to advertise the research, as well as linking in with local psychology teams to support advertisement and meeting with ward managers. The researcher also met with the head of mental health nursing for NHS England in an attempt to gain support for the research. The consultation team had recommended going onto the wards directly due to the challenges nurses would have in accessing their emails, this unfortunately was not allowed due to the impact of the Omicron COVID variant in the first half of the year. After three months of attempts to recruit, no participants had been identified and the feasibility of the research was called into question. Recruitment was finally achieved when the researcher and the nurse consultation team were permitted to access the wards of an inpatient unit, with the consultants replacing the on-shift nurse so that the ward maintained its nursing ratios. Following the first few interviews, word of mouth led to the recruitment of the remaining participants. Although this method allowed for interviews to be conducted, it meant that the majority or participants were recruited from one hospital despite the research being open to all inpatient units across three trusts.

Although a considerable challenge, this experience has demonstrated that, nurses are far from accessible due to their competing demands. This was further evidenced by the discovery that all those recruited were unaware of any advertising for the study beyond word of mouth. This speaks to the trust nurses seem to place in one another, linking with the theme of "family" and the challenges in being an outsider researcher.

This seems to be further evidenced by the difficulties in engaging participants with member checking. In an attempt to mitigate this, the data was checked with both the nurse consultation team and the project's external supervisor who was also a nurse. Their feedback and recommendations supported the development of the final themes.

Discussed earlier is the term nondisclosure and the potential for multiple interpretations based on context. Although this research has made clear how it has defined the phenomenon which is grounded in existing literature, there are some limitations with this. Firstly, as highlighted in the systematic review, within the existing literature, differences across type, demographics, methodology, time frame and construct explored, all impacted on reported nondisclosure and how it is subsequently defined. Secondly, as this was the first time the phenomenon has been looked at within nursing, it was unknown as to whether disclosure within the profession has the same value placed upon it as in psychological supervision. Although, following the implementation of regulations such as the Duty of Candour in 2014 (CQC, 2022b) it can be assumed that disclosure more broadly is underpinned by the profession through accountability and governance. Finally, in line with previous research this study focused on verbal forms of nondisclosure 'what's not being said' as Sweeny and Creaner (2014) put it. Therefore, nonverbal communication such as not

attending to supervision or reminding managers if they had not had it, might also be a form of nondisclosure.

A final limitation is the nature of the study itself; discussing something you have chosen not to discuss. Although the researcher made clear to participants that they only need give broad themes and not specifics, this may have felt too risky or challenging for potential participants. Similarly, it was observed that discussions regarding staff relationships were the main example of nondisclosure within the study. It is possible that, given fears regarding a blame culture, clinical issues regarding patient care may have been to challenging to disclose. A quantitative methodology may therefore have elicited different results due to participant anonymity.

Clinical Implications

The principle aim of this research was to explore experiences of nondisclosure within supervision. Although this aim was achieved, what also emerged from the accounts of the nurse participants, was the experiences of supervision in general. The impacts this has had on nondisclosure have been discussed, but it is also important for senior managers and policy makers to be aware of how supervision looked for these participants as the common theme of inconsistency is likely to be applicable to other settings. Recommendations from inquiries like the Francis report (2013) and the Ockenden report (2022) should also be considered alongside these reported experiences. For example, maintaining a culture of safety, where concerns can be raised, staff feel valued and reflective practice is firmly embedded (Freedom to Speak, 2015). Also, the creation of an environment where the principles of psychological safety, or the belief that speaking up with questions, concerns, or

mistakes will not lead to humiliation or punishment, are upheld (Department of Health &

Social Care, 2022).

A clear understanding of what supervision is and what it should look like, was

difficult to identify. This is a known issue within the nursing supervision literature, with a

lack of agreed definition being described as the most serious obstacle to developing the

field of supervision (Buus & Gonge, 2009), it has also been highlighted as a concern within

the therapy supervision literature (Cook et al., 2019). However, it is likely exacerbated by

the numerous clinical and logistical pressures on the ward, which means when supervision is

conducted there may be little structure and focus on process. This is in line with the

observations of Gonge and Buus (2014) who noted that clinical environments that are

stressful, anxiety-provoking and defensive are unlikely to enable supervisees to engage

effectively and meaningfully in supervision.

Participants were unaware of the concept of a supervision contract but did comment

on the use of a supervision template. Its purpose however, appears to have been

misunderstood; instead of acting as a tool to guide conversations it became the agenda to

work through, possibly in a 'tick box' fashion. As mentioned earlier, this is contrary to the

recommendations of research into clinical supervision. An additional concern is that it

leaves supervisees feeling disempowered within the space and may lead to a silencing effect

and the perpetuation of nondisclosure.

In the absence of a clear definition, and a consistent and prioritised space,

participants described finding their needs met in other ways, for example in ad hoc 'PRN

supervisions' where they can catch their supervisor or manager for five minutes to discuss

an issue, or by using other meetings such as handovers and safety huddles.

This has a number of implications, for example participants appeared to perceive ad hoc discussions as akin to supervision. This meant aspects of Proctor's model, for example detailed case discussion with reflection on practice, were unable to be facilitated as effectively. This finding was also observed by Cleary and Horsfall (2011) in their research looking at supervision among mental health nurses on inpatient wards. They concluded that although participants understood the purpose of clinical supervision and were aware of its many advantages, they preferred more informal ad hoc methods of support. This in-the-moment supervision while beneficial, meant that longer term it reinforced a cautious attitude towards supervision and embedded the belief that it has limited value in-practice. Coupled with the themes identified in this research (e.g. concerns about the teams and expectations to be superhuman) it suggests the creation of an environment that facilitates nondisclosure.

Another implication is the comments that some participants valued this type of quick, readily available space, commenting that it was better than having to wait an unknown period of time for clinical supervision. The meaning behind this preference is interesting; it could be due to the ability to get one's needs met in a practical way, or it could be the result of a lack of understanding of what supervision is and can provide 'you don't know what you don't know', or it could be relationally safer. An ad-hoc space is time-limited, its agenda is set by the supervisee with a clear task in mind, it can be ended easily and it is not recorded. The theme 'relationally unsafe' was an identified contributor to nondisclosure and this approach can be a way by which supervisees avoid disclosure. Another possibility is one raised by Jones (2006) who questions the assumption that, all nurses possess an innate ability to reflect on their practice and that practicing this skill always feels safe and comfortable.

The suggestion from participants that the ward environment may not be conducive to a standardised format of supervision have created a space that does not align with recommendations and leads to an increased likelihood of nondisclosure. The resulting nondisclosure then appears to impact on nurses' wellbeing and team dynamics which impacts of the delivery of care and patient need. Inconsistent support from senior managers and executive boards can lead to nurses feeling unaided (DoH, 2000) and a lack of acknowledgement of wider organisational contexts within which supervision takes place, means there is little understanding of how these contexts impact upon supervision.

As research continues to point to the benefits of clinical supervision for nurses, including recent evidence showing that clinical supervision improves retention by improving skills, engagement and satisfaction (Aparício & Nicholson, 2020). In addition to the current NHS Standard Contract which makes clear that all registered nurses should have access to restorative supervision that incorporates all the elements of Proctor's model (NHS Standard Contract, 2022/23). It is important for senior managers to consider how they implement effective clinical supervision within inpatient environments and how best they support supervisors through training.

The focus on nondisclosure in the context of relational dynamics is another important implication. It highlights both the importance of team working but also the pressures that are placed on nurses which have likely been considerably impacted over the last two years as the health service has navigated a global pandemic (Muller, et al., 2020; Foye, et al., 2021; The King's Fund, 2020b). When thinking about the effects of burnout and wellbeing, it might be important to broaden out the focus from the individual to the team,

especially in environments that rely heavily on team connection and collaboration to function effectively.

A final implication and arguably the most important is the heard voices of the nurses who participated. Nurses described often feeling unheard, not held in mind and not prioritised. This led them to feel unsafe and distrustful within supervision and doubtful that things would change. Ultimately this meant that participants did not feel able or willing to always disclose. New initiatives such as the nurse advocate programme offer exciting new possibilities for change and a refocusing on supervision. As the divide between theory and practice appears considerable within inpatient settings, nurse advocates should hold in mind that their colleagues may feel a need to withhold certain information, the possible reasons why this might be the case and ways they can re-engage and enter into new conversations. In this way the power of the nurse voice is centred so that it can influence policy change.

It is important when considering these implications and recommendations to revisit the earlier imagery of a fox in the hen house, and reaffirm the aim of this research being the search for the nondisclosure phenomenon and not the judgement or evaluation of nursing supervision by clinical psychology. Indeed, many of the observations and recommendations offered align with those in existing nursing literature. It is hoped therefore, that these findings will be viewed in such light and considered of interest to nurses, also that this may lead to further research on the phenomenon conducted by nurses.

Directions for Future Research

This study has established that the phenomenon of nondisclosure is present within nursing supervision. Future research should continue to build on this work, which will also

add to the relatively small but growing body of recent literature on clinical supervision

within nursing.

It would be helpful to understand how the phenomenon manifests among

community nurse supervision as there are anticipated to be a different set of pressures, for

example, although the individuals they work with may be less acutely unwell, it is likely they

spend more time working independently. The community environment may also be more

predictable, allowing for a more consistent supervision space. As current literature notes

that a consistent and predictable space should encourage disclosure, it would be interesting

to see how this works in practice and whether other factors are present such as fear of

blame and needing to be "superhuman".

There is little research that has looked specifically at supervisor's experiences of

supervision. It therefore will be helpful to develop understanding in this area by building on

the research by Singh-Pillay and Cartwright (2021), for example, who reported accounts that

described no formal training or guidance which left supervisors feeling ill-equipped and

doubting their abilities. Supervisors commented a felt need to be omnipotent and all-

knowing whilst others felt powerless and became disinterested in supervising, seeing it

instead as a burden. This has potential symmetry with the themes of 'expected to be

superhuman', 'relationally unsafe' and 'an invalidating experience' identified in this

research. As band five and six nurses are often supervisors as well as supervisees, they

might be experiencing this negative appraisal from both sides. Therefore, future research

might look to see how supervisors make meaning out of their role. This could be conducted

with both junior and senior nurses.

This research used a qualitative methodology, whereas previous research has utilised a quantitative methodology. As mentioned earlier there are benefits to a quantitative approach when discussing nondisclosure as it allows for more anonymity, however a qualitative design enables a deeper understanding. Now that the phenomenon has been found to be present, a quantitative design might enable a better understanding of how common it is and how frequently it occurs. Alternatively, a mixed methods design would offer insight into both the frequency and intensity but also the lived experience of nondisclosure within supervision.

Another area of future research could focus on nondisclosure within team supervision as this is frequently offered to ward staff. This will be especially of interest to clinical psychologists who often facilitate such spaces. It is possible that a challenge to recruitment for this study was due to the researcher being an outsider and an unknown to potential nurses, recruitment only became successful when the researcher was 'endorsed' through conversation with peers. If a psychologist providing team supervision is also seen as an unknown it might lead to nondisclosure if the space does not feel relationally safe. Similarly understanding how the subthemes of not wishing to be seen as a grass, operates in such a setting.

Power differences within the supervisory space are an inevitable outcome of its nature; junior members of staff being overseen by senior members of staff. It is important to therefore acknowledge and be transparent around this inequality even if it cannot directly be changed. Other power differences that originate outside of the supervisory space and play out on a societal level, will also impact on interactions within the space. Burnham and his colleagues (1993) outline many of these areas of difference in their Social Graces

acronym. It is vital therefore that supervisors and supervisees engage meaningfully in multiculturally competent supervision. As nurses comprise a diverse workforce a focus on intersectionality and the experiences of minority supervisees and supervisors will be important to understand for the above reasons. Difference will also potentially add an additional layer of power and disadvantage and understanding how these topics are approached and discussed safely in supervision, will enable an understanding of whether they contribute to nondisclosure within the space.

A large part of this research's success was down to its values and set up; aspiring to maintain a joint venture between clinical psychology and the nursing profession. This arguably allowed for deeper meaning making as knowledge from both professions was woven together. Hopefully this demonstrates the value of interdisciplinary working within research, especially when looking at phenomena that co-occur. It is therefore important that future research within clinical psychology, looks to continue to co-construct the development of knowledge with their multidisciplinary colleagues and those with lived experience.

Reflections

Throughout this research the author reflected on the process and their relationship to the topic. The origins for the research idea came from two sources, first, lived experience of working on acute wards and alongside nurses who, in spite of working with the same population, had a different set up for clinical supervision. Second was the sister of the lead author, herself a nurse, who would describe challenging working conditions without the supervision structures that the author expected.

At the design stage the author considered methodology and chose to adopt a qualitative approach after consulting with nurse colleagues and recognising that a deeper exploration might be more valuable, with most of these colleagues acknowledging the role of nondisclosure.

Also, at the design stage and throughout the research, the author considered their position as a clinical psychologist in training and how this might be experienced. In the author's clinical experience, nurses often described feeling disempowered compared to other members of the multidisciplinary team and this was not something that the researcher wanted to perpetuate. The author was also mindful of unconscious biases they may hold about the discipline of nursing and how this might inform any decisions and interpretations, also the conflict that might be experienced when applying their own values onto the data, such as a strong belief in the importance of supervision which needed to look a certain way.

This meant that the input from the nurse consultation team was crucial to informing the research and maintaining quality. The team provided their input in the design but also acted as a counter to the author by providing a perspective that informed and at times challenged held beliefs. The team were also effective at changing the pace of the research when required, for example in the recruitment phase moving from a more reflective stance to an active practical one as this was what was required to maximise recruitment.

Finally, as the research came to a close, the author reflected on the role of a psychologist within clinical settings and the support they can offer to colleagues both within a supervision space but also outside through being actively curious and where necessary advocating for change.

Conclusions

This research set out to discover whether the phenomenon of nondisclosure was present within nursing clinical supervision by looking at the experiences of inpatient mental health nurses. The findings indicate that the phenomenon is indeed present and although there are similarities with how it has been reported in the therapy supervision literature, there are also differences linked to held beliefs, set up and culture. The findings will be of interest to organisations who are advocating for clinical supervision, as well as initiatives such as the nurse advocate programme. Nondisclosure in this study impacted upon nurse wellbeing and team dynamics which was indirectly impacting on patient care. With the ongoing nurse shortage, recruitment and retainment issues, and the aging nurse population (Taylor et al., 2019), coupled with the 'perfect storm' of interacting variabilities in supervisor, content and environment, it appears vital that facilitating a space that enables disclosure will improve wellbeing and retention. In this way it is hoped that the voices of the mental health nurses who participated in this study will inform policy and practice going forward.

I don't think I physically could have … I think it would be like talking to a brick wall. I don't think it would get anywhere. I think it would probably do more harm than good.

Tracy

I probably covered up in all of them. Just to get … you know… I didn't want to cause any trouble for myself, so I just, you know, covered up a bit.

Danielle

References

Aparicio, C. & Nicholson, J. (2020). Do preceptorship and clinical supervision programmes support the retention of nurses? *British Journal of Nursing, 29*(20), 1192-1197.

Barrett, D. (2016). *Degree level education in nursing – time to move the discussion on*. https://blogs.bmj.com/ebn/2016/10/10/degree-level-education-in-nursing-time-to-move-the-discussion-on/

Birt, L., Scott, S., Cavers, D. Campbell, C. and Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research, 26*(13), 1802-1811.

Bonner, A. and Tolhurst, G. (2002). Insider/Outsider Perspectives of Participant Observation. *Nurse Researcher, 9*(4), 7-19.

Bos, E., Silvén, C. & Kalia, P. (2015). Clinical supervision in primary health care; experiences of district nurses as clinical supervisors - a qualitative study. *BMC Nursing, 14*(1).

Braun, V and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology 3,* 77-101.

Braun, V. & Clarke, V. (2022). *Thematic Analysis A Practical Guide*. Sage.

British Psychological Society. (2017). *Practice Guidelines Third edition*. https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Practice%20Guidelines%20(Third%20Edition).pdf

Butterworth, T. & Faugier, J. (1992). *Clinical Supervision and Mentorship in Nursing*. Stanley Thornes.

Butterworth, T. (1997). Clinical supervision as an emerging idea in nursing. In Butterworth, T., Faugier, J. & Burnard, P. (Eds.), *Clinical Supervision and Mentorship in Nursing*. (2nd ed., pp 1-19). Stanley Thornes Ltd.

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

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

Butterworth, T. (2022). What is clinical supervision and how can it be delivered in practice? *Nursing Times, 118*(2), 20-22.

Carson, J. (2007). Instruments for evaluating clinical supervision. In: Bishop, V. (Ed*.), Clinical Supervision in Practice, second ed*. Palgrave Macmillan.

Cleary, M. & Horsfall, J. (2011). The realities of clinical supervision in an Australian acute inpatient setting. In Cutcliffe, J.R., Hyrkäs, K. & Fowler, J. (eds) *Routledge Handbook of Clinical Supervision, Fundamental International Themes.* Routledge.

Cook, R.M., Jones, C.T. & Welfare, L.F. (2020). Supervisor Cultural Humility Predicts Intentional Nondisclosure by Post-Master's Counsellors. *Counsellor Education & Supervision, 59,* 160-17.

Cooke, H. (2012). Changing Discourses of Blame in Nursing and Healthcare. In Holmes, D., Rudge, T. & Perron, Amélie. (Eds.), (Re)*Thinking Violence in Health Care Settings A Critical Approach*. Routledge.

Cottrell, S. (2002). Suspicion, resistance, tokenism and mutiny: problematic dynamics

relevant to the implementation of clinical supervision in nursing. *Journal of*

Psychiatric and Mental Health Nursing, 9, 667-671.

CQC. (2013). *Supporting information and guidance: Supporting effective clinical supervision*.

https://work-learn-live-blmk.co.uk/wp-content/uploads/2018/04/CQC-Supporting-

information-and-guidance.pdf

CQC. (2022a). *Regulation 18: Staffing*. https://www.cqc.org.uk/guidance-

providers/regulations-enforcement/regulation-18-staffing

CQC. (2022b). *Regulation 20: Duty of Candour*. https://www.cqc.org.uk/sites/default/files/2022-

07/20220722-duty-of-candour-pdf-version-FINAL_0.pdf

Davey, B., Desousa, C., Robinson, S. & Murrells, T. (2006). The policy–practice divide Who

has clinical supervision in nursing? *Journal of Research in Nursing, 11*(3) 237-248.

Department of Health. (2000). *Making a Difference Clinical Supervision in Primary Care*.

Department of Health.

Department of Health. (2009). *Preceptorship Framework for Newly Registered Nurses,*

Midwives and Allied Health Professionals. Department of Health.

Department of Health and Socia Care. (2012). *Health and Social Care Act 2012 C7*.

https://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

Department of Health and Social Care (2022). *Ockenden review: summary of findings,*

conclusions and essential actions.

https://www.gov.uk/government/publications/final-report-of-the-ockenden-

review/ockenden-review-summary-of-findings-conclusions-and-essential-

actions#immediate-and-essential-actions-to-improve-care-and-safety-in-maternity-

services-across-england

Duncan-Grant, A. (2000), Clinical supervision and organisational power: a qualitative study.

Mental Health Care, 3(12), 398–401.

Driscoll, J., Stacey, G. & Harrison, K. (2019). Enhancing the quality of clinical supervision in

nursing practice. *Nursing Standard*. doi: 10.7748/ns.2019.e11228.

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil, A. and

Coyle, D. (2006). Clinical supervision and burnout: the influence of clinical supervision

for community mental health nurses. *Journal of Clinical Nursing, 15,* 1007–1015.

Faugier, J. (1997). The Supervisory Relationship. In Butterworth, T., Faugier, J. & Burnard, P.

(Eds.), *Clinical Supervision and Mentorship in Nursing*. (2nd ed., pp 1-19). Stanley

Thornes Ltd.

Fowler, J. & Cutcliffe, J.R. (2011). Clinical supervision Origins, overviews and rudiments. In

Cutcliffe, J.R., Hyrkäs, K. & Fowler, J. (eds) *Routledge Handbook of Clinical*

Supervision, Fundamental International Themes. Routledge.

Fowler, J. (2011). Solution-focused clinical supervision Using solution-focused techniques

within clinical supervision. In Cutcliffe, J.R., Hyrkäs, K. & Fowler, J. (eds) *Routledge*

Handbook of Clinical Supervision, Fundamental International Themes. Routledge.

Foye, U., Dalton-Locke, C., Harju-Seppänen, Lane, R., Beames, L., Juan, N.V.S., Johnson, S. &

Simpson, A. (2021). How has COVID-19 affected mental health nurses and the

delivery of mental health nursing care in the UK? Results of a mixed-methods study.

Journal of Psychiatric and Mental Health Nursing, 28, 126-137.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*

Executive summary.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attac

hment_data/file/279124/0947.pdf

Franklin, N. (2013). Clinical supervision in undergraduate nursing students: A review of the

literature. *e-Journal of Business Education & Scholarship of Teaching, 7*(1), 34-42.

Freedom to Speak Up. (2015). *Executive Summary*. http://freedomtospeakup.org.uk/wp-

content/uploads/2014/07/F2SU_Executive-summary.pdf

Galanis, P., Vraka, I., Fragkou, D., Bilali, A. & Kaitelidou, D. (2020). Galanis P, Varka I, Fragkou

D, et al. Nurses' burnout and associated risk factors during the COVID-19 pandemic:

a systematic review and meta-analysis. *Journal of Advanced Nursing, 77,* 3286-3302.

Gilbert, P. (2010). *Compassion Focused Therapy*. Routledge.

Gonge, H. & Buus, N. (2014). Is it possible to strengthen psychiatric nursing staff's clinical

supervision? RCT of a meta-supervision intervention. *Journal of Advanced Nursing,*

71(4), 909–921

Grant, A. & Townend, M. (2007). Some emerging implications for clinical supervision in

British mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 14,*

609-614.

Hernández, P. and McDowell, T. (2010). Intersectionality, Power, and Relational Safety in

Context: Key Concepts in Clinical Supervision. *Training and Education in Professional*

Psychology, 4(1), 29-35.

House of Commons. (2022). *Ockenden Report – Final*.

https://www.ockendenmaternityreview.org.uk/wp-

content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERN

ITY_SERVICES_REPORT.pdf

HCPC. (2021). *What is supervision?* https://www.hcpc-uk.org/standards/meeting-our-

standards/supervision-leadership-and-culture/supervision/what-is-supervision/

Hook, A. & Andrews, B. (2005). The relationship of non-disclosure in therapy to shame and

depression. *British Journal of Clinical Psychology, 44*, 425-438.

Huntman, H. & Ellis, M.V. (2019). Supervisee Nondisclosure in Clinical Supervision: Cultural

and Relational Considerations. Training and Education in *Professional Psychology,

14*(4), 08-315.

Hyrkäs, K., Koivula, M. & Paunonen, M. (1999). Clinical supervision in nursing in the 1990s—

current state of concepts, theory and research. *Journal of Nursing Management, 7*,

177-187.

Joffe, H. (2011). Thematic Analysis. In Harper, D. and Thompson, A.R. (Eds.), *Qualitative

Research Methods in Mental Health and Psychotherapy: A Guide for Students and

Practitioners, First Edition*. Chichester: John Wiley and Sons, Ltd.

Jones, A. (2006). Clinical supervision: what do we know and what do we need to know? A

review and commentary. *Journal of Nursing Management, 14,* 577-585.

Jones, S. (2022). 'Nursing must take a united position on clinical supervision'. *Nursing Times.*

https://www.nursingtimes.net/opinion/nursing-must-take-a-united-position-on-

clinical-supervision-27-04-2022/

Kerstetter, K. (2012). Insider, Outsider, or Somewhere in Between: The Impact of

    Researchers' Identities on the Community-based Research Process. *Journal of Rural*

    Social Sciences, 27(2), 99–117.

Kolts, R.L. (2016). *CFT made simple a clinician's guide to practicing compassion-focused*

    therapy. New Harbinger Publications Inc.

Lord, M. (2002). Making a Difference: the implications for nurse education. *Nursing Times,*

    98(20), 38-40.

Maben, J. & Bridges, J. (2020). Covid-19: Supporting nurses' psychological and mental

    health. *Journal of Clinical Nursing, 29*, 2742-2750.

Macdonald, J. & Morley, I. (2001). Shame and non-disclosure: A study of the emotional

    isolation of people referred for psychotherapy. *British Journal of Medical Psychology,*

    74, 1-21.

Mason, B. (1993). Towards positions of safe uncertainty. *Human Systems, 4(*3-4), 189-200.

McAllister, M., Brien, D.L. & Dean, S. (2020). The problem with the superhero narrative

    during COVID-19. *Contemporary Nurse, 56*(3), 199-203.

McKinney, J. (2020). Towards Safe(R) Uncertainty: An Offering for Managers and Supervisors

    during a Pandemic. *Murmurations: Journal of Transformative Systemic Practice, 3*(1),

    113-129.

Mehr, K.E. Ladany, N. & Caskie, G.I.L. (2010). Trainee nondisclosure in supervision: What are

    they not telling you? *Counselling and Psychotherapy Research, 10*(2), 103-113.

Muller, A.E., Hafstad, E.V., Himmels, J.P.W., Smedslund, G., Flottorp, S., Stensland, S.O.,

Stroobants, S. Van de Velde, S. & Vist, G.E. (2020). The mental health impact of the

covid-19 pandemic on healthcare workers, and interventions to help them: A rapid

systematic review. *Psychiatry Research, 293*.

NHS Education for Scotland. (2021). *Clinical Supervision: Nursing and Midwifery Workforce*

Mission Statement.

https://nesvleprdstore.blob.core.windows.net/nesndpvlecmsprdblob/4cc238de-

d4a2-4f39-9098-

c8177bc425a5_Clinical%20SupervisionNM_NES%20position%20statement_SEPT21.p

df?sv=2018-03-

28&sr=b&sig=ReSPSsStauwr3oIjN3%2Bkox53t2FB6A%2FjBbWR6YwtFkc%3D&st=202

2-03-07T20%3A12%3A37Z&se=2022-03-07T21%3A17%3A37Z&sp=r

NHS. (2022). *NHS Standard Contract 2022/23 Technical Guidance*.

https://www.england.nhs.uk/wp-content/uploads/2022/03/08-nhs-standard-

contract-22-23-technical-guidance.pdf

NHS. (2021). *Professional Nurse Advocate*.

https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/professional-

nurse-advocate/

NHS. (2019a). *Interim NHS People Plan*. https://www.longtermplan.nhs.uk/wp-

content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

NHS. (2019b). *NHS Standard Contract 2019/20 General Conditions (Full Length)*.

https://www.england.nhs.uk/wp-content/uploads/2019/03/4-FL-GCs-1920-sepsis.pdf

NHS. (2018). *A Just Culture Guide*. https://www.england.nhs.uk/wp-

content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf

NHS. (2016). *NHS Standard Contract 2016/17 General Conditions (full length).*

https://www.england.nhs.uk/wp-content/uploads/2016/04/3-nhs-contrct-full-

length-apr16.pdf

NHS. (2013). *NHS Standard Contract 2014/14 General Conditions.*

https://www.england.nhs.uk/wp-content/uploads/2013/03/contract-gen-conds.pdf

NHS. (2004). *Agenda for Change NHS Terms and Conditions of Service Handbook*.

https://www.nhsemployers.org/sites/default/files/2021-06/tcs-handbook-version-

2004.pdf

Nowell, L.S., Norris, J.M., White, D.E. & Moules, N.J. (2017). Thematic Analysis: Striving to

Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods, 16,*

1–13.

Nursing and Midwifery Council. (2020). *Principles for preceptorship*. Nursing and Midwifery

Council.

Proctor, B. (2011). Training for the supervision alliance Attitude, skills and intention. In

Cutcliffe, J.R., Hyrkäs, K. & Fowler, J. (eds) *Routledge Handbook of Clinical

Supervision, Fundamental International Themes.* Routledge.

Rees, J. (2022). *Covid: Superhero images unhelpful, says nurse chief*.

https://www.bbc.co.uk/news/uk-wales-61412032

Rice, F., Cullen, P., Mckenna, H., Kelly, B., Keeney, S. & Richey, R. (2007). Clinical supervision

for mental health nurses in Northern Ireland: formulating best practice guidelines.

Journal of Psychiatric and Mental Health Nursing, 14, 516-521.

Royal College of Nursing. (2021). *NMC: Preceptorship.* https://www.rcn.org.uk/get-help/rcn-

advice/nmc-

preceptorship#:~:text=Preceptorship%20within%20the%20NHS&text=An%20NHS%2

0employer%20is%20obliged,the%20specific%20arrangements%20in%20place.

Royal College of Nursing. (2019). *Debate: Clinical Supervision by Other Professional*.

https://www.rcn.org.uk/congress/what-happened-at-congress-2019/4-clinical-

supervision-by-other-professional.

Singh-Pillay, N. & Cartwright, D. (2018). The unsaid: In- depth accounts of non-disclosures in

supervision from the trainees' perspective. *Counselling Psychotherapy Research, 19*,

83-92.

Sirola-Karvinen, P. & Hyrkäs, K. (2011). Clinical supervision for nurses in administrative and

leadership positions. In Cutliffe, J.R., Hyrkäs, k. & Fowler, J. (eds) *Routledge

Handbook of Clinical Supervision Fundamental International Themes.* Routledge.

Sloan, G. (2011). Clinical supervision in the United Kingdom – ten years on A review of the

United Kingdom clinical supervision literature. In Cutcliffe, J.R., Hyrkäs, K. & Fowler, J.

(eds) *Routledge Handbook of Clinical Supervision, Fundamental International

Themes.* Routledge.

Sloan, G. & Watson, H. (2002). Clinical supervision models for nursing: structure, research

and limitations. *Nursing Standards, 17*(4), 41-46.

Stacey, G., Aubeeluck, A., Cook, G. & Dutta, S. (2017). A case study exploring the experience

of resilience-based clinical supervision and its influence on care towards self and

others among student nurses. *International Practice Development Journal, 7*(2).

Stevenson, C. (2011). Postmodernising clinical supervision in nursing. In Cutcliffe, J.R.,

Hyrkäs, K. & Fowler, J. (eds) *Routledge Handbook of Clinical Supervision,*

Fundamental International Themes. Routledge.

Stokes-Parish, J., Elliott, R., Rolls, K. & Massey, D. (2020). Angels and Heroes: The

Unintended Consequence of the Hero Narrative. *Journal of Nursing Scholarship,* 0:0,

1-5.

Sweeney, J. & Creaner, M. (2014). What's not being said? Recollections of nondisclosure in

clinical supervision while in training. *British Journal of Guidance & Counselling, 42*(2),

211-224.

Taylor, L.M., Eost-Telling, C.L. & Ellerton, A. (2018). Exploring preceptorship programmes:

Implications for future design. *Journal of Clinical Nursing, 29* 1164-1173.

The King's Fund. (2020a). *The King's Fund History of Nursing*.

https://my.visme.co/view/q6jz4wre-the-king-s-fund-nursing-exhibition-2020

The King's Fund. (2020b). The courage of compassion Supporting nurses and midwives to

deliver high-quality care. https://www.kingsfund.org.uk/sites/default/files/2020-

09/The%20courage%20of%20compassion%20summary_web_0.pdf

Tracy, S.J. (2010). Qualitative Quality: Eight ''Big-Tent'' Criteria for Excellent Qualitative

Research. *Qualitative Inquiry, 16*(10), 837-851.

Traynor, M. (2018). Guest editorial: What's wrong with resilience. *Journal of Research in Nursing, 23*(1), 5-8.

Trueland, J. (2019). Blame Culture: How to Make a Change in Your Workplace. *Nursing Standard, 34*(9), 14-19.

Wand, T. (2017). Considering the culture of blame in mental health care and service delivery. *International Journal of Mental Health Nursing, 26*, 3-4.

Wand, T., Isobel, S. & Derrick, K. (2015). Surveying clinicians perspectives of risk assessment and management practices in mental health service provision. *Australasian Psychiatry, 23*, 147–153.

WHO. (2020). *WHO and partners call for urgent investment in nurses*. https://www.who.int/news/item/07-04-2020-who-and-partners-call-for-urgent-investment-in-nurses

Willig, C. (2013*). Introducing Qualitative Research in Psychology*. New York; Open University Press.

Winstanley, J. & White, E. (2011). The MCSS-26©: Revision of the Manchester Clinical Supervision Scale© Using the Rasch Measurement Model. *Journal of Nursing Measurement, 19*(3), 160-178.

Winstanley, J. & White, E. (2014). The Manchester Clinical Supervision Scale©: MCSS-26©. In C. E. Watkins, Jr. & D. L. Milne (Eds.) *The Wiley international handbook of clinical supervision,* 386–401. Wiley-Blackwell.

Wolvaardt, E. (2019). Blame does not keep patients safe. *Community Eye Health Journal, 32*(106).

Yegdich, T. (1999). Clinical supervision and managerial supervision: some historical and

conceptual considerations. *Journal of Advanced Nursing, 30*(5), 1195-1204.

Yegedich, T. (1998). How not to do clinical supervision in nursing. *Journal of Advanced

Nursing, 28*(1), 193-202.

Yourman, D.B. (2003). Trainee Disclosure in Psychotherapy Supervision: The Impact of

Shame. *Journal of Clinical Psychology, 59*(5), 601-609.

Appendix one – CASP qualitative checklist tool

CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

Are the results of the study valid? (Section A)

What are the results? (Section B)

Will the results help locally? (Section C) The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided. About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners. For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate. Referencing: we recommend using the Harvard style citation, i.e.: Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed. ©CASP this work is licensed under the Creative Commons Attribution – Non-Commercial-Share A like. To view a copy of this license, visit http://creativecommons.org/licenses/by-nc-sa/3.0/ www.casp-uk.net Critical Appraisal Skills Programme (CASP) part of Oxford Centre for Triple Value Healthcare www.casp-uk.net

Section A: Are the results valid?

1.Was there a clear statement of the aims of the research?

Yes

HINT: Consider

•what was the goal of the research

•why it was thought important

•its relevance

Can't Tell

No

Comments:

2.Is a qualitative methodology appropriate?

Yes

HINT: Consider

•If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants

•Is qualitative research the right methodology for addressing the research goal

Can't Tell

No

Comments: Is it worth continuing?

3.Was the research design appropriate to address the aims of the research?

Yes

HINT: Consider

• if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Can't Tell

No

Comments: Paper for appraisal and reference:

4. Was the recruitment strategy appropriate to the aims of the research?

Yes

HINT: Consider

• If the researcher has explained how the participants were selected

• If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study

• If there are any discussions around recruitment (e.g. why some people chose not to take part)

Can't Tell

No

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes

HINT: Consider

• If the setting for the data collection was justified

• If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)

• If the researcher has justified the methods chosen

• If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)

• If methods were modified during the study. If so, has the researcher explained how and why

• If the form of data is clear (e.g. tape recordings, video material, notes etc.)

• If the researcher has discussed saturation of data

Can't Tell

No

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes

HINT: Consider

• If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location

• How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Can't Tell

No

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes

HINT: Consider

• If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained

• If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)

• If approval has been sought from the ethics committee

Can't Tell

No

Comments:

8. Was the data analysis sufficiently rigorous?

Yes

HINT: Consider

• If there is an in-depth description of the analysis process

• If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data

• Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process

• If sufficient data are presented to support the findings

• To what extent contradictory data are taken into account

• Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Can't Tell

No

Comments:

9. Is there a clear statement of findings?

Yes

HINT: Consider whether

• If the findings are explicit

• If there is adequate discussion of the evidence both for and against the researcher's arguments

• If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)

• If the findings are discussed in relation to the original research question

Can't Tell

No

Comments:

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

• If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature

• If they identify new areas where research is necessary

• If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix two - Critical Appraisal of a Survey tool

Critical Appraisal of a Survey

Appraisal questions   Yes - Can't Tell - No

1. Did the study address a clearly focused question / issue?

2. Is the research method (study design) appropriate for

answering the research question?

3. Is the method of selection of the subjects (employees, teams,

divisions, organizations) clearly described?

4. Could the way the sample was obtained introduce (selection)bias?

5. Was the sample of subjects representative with regard to the

population to which the findings will be referred?

6. Was the sample size based on pre-study considerations of

statistical power?

7. Was a satisfactory response rate achieved?

8. Are the measurements (questionnaires) likely to be valid and

reliable?

9. Was the statistical significance assessed?

10. Are confidence intervals given for the main results?

11. Could there be confounding factors that haven't been

accounted for?

12. Can the results be applied to your organization?

Adapted from Crombie, The Pocket Guide to Critical Appraisal; the critical appraisal approach used by the Oxford Centre for

Evidence Medicine, checklists of the Dutch Cochrane Centre, BMJ editor's checklists and the checklists of the EPPI Centre.

CEBMa center for Evidence-Based Management

Appendix three – Systematic literature review protocol

SLR protocol

Background	Clinical supervision is imbedded within the majority of therapeutic practices and is considered a integral of the discipline (Roth and Fonagy, 1996; Milne, 2003; Fleming and Steen, 2005 & BPS, 2017). Non-disclosure, distinct from disclosure, within supervision is the phenomenon whereby supervisees, or supervisors, purposefully withhold personal, relational or clinical information. Although withholding information is a normal process that we all engage in daily, within clinical settings it has the potential to both adversely affect the supervisee's development and the outcomes of clients they are working with. Several studies using different methodologies have attempted to shed light and explain what might cause the phenomenon to occur and what might help mitigate it. Much of this research has been conducted within the last few years suggesting a review might be helpful to compile ideas.
Research Question	What is known about non-disclosure within clinical supervision? Search for similar reviews carried out on PROSPERO on 12.10.21, no results were found.
Method:	
Search strategy	Using bibliographic databases (specifically Pubmed, CINAHL Plus, Scopus and Psyarticles) I will search published data from journals. This will begin with several scoping searches to get an overview of the literature and help develop the main search terms.
Inclusion/exclusion criteria	Exclusion criteria: - Research using case studies (due to reduced research rigor)

	- Group supervision (research focused on individual supervision) - Literature reviews/editorials (to keep the focus on experimental data) PICOSS table for inclusion criteria:	
	Review Question	What is known about non-disclosure within clinical supervision?
	Population	Healthcare professionals accessing individual clinical supervision
	Intervention	Direct reference to and discussions of non-disclosure within the supervisory space
	Comparator	none
	Outcomes	Reports of impacts of disclosure within Clinical supervision
	Study Design	Quantitative or Qualitative
	Setting	Clinical/trainee settings
Screening and selection	Once search terms have been applied, a title and abstract screening will be used to identify papers. These will be stored using the 'saved search' function on the bibliographic databases and once all search terms have been applied further screening will be conducted, applying the inclusion and exclusion criteria to reduce the final number down to between 12-15 papers.	

Data extraction	A data extraction table will be used for each paper. This will ask certain questions to extract study characteristics data, such as: study design, number of participants and outcomes.
Quality assessment	As the study will use both qualitative and quantitative study designs, two different and appropriate assessment tools will be used. For quantitative I will use a tool adapted from Crombie (1996) designed for the appraisal of surveys. For qualitative I will use the Qualitative appraisal tool designed by CASP.
Data analysis	The data will be extrapolated into tables and then narrative discourse will be used to describe and evaluate the findings and make recommendations.
Patient & public involvement	There will be no external involvement, due to the nature of the topic and that the requirements for it to be an individual piece of work for thesis submission.
Dissemination plan	The review will be disseminated in university research presentation days and may be considered for publication submission.
Time Frame	To be finished by June 2022

Appendix four – Scooping search

Search Terms	Results
Non-disclosure OR nondisclosure	2136
Disclosure	89,867
Self-disclosure	11,123
sharing OR openness OR transparency	497,241
Supervision	93,434
Clinical and Supervision	22,313
"clinical supervision"	4730
Nursing	694.533
"Mental health nursing"	2969
Clinical and Supervision and Non-disclosure OR nondisclosure	19
"Clinical Supervision" and Non-disclosure OR nondisclosure	13
"Clinical Supervision" and disclosure	58
Clinical and supervision and supervisor and self-disclosure*	29
Clinical and Supervision and "mental health nursing"	125
Supervision and nondisclosure or non-disclosure	45
"Clinical Supervision" and "mental health nursing"	90
"mental health nursing" and Non-disclosure OR nondisclosure	0
"mental health nursing" and disclosure	29
"mental health nursing" and "clinical supervision" and disclosure	1
Clinical and Supervision and Non-disclosure OR nondisclosure and "mental health nursing"	0
"Clinical Supervision" and Non-disclosure OR nondisclosure and "mental health nursing"	0
Clinical and Supervision and Non-disclosure OR nondisclosure and nursing	0
"Clinical Supervision" and Non-disclosure OR nondisclosure and nursing	0
Supervision and Nursing and nondisclosure or non-disclosure	0
Supervision and mental health Nursing and nondisclosure or non-disclosure	0
"Clinical Supervision" AND sharing OR openness OR transparency	94
"Clinical Supervision" AND sharing OR openness OR transparency AND disclosure	4

Appendix five – Example data extraction table

Title	What's not being said? Recollections of nondisclosure in clinical supervision while in training
Lead author	Jennifer Sweeney & Mary Creaner
Year of publication	2014
Journal	British Journal of Guidance and Counselling
Study design	Qualitative design using semi-structured interviews
Where conducted	Ireland
Studies inclusion/exclusion criteria	Not provided "those who met inclusion criteria" All participants needed to be engaged in a supervisory relationship at time of study
Participant type and numbers (including drop outs) demographic information	N = 6 (3x male, 3x female age 28-55) Counselling Psychology graduates two years post training
Intervention or comparator	Semi-structured interviews, exploring the recollections of non-disclosure in individual clinical supervision.
Type of analysis	Consensual qualitative research (used to study inner experiences, attitudes, and beliefs, all of which are not readily observable) Cross-analysis to establish frequency of occurrences Validity checks and auditing conducted by supervisor and peer researcher
Outcomes	Four categories were identified: 1. The nature of the difficulty 2. Reasons for non-disclosure 3. The supervisory relationship 4. Facilitative factors: what could have helped and what did help disclosure
Conclusions	Important for supervisors to be aware of and facilitate optimal disclosure and reflect on own disclosures. Supervisors to consider role more fully in terms of facilitating supportive learning environment, address anxiety and maximise professional development Shared responsibility important to overcome difficulties Training programmes could to explicitly address non-disclosure by engaging in discussion in the implications
Study sponsorship	Not mentioned

Appendix six -Sponsorship in Full agreement from the University of Hertfordshire

University of Hertfordshire UH

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax   +44 (0) 1707 284115
Website   www.herts.ac.uk

John M Senior
BSc MSc DSc PGCE CEng FIET FRSA FHEA
Professor of Communication Networks
Pro Vice-Chancellor (Research and Enterprise)

Dr E Karwatzki & Mr S Farley
Department of Psychology, Sport & Geography
School of Life & Medical Sciences

10 September 2021

Dear Dr Karwatzki and Mr Farley

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
        RESEARCH STUDY TITLE: What are Mental Health Nurses Experiences of Non-Disclosure
        within Clinical Supervision?
        NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Emma Karwatzki
        NAME OF INVESTIGATOR (Student): Mr Stuart Farley
        UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PGT/UH/04678
        HEALTH RESEARCH AUTHORITY REFERENCE: 21/HRA/2229

This letter is to confirm your research study detailed above has been reviewed and accepted and I
agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief
Investigator to inform the Sponsor at any time of any changes to the duration or funding of the
project, changes of investigators, changes to the protocol and any future amendments, or deviations
from the protocol, which may require re-evaluation of the sponsorship arrangements.

Permission to seek changes as outlined above should be requested from myself before submission
and notification to the Health Research Authority (HRA) or University of Hertfordshire Ethics
Committee with Delegated Authority (ECDA) as relevant, and I must also be notified of the outcome.
It is essential that evidence of any further relevant external permissions is provided as they are
received. Copies of annual reports and the end of study report as submitted to the HRA also need to
be provided. Please do this via email to research-sponsorship@herts.ac.uk

**Please note that University Sponsorship of your study is invalidated if this process is not
followed.**

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

Professor J M Senior
Pro Vice-Chancellor (Research and Enterprise)

Appendix seven – Ethical Approval from the University of Hertfordshire

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Stuart Farley
CC	Dr Emma Karwatzki
FROM	Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair
DATE	07/09/2021

Protocol number: **LMS/PGT/UH/04678**

Title of study: What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 07/09/2021

To: 31/01/2022

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix eight – HRA approval from NHS England

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Dr Emma Karwatzki
Clinical Psychologist, Academic Manager & Clinical
Lead
University of Hertfordshire
Doctorate in Clinical Psychology
Health Research Building, College Lane Campus
University of Hertfordshire
AL10 9AB

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

15 June 2021

Dear Dr Karwatzki

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title:	**What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?**
IRAS project ID:	298172
Protocol number:	tbc
REC reference:	21/HRA/2229
Sponsor	**University of Hertfordshire**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval
has been given for the above referenced study, on the basis described in the application form,
protocol, supporting documentation and any clarifications received. You should not expect to
receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in
line with the instructions provided in the "Information to support study set up" section towards
the end of this letter.

**How should I work with participating NHS/HSC organisations in Northern Ireland and
Scotland?**
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland
and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of
these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 298172. Please quote this on all correspondence.

Yours sincerely,
Rachel Katzenellenbogen
Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: Ms Ellie Hubbard

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Copies of materials calling attention of potential participants to the research	2	01 June 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		
Interview schedules or topic guides for participants		
IRAS Application Form [IRAS_Form_18052021]		18 May 2021
Letter from sponsor		
Organisation Information Document	2	01 June 2021
Other [Debrief]	2	01 June 2021
Other [Expression of interest form]	2	01 June 2021
Participant consent form		
Participant information sheet (PIS)		
Research protocol or project proposal [Protocol]	2	01 June 2021
Schedule of Events or SoECAT	2	01 June 2021
Summary CV for Chief Investigator (CI) [CV]		
Summary CV for student		

IRAS project ID	298172

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	All sites will perform the same research activities therefore there is only one site type.
Expectations related to confirmation of capacity and capability	Organisations will not be required to formally confirm capacity and capability, and research procedures may begin 35 days after provision of the local information pack, provided the following conditions are met: - You have contacted participating NHS organisations (see below for details) - HRA and HCRW Approval has been issued - The NHS organisation has not provided a reason as to why they cannot participate - The NHS organisation has not requested additional time to confirm. You may start the research prior to the above deadline if HRA and HCRW Approval has been issued and the site positively confirms that the research may proceed. You should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHSR&D Forum website and these contacts MUST be used for this purpose. The password to access the R&D contact list is Redhouse1.
Agreement to be used	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
Funding arrangements	No study funding will be provided to sites, as stated in the Organisation Information Document.
Oversight expectations	A Local Collaborator should be appointed at study sites.
HR Good Practice Resource Pack expectations	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access if focus groups/interviews were held in clinical areas. Letters of Access would not be expected if they were held in non-clinical/administrative buildings.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

The applicant has indicated they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix nine – Amendment approval one from HRA

Dear Dr Karwatzki,

IRAS Project ID:	298172
Short Study Title:	MH Nurses Experiences of Non-Disclosure Within Supervision
Amendment No./Sponsor Ref:	NSA01
Amendment Date:	23 December 2021
Amendment Type:	Non Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the guidance in the amendment tool.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact amendments@hra.nhs.uk for any queries relating to the assessment of this amendment.

Kind regards

Mr Mark Sidaway
Approvals Specialist
Health Research Authority
Ground Floor | Skipton House | 80 London Road | London | SE1 6LH
E.amendments@hra.nhs.uk
W. www.hra.nhs.uk

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Appendix ten – Amendment approval two from HRA

Dear Dr Karwatzki,

IRAS Project ID:	298172
Short Study Title:	MH Nurses Experiences of Non-Disclosure Within Supervision
Amendment No./Sponsor Ref:	NSA02
Amendment Date:	21 January 2022
Amendment Type:	Non Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the guidance in the amendment tool.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact amendments@hra.nhs.uk for any queries relating to the assessment of this amendment.

Kind regards

Owain Richardson
Health Research Authority
Ground Floor | Skipton House | 80 London Road | London | SE1 6LH
E.amendments@hra.nhs.uk
W. www.hra.nhs.uk

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Appendix eleven – Participant information sheet

Participant Information Sheet

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An invitation to take part in research…

What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?

</div>

Are you a Band 5 or 6 mental health nurse working within an inpatient setting who is receiving clinical supervision?

What are the aims of this research?
The purpose of the study is to look at the phenomenon on non-disclosure in nurse clinical supervision. Non-disclosure within supervision refers to times when a supervisee may feel unable, or choose not to share information with their supervisor; this information may be personal or related to their clinical work. Non-disclosure can impact on supervisee development as well as patient outcomes. Within other mental health professions, non-disclosure has been found to occur frequently and a number of strategies have been put forward to help support better dialogue. This study aims to expand on this research by exploring whether non-disclosure occurs within nursing, what might cause it to occur and what can support more open conversations within clinical supervision.

What would this involve?
The lead researcher for the project, Stuart, would arrange a time to meet with you for the interview. This would either be at your base of work or over remote video technology, depending on COVID-19 guidance and your preference. Stuart will interview you for about approximately 60 minutes; this is to allow you time and space to talk about your experience. You will only be invited to talk about what you feel willing and able to. It has been agreed that nurses will be allowed to use shift time to attend interviews and they will be paid for this. This will depend on the needs of the ward at the time.

Once interviews with all participants have been conducted, patterns and common themes will be identified. A summary of these will then be returned to you to check that we have captured your experience correctly. This information will not be identifiable as it will be an amalgamation of similarities from all interviews.

What will you do with the information I give you?
All information collected is strictly confidential. All paper-based Information will be stored in a locked filing cabinet that is only accessible by the lead researcher. All electronic information will be stored within the encrypted cloud of the University of Hertfordshire or on encrypted storage devices. Personal identifiable information will only be accessed by the lead researcher. Information that could identify you, such as your name and other details, will be removed or changed. It is possible that quotes from what you talk about will be included in the write up, if this were to occur, they will appear under a pseudonym.

All interviews will be audio recorded; this is because it is then transcribed for analysis later on in the research. These recordings will be accessed by the lead researcher and Dr Emma Karwatzki (supervisor on the research team, University of Hertfordshire). The interview recording will be sent to an independent translation company, using the pseudonym. They must follow our rules about keeping your information safe. No one other than Stuart will know your real name. Once transcribed and checked for accuracy, the recordings will be destroyed. Those who do not need to know who you are, will not be able to see your name or contact details. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

How will you use this information?
The results of the research will be written up in a report for the lead researcher's Doctorate in Clinical Psychology. The research will be written up for submission to peer-reviewed academic journals and conferences, so that other health professionals can learn from the research.

Are there any situations when information I tell you will be shared?
Disclosure of any personal information from the interview would only occur in exceptional circumstances, such as if you revealed information that may indicate a risk to yourselves or others.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

- at www.hra.nhs.uk/information-about-patients/
- or contacting the University of Hertfordshire's Data Protection Team on dataprotection@herts.ac.uk.
- by sending an email to the Stuart on sf19aba@herts.ac.uk

Are there any potential benefits in taking part?
There are not any direct benefits for taking part, but we hope to provide a space where you can share your experiences of clinical supervision. Talking with someone who is impartial may be helpful in making meaning from the experience. Also, you will be contributing to a growing area of research, which may have implications for nurses in the future.

Are there any potential risks in taking part?
There are no known risks, however, there is a chance that the interview may be emotionally distressing for some. Stuart has experience in providing emotional support to people who are experiencing distress, and will be sensitive to this in his interview technique and delivery. For example, if he feels you are becoming distressed, he may ask you to pause for a moment and check you are not feeling too anxious. As stated above, Stuart may ask clarifying questions but not questions which will involve asking details about specifics of an event. You will be reminded that you should only talk about the experiences that feel you feel willing to talk about, and in a way that feels manageable for you.

What happens after the interview?
As mentioned above, following the interview, you will be shown a summary of common themes found across interviews, to make sure that we have correctly captured your experience.

Following the end of the project, a summary of the findings will be documented and made available to those who took part, if you would like.

What happens if I agree to take part but then later change my mind?
You can withdraw from the interview at any time point, including during the interview and up to 14 days after the interview. You can withdraw for any reason, and you do not have to give the reason for this. Withdrawal from the study would have no impact on your job role.

Who is in the research team?

Name	Role	Email
Stuart Farley	Lead researcher for the project Trainee Clinical Psychologist, University of Hertfordshire	sf19aba@herts.ac.uk
Dr. Emma Karwatzki	Clinical Psychologist & Academic Manager & Clinical Lead, University of Hertfordshire	e.karwatzki@herts.ac.uk
Dr. Barbara Mason	Consultant Clinical Psychologist Associate Clinical Director Training & Partnerships	barbara.mason2@nhs.net
Dr. Jane Padmore	Executive Director of Quality and Safety (Chief Nurse)	jane.padmore@nhs.net

---

What do I do if I am interested in taking part?

1. Participation is entirely voluntary, so we first encourage you to **have some time and space to think** about whether you would like to take part. If you have any questions, or would like more information, you can email the lead researcher, or if you would prefer, you can email to arrange a time to talk with him over the phone.
2. If you decide you would like to take part, **please email Stuart**: sf19aba@herts.ac.uk to express your interest.

Please note that there is <u>no guarantee</u> that all those who apply to take part will be interviewed.

This research is being conducted as part of Stuart's Doctorate in Clinical Psychology, sponsored by the University of Hertfordshire. It is supported by Hertfordshire Partnership Foundation Trust, Essex Partnership University Trsut & East London Foundation Trust The research team work in accordance to professional code of conduct including ethical practice.

University of HERTFORDSHIRE UH Ethics Committee

This is an official notification by student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?
Protocol Number: : LMS/PGT/UH/04678
Approving Committee: Health, Science, Engineering & Technology ECDA

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Stuart Farley Trainee Clinical Psychologist, 0777 9149460, sf19aba@herts.ac.uk or my supervisor Dr Emma Karwatski, Academic Manager & Lead, e.karwatzki@herts.ac.uk

Appendix twelve – Expression of interest form

EXPRESSION OF INTEREST FORM

What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?

Please make sure you have first read the Participant Information Sheet.

This study is part of Stuart's doctoral training, and therefore there are time limits to complete the project. As more than the required number of participants may register their interest to take part, it may be that not everyone who expresses an interest can take part in the research. We want to make sure we include nurses from a range of backgrounds and different living situations. We hope that this will contribute to the literature and may inform better emotional support for nurses in the future.

PLEASE COMPLETE SECTIONS IN BLUE

First and last name:	
Age:	
Gender:	
Length of experience of being a mental health nurse (in years and/or months):	
Length of experience working within a mental health inpatient setting (in years and/or months):	
Length of time in your current post (in years and/or months):	
Do you routinely access Clinical supervision (in addition to managerial supervision)?	
NHS banding (e.g. 5 / 6):	
How would you describe your ethnic background?	
Do you live alone or with others? If you live with others, please give brief description (eg, two children under 18; adult partner; three adult flat-mates; parents)	
Any other information you think is important:	

If you would like to take part, and you have read the Participant Information Sheet, please email this completed form to sf19aba@herts.ac.uk

Stuart will assume that the email address you send the form from is the preferred email address for contact.

What happens to this information?

If you are selected to be interviewed, the above information you have provided will be kept **strictly confidential** in accordance with the Data Protection Act 1998. Hardcopies of documents information will be stored in a locked filing cabinet and only accessible by Stuart and Dr Emma Karwatzki. Electronic documents will be password protected and stored on the University of Herefordshire secure cloud that will only be able to be accessed by Stuart. If you are selected to take part in the research, then you will be given a pseudonym so that you cannot be identified. If you are not selected to be interviewed, this information will be destroyed.

Thank you for your time.

University of Hertfordshire UH Ethics Committee

This is an official notification by student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?
Protocol Number: : LMS/PGT/UH/04678
Approving Committee: Health, Science, Engineering & Technology ECDA

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Stuart Farley, Trainee Clinical Psychologist, 0777 9149460 sf19aba@herts.ac.uk or my supervisor Dr Emma Karwatzki, Academic Manager & Lead, e.karwatzki@herts.ac.uk

Appendix thirteen - Participant consent form

CONSENT FORM

What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?

> **PLEASE COMPLETE SECTIONS IN BLUE**

	PLEASE TICK
1) I confirm that I have been given a Participant Information Sheet for the above study. I am aware that it states the aim, methods and design, the names and contact details of key people, the potential risks and potential benefits and how the information collected will be stored and for how long. I have had the opportunity to consider and information, ask questions and have these questions answered.	
2) I understand that my participation is voluntary and that I can withdraw at any time, without having to provide reason, and that my job role and legal rights will not be affected.	
3) I understand that my interview will be audio recorded.	
4) I understand that when a report is written and published about the study, quotes/sentences from my interview may be used, but all identifying information will be removed or changed. I give permission for publication of these anonymised quotes.	
5) I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.	
6) I understand that my participation in this study may reveal findings that could indicate that I might require further advice and support. I am also aware that I will be emailed a list of contact details for support services following the interview.	
7) I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.	
8) I give my agreement to take part in the above study.	

PARTICIPANT:	NAME:	
	CHOSEN PSEUDONYM:	
	DATE:	
	SIGNATURE:	
LEAD RESEARCHER:	NAME:	
	DATE:	
	SIGNATURE:	

University of Hertfordshire UH Ethics Committee

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Appendix fourteen – Research advert

New Research - What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?

Are you a band 5 or 6 mental health nurse?

Do you work as permanent staff, within an inpatient setting?

Do you access individual clinical supervision?

If so, then we would like to hear about your experiences

Clinical supervision, separate to managerial supervision, provides an environment in which nurses can explore their own personal and emotional reactions to their work; reflect on and challenge their own practice in a safe and confidential environment (Royal College of Nursing, 2019).

Non-disclosure within supervision is where a supervisee choses to or feels unable to talk about a topic which can be either personal or professional. Non-disclosure has the potential to have negative consequences to both the supervisee's development and the patients they work with.

For this research, we are looking for nurses who would be happy to be interviewed confidentially about their experiences of clinical supervision and non-disclosure.

If you would like further information, please look at the linked information sheet and if you would like to take part, please complete the expression of interest form linked. Or email Stuart: sf19aba@herts.ac.uk

Appendix fifteen – Participant debrief sheet

Contacts for further support

What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?

Thank you for taking part in this study.

Talking about your experiences of clinical supervision, may have been distressing for you. We hope that the below resources will be helpful should you find yourself needing some extra support.

The professional code of conduct and ethical approval for this study means that the lead researcher Stuart Farley cannot personally support individuals with support beyond the remit of the study. This is why we have created this debrief sheet with a list of contact details for further support.

- **GP or local Psychological Therapy Services:** for advice if you are feeling low in mood, anxious or other emotional difficulties since working through COVID-19.

- **National NHS Helpline:** you can call this service on 0300 131 7000

- **Support via text messages - Shout:** text FRONTLINE to 85258

- **Royal College of Nursing** – can offer support for a range of issues including: with professional practice, bullying, harassment and stress.
  https://www.rcn.org.uk/get-help/bullying-harassment-and-stress

- **Cavell Nurses Trust** – Supports those suffering from personal or financial hardship
  https://www.cavellnursestrust.org/

- **Samaritans** – A non-judgemental service who will always listen
  https://www.samaritans.org/   Call 116 123 free

- **Here for you** – A staff support service for those employed by HPFT and EPUT - 0344 257 3960   hereforyou@nhs.net

Please note: *This debrief sheet should not be considered equivalent to consultation with a professional – please do seek support should you feel you need it.*

Appendix sixteen – Recruitment presentation

WHAT ARE MENTAL HEALTH NURSES EXPERIENCES OF NONDISCLOSURE WITHIN CLINICAL SUPERVISION?

STUART FARLEY

TRAINEE CLINICAL PSYCHOLOGIST

UNIVERSITY OF HERTFORDSHIRE

NONDISCLOSURE IN THE SUPERVISORY SPACE

- THE INTENTIONAL WITHHOLDING OF INFORMATION EITHER PERSONAL, PROFESSIONAL OR RELATIONAL

- POTENTIAL TO IMPACT ON ALL THREE PARTS OF SUPERVISORY TRIAD, DEVELOPMENT, RISK IMPLICATIONS, ACCOUNTABILITY.

- EVIDENCE POINTS TO HIGH FREQUENCY - 97% WITHHELD INFORMATION IN A SINGLE SUPERVISION (LADANY ET AL. 1996). AVERAGE 2.6 NONDISCLOSURES PER SUPERVISION (MEHR ET AL. 2010).

- SMALL BUT GROWING BODY OF LITERATURE- FOCUSED ALMOST ENTIRELY ON PSYCHOLOGY/PSYCHOTHERAPY TRAINEES

WHAT IS CLINICAL SUPERVISION?

- 'AN EXCHANGE BETWEEN PRACTISING PROFESSIONALS TO ENABLE THE DEVELOPMENT OF PROFESSIONAL SKILLS' – BUTTERWORTH 1992

- 'A TERM USED TO DESCRIBE A FORMAL PROCESS OF PROFESSIONAL SUPPORT AND LEARNING WHICH ENABLES INDIVIDUAL PRACTITIONERS TO DEVELOP KNOWLEDGE AND COMPETENCE, ASSUME RESPONSIBILITY FOR THEIR OWN PRACTICE AND ENHANCE CONSUMER PROTECTION AND SAFETY OF CARE IN COMPLEX CLINICAL SITUATIONS' – DOH 1993

- PROCTOR'S MODEL – NORMATIVE, FORMATIVE, RESTORATIVE- OR MANAGEMENT, LEARNING AND SUPPORT

WHY NURSING?

- PERSONAL INTEREST

- UTILISE SUPERVISION BUT HAVE A DIFFERENT RELATIONSHIP TO AND HISTORY OF

- CHALLENGES IN IMPLEMENTATION, UNDERSTANDING, EVALUATION

- STAFF SUPPORT

THE RESEARCH

- QUALITATIVE METHODOLOGY, USE OF THEMATIC ANALYSIS

- WORKING ACROSS 3 TRUSTS

- LOOKING TO RECRUIT 15 BAND 5/6, INPATIENT MH NURSES, WHO ACCESS INDIVIDUAL CLINICAL SUPERVISION AND ARE PERMANENT (NOT BANK). CAN BE DUEL TRAINED/PRECEPTEES.

- TAKE PART IN A 1 HOUR INTERVIEW (ONLINE) AND MIGHT BE SELECTED OR MEMBER CHECKING

WHAT WILL I GET FROM TAKING PART?

- TAKING PART IN INNOVATIVE NURSING RESEARCH

- HELPFUL FOR REVALIDATION

- YOUR OWN DEVELOPMENT

- SERVICE DEVELOPMENT

HOW DO I TAKE PART?

- COMPLETE AN EXPRESSION OF INTEREST FORM – I CAN EMAIL ACROSS

- SEND IT TO ME, STUART FARLEY – SF19ABA@HERTS.AC.UK

Appendix seventeen –Interview schedule

<u>Interview Procedure and Schedule</u>

Introduction

Hello and thank you for agreeing to be interviewed.

My name is Stuart and I am a Trainee Clinical Psychologist with the University of Hertfordshire. I am interested in the phenomenon known as non-disclosure and specifically within nursing supervision. Non-disclosure within supervision refers to times when a supervisee may feel unable, or choose not to share information with their supervisor; this information may be personal or related to their clinical work. Non-disclosure can impact on supervisee development as well as patient outcomes.

Within psychology, non-disclosure has been found to occur frequently and a number of strategies have been put forward to help support better dialogue. I aim to expand on this research by exploring whether nurses describe experiences of non-disclosure within clinical supervision, what they feel leads it to occur and what might support more open conversations within clinical supervision.

This interview will last 45-60 minutes during which time I will ask you a series of questions around your experiences of supervision. You will have received an information sheet from me, but just a reminder that this interview will be recorded but everything you say to me will be kept confidential and stored within encrypted devices. Once transcribed, all interviews will be assigned a pseudonym so your interview and your real name will not be kept together. Although themes from our discussion will appear in the final write-up, no identifiable information will feature. You have the right to withdraw from the process at any point (including during the interview or afterwards) if you choose to, any information you have provided will be destroyed and not used in the research.

Before we move on, can I check that you have had the chance to read the information sheet that I sent through? Are there aspects that you would like clarified or any questions that you might have?

[Answer questions and ensure full understanding of the Information Sheet]

Do you wish to proceed with the interview? Please can you sign the consent form?

[Confirm consent – through either using the shared access function on video calls or email signed and received before the interview starts]

If you need a break during the interview just let me know and if you would prefer to have the camera off at points that is also ok.

Screening questions

- Are you a qualified mental health nurse?
- Do you currently hold a band 5 or 6 post?
- Do you currently work or have experience of working within inpatient settings?
- Full time not bank?

Demographic questions

- What is your age?
- How would you define your ethnicity?
- What is your gender?
- How long have you been qualified?
- How long have you worked in your current post?

Warming Questions

- How regularly do you have supervision?
- Where do you have it?
- How has it changed since the outbreak of Covid-19?

Interview Schedule

For all the questions in this interview I would like you to consider any clinical supervision you have had over the last three years.

1. **What is the format of your supervision?**

   Do you have a supervision contract?
   Do you set an agenda each supervision?
   What are the types of topics you usually discuss?
   What do you feel is the purpose of your supervision?
   How able do you feel to reflect on your practice within supervision?

2. **How easy do you find it to talk to your supervisor?**

   What types of topic do you feel comfortable to talk about in supervision, what topics do you find uncomfortable? - What would some examples look like?
   How often do you censor what you say?
   What do you feel makes it harder/easier?
   How would you introduce a difficult topic?

3. **How would you describe your relationship with your supervisor?**

Does it feel mutually respectful? How do you see this?
In what ways is supervision prioritised?
Is empowerment important in your supervision?
How are issues around diversity and difference discussed?
In what ways does your supervisor support you?
If you could make changes to your supervisory relationship, what would they be?
If your supervisor behaved in a way that upset or annoyed you, how would you feel to raise it with them? How do you imagine you'd feel?

4. **What do you feel are the benefits of your supervision?**

Can you describe a time when you felt supported and validated by your supervisor?
What do you feel are important if the supervisory space is to be safe and supportive?
What role does supervision play in your practice?
In what ways does your supervision support your skills development?
How is case discussion and problem solving prioritised?
Do you see value in participating in supervision?

5. **What do you feel are the challenges of your supervision?**
How are environmental challenges navigated – time/space?
Is confidentiality a concern for you? – how come?
If you could make one change to the supervision process, what would it be?

Appendix eighteen – Confidentiality agreement with transcription service

Non-Disclosure Agreement with Transcription Company

This non-disclosure agreement is in reference to the following parties:

Stuart Farley (discloser)

and

Kate MacFarlane (transcriber)

- The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.
- If the recipient is able to identify and knows the participant in the recording, the recipient agrees to cease transcription, inform the disclosure and destroy any copies of the recording.
- The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.
- The recipient agrees to return and/or destroy any copies of the recordings they were able to access provided by the discloser.

TRANSCRIBER TO COMPLETE:
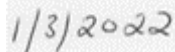
SIGNED: _Kate MacFar_

NAME: KATE MACFARLANE

DATE: 1/3/2022

University of Hertfordshire UH Ethics Committee

This is an official notification by student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: What are Mental Health Nurses Experiences of Non-Disclosure within Clinical Supervision?
Protocol Number: TBC
Approving Committee: Health, Science, Engineering & Technology ECDA

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Stuart Farley Trainee Clinical Psychologist, 0777 9149460, sf19aba@herts.ac.uk or my supervisor Dr Emma Karwatski, Academic Manager & Lead, e.karwatzki@herts.ac.uk

Appendix nineteen - Extract from transcript

: … did you feel comfortable to talk about in supervision? And, again, what topics did you feel uncomfortable to talk about in supervision?

P: Yeah (sighs) … God … yeah, it sounds bad … um … looking back, I'd probably say I didn't feel comfortable talking about a lot to be honest (gives a bit of a laugh) … um … like kind of basics of work stuff really because again, as I've said I felt like I had a lot of pressure on me to kind of … um … to carry sort of the load of the … of the ward and keep my chin up sort of thing so, I didn't … I didn't really feel comfortable saying if things were hard … like … yeah … I was someone that … um … I was asked like continuously to do extra bank shifts and stuff like that … so, I felt like there was a lot of pressure from management and … yeah, to just sort of keep going …so …

I: … mmm …

P: … yeah … I didn't feel too comfortable talking about how work would be affecting me … um … and I definitely didn't feel comfortable talking about like my sort of personal life and … um … yeah … and as I said, I kind of do feel that's because I was just aware that some of my friends and colleagues in the ward did speak about their personal life and it wasn't really necessarily supported it would seem, by management or … yeah … it didn't seem to be useful … so, I just kind of didn't really (gives a bit of a chuckle) …

I: … yeah … yeah … and who could you speak to about these personal issues? Or did you … did you find anyone to speak about these personal issues to?

P: Yeah. Just my work colleagues and my friends at work, so …

I: … so … yeah … so, it would be a bit more informal with peers than …

P: … yeah …

I: … than formal supervision …

P: … yeah … yeah … yeah …

I: … yeah … um … yeah, OK. And so … how often did you censor what you said in supervision?

P: … what and not …?

I: … do you know what I mean by censor?

P: Yeah, do you mean like withholding? Like not …?

I: … well, withholding, or perhaps not telling everything … giving all details or withholding entirely … yeah.

P: Well, if it was work-related, I feel like I was … like, if it was something to do with my … you know, running of the service, or with a young person, I was … like in that sense … like I didn't really feel like I was keeping anything back …

I: … mmm … hmm …

P: … but … um … yeah … I mean, I did definitely censor myself in the sense that I didn't fully let on how I was coping (gives a small chuckle) … I think that was probably the main thing with me … yeah … with my supervision … um …

I: … mmm …

P: … yeah, I probably did that … yeah … I'm trying to think back (pause) … yeah, I remember say … I remember on a couple of occasions saying "You know, things really feel quite difficult on the ward right now. It's … it's quite tough" … and it would kind of … I didn't feel that was kind of contained by my supervisor because they would kind of be like "Yeah. I know. Like I … I've got so much as well." And it was kind of a bit of back and forth, so I didn't really feel … yeah … I don't know …

I: … um … like validated perhaps?

P: Yeah. And also, I kind of felt like the boundaries were a little bit blurred between being like supervisor and supervisee because they were kind of in agreement and they were also kind of using the space to offload that they were too … quite stressed with the environment … so, I felt a bit more … again, I felt like I didn't want to talk too much about (gives a small chuckle) … how bad things were because they were clearly stressed out too. And I just thought (ugh) … everyone's stressed …

I: … mmm …

P: … I've just got to get on with it … yeah …

I: … did it feel like … yeah … you didn't want to almost burden them with this because they were clearly …

P: … yeah …

I: … yeah …

P: … yeah and it was quite clear how bad things were on the ward … so, I kind of felt sometimes if I mentioned it and named it, it would be like "Yeah!" (gives a small chuckle) … "It's pretty bad. It's been this way for a long time." Like … I don't know … that's kind of how I … yeah … that's how … how I felt from it … um … yeah …

I: … talk to me just a little bit more about that … so, what … what did you think would happen? What was the… the fear that would happen if you did name that?

P: … I think about … yeah … like how bad things were? So … I kind of … I just felt like it was kind of accepted that the working environment was pretty bad, and … um … it went kind of hand in hand with the ward, and also, I suppose too within the context of covid …

I: … mmm … hmm …

P: … I think that's probably impacted the supervision a lot, actually, thinking about it because things were so extreme on the ward, and we didn't really know what was going on in … um … with … with covid … kind of in a wider sense that … it always felt quite chaotic and … um … I felt like by naming it and saying how bad things were, it was kind of like "Well, yeah, things are really bad … that's clear, sort of thing …" … I don't know … I'm probably not explaining it very well but … um (slight pause) … yeah, I kind of felt like it wasn't much use in bringing it up because it was just kind of like widely known that it was pretty awful … um … and it …

15.00

P: … wasn't going to make me necessarily feel any better by bringing it up because … I mean, what I probably would have liked if … if I had said, you know … "Things … things are like especially bad at the moment" … I feel probably would have liked my supervisor to be like "How are you looking after yourself? Like, are you doing any self-care? What could … what could we do to sort of relieve the pressure a bit?" … but, instead, it was almost like "Yeah. Things are pretty bad. Can you do a bank shift tomorrow?" (laughs) … So …

I: … right … yeah … so, it was almost normalised that …

P: … yeah …

I: … yeah this … this is it … um …

P: … yeah …

I: Yeah … which, I guess, might feel a little bit disempowering and disheartening …

P: … yeah …

I: … as well … yeah … there's no point in raising it because …

P: … mmm …

I: … it almost is what it is … um …

P: … yeah (gives a little chuckle) … mmm …

I: Yeah. And I guess in … in … so … it … it sounds like covid was definitely a factor …

P: … mmm …
I: … but … um … are there any other things that you think makes it harder or easier to talk to your supervisor?

P: Yeah, I think (sighs) … having … having like an agenda is … is helpful as well because it kind of … um … yeah … it brings some structure and I feel it … I don't know … it helps it

to flow a little bit, and to I think to … to have those boundaries between supervisor and supervisee … I don't know, but having that structure makes it easier to talk I feel.

I: … mmm … hmm … mmm … hmm …

P: … but do you mean about talking about my wellbeing and stuff, or just a general sense?

I: Just in general … I mean … wellbeing might be … might be one of those topics as well … but … sure … but just … yeah, what makes it harder or easier for you?

P: I think … I think what really helps is having kind of like … um … a specific room to go to and just like knowing that you'll kind of have that … um … the same sort of … the same supervision environment, because when … when we were kind of … we would be just fumbling around trying to find a room to do it in …

I: … mmm …

P: … and it felt really quite rushed and to be sat there with a notebook, and it was all a bit like … yeah … it just felt disorganised and I felt that … um … conscious that she was busy and hadn't kind of made official space for us to do the supervision in … yeah … and I didn't want to make matters worse by like just … yeah … talking about (sighs) … how bad things were or how … if I was struggling, or if I … you know, wasn't able to fit in yoga time and stuff like that … I think … um … yeah … those kind of things impacted it, but also I suppose just on like … um … communication sort of level, I suppose like it would have been nice if she was a bit more like … more empathic and just a bit warmer, and a bit more validating perhaps, yeah. And just kind of … like … yeah … really checking in that I was managing … um … outside of work because it was … yeah … it was like relentless, it was so chaotic – that ward.

I: Mmm … yeah, yeah … it sounds like it.

P: Oh, it was awful … like I say … you can probably guess where it was (laughs) …

I: And I suppose that … that then leads into my next question which is how would you introduce a difficult topic?

P: Well, rarely did to be honest … it's difficult to think of because I wouldn't … yeah … I don't think I ever really kind of brought … brought it up myself … um … I think that I probably would have laughed about it a little bit because it was just so awkward to bring up, I'd be like "Yeah, things are pretty bad aren't they?" And just kind of like … I don't know … just sort of laugh about how awful it was (gives a bit of a chuckle) … so … um …

I: … mmm …

P: … yeah … but rarely … um … I'd rarely bring up … um … I'd kind of just respond to her questions in supervision basically.

I: Right.

P: Yeah.

I: So, it almost … you wouldn't bring up a difficult topic, or if you … you did it would be perhaps maybe minimised a little with laughter … um …

P: … yeah, yeah … definitely … that's right … yeah.

I: Um … so, the next few questions is looking at how would you describe your relationship with your supervisor. So …

P: … mmm … hmm …

I: … did it feel mutually respectful your supervision?

P: Um (slight pause) … yeah, I would say probably mostly, apart from when we did it in the printer room (chuckles) … that felt a little bit … yeah … I felt a bit devalued … I thought "Oh, I'm not even worth (gives a bit of a laugh) … like scheduling a room to go into … but doing it quite cramped … in yeah … a tiny little room" … um … so, that … but I know that as well … that it was super busy, and you know there wasn't rooms free and all of that – so I get that – but I'd say probably during the supervision it felt respectful …

20.00

P: … but I felt it was probably a bit disrespectful that I was never sent the supervision notes …

I: … mmm …

P: … so, I couldn't kind of … um … you know, I wouldn't be able to reflect on the supervision in my own time, or just have it for my records, so I felt a bit like it wasn't taken very seriously … and I would probably say that's the only thing that made it feel a little bit … um … disrespectful. Yeah.

I: Mmm … and in what ways did you see … did you see it as respectful? Or what … obviously, you've spoken about … that was … what was disrespectful and some examples of that, but what examples were there for … that you felt respected?

P: Um … well, I just … I feel like … um … I did … I guess … because it's weird … it's difficult to identify … um … identifying it more so in the sense that I never felt disrespected.

I: Mmm …

P: So, it was kind of in a sense that … yeah … she was never really unprofessional, or anything like that … um … or … um … or inappropriate I wouldn't say … so, it felt respectful in that sense … yeah.

I: Mmm … yeah … do you think it might be more non-verbal perhaps than anything that they said?

P: Yeah. Yeah, yeah, yeah … and just how it was … well, disorganised and … yeah …

I: And you've spoken a lot to my next question but it's …

P: … mmm …

I: … in what ways was supervision prioritised?

P: (Sighs) … it just didn't really seem to be prioritised at all … um … I feel like … yeah … it was a bit all over the place to be honest … um … it would just rarely happen and … yeah … the rooms weren't booked out … and notes were never sent and there wasn't an agenda as you said … and … um … yeah … I … yeah … I did feel like … I felt like as a priority it was like a tick box sort of thing – like they knew that they had to get it done – so, like they tried to squeeze it in wherever they could basically …

I: … yeah …

P: … that's kind of how it felt … yeah …

I: And … um … and was empowerment important in your supervision? Did you feel empowered leaving supervision?

P: Not really … um … me and my colleagues were just kind of like … have a little laugh after and just be "Yeah, I see you've had your supervision!" And just go (gives a thumbs up) … sort of thing … it was just …

I: … mmm …

P: … yeah … it didn't really feel … it wasn't so much a useful space, and I think we were all feeling a little bit disillusioned with it because those that would bring up there sort of wellbeing or … you know, lack thereof from work, there wasn't any support system that were put in place to kind of … you know, like help with that, so … yeah … it's … it was just kind of like I had my supervision in the print office today, and it was kind of just a bit funny …

I: … mmm …

P: … that sort of thing … yeah … it wasn't taken too seriously within the team.

I: So … so, that kind of emotional support would come from within the team …

P: … yeah …

I: … in terms of that … that … those conversations with other nurses …

P: Mmm … yeah, definitely … we really supported each other which was nice (gives a small chuckle) …

I: And how were issues around diversity and difference discussed within supervision?

P: Mmm (slight pause) … it's not really something that came up to be honest. Um … yeah, it's not really something that I can remember coming up really.

I: Mmm …

P: … um (pause) … yeah … oh gosh, I do … I remember something that was quite troubling actually (chuckles) … quite embarrassing … um … so, one of the … it was really inappropriate actually … one of the support workers asked me out on a date at work which was like really awkward …

I: … right …

P: … I remember bringing it up in supervision, and I kind of felt like it wasn't taken that seriously … kind of like … I mean, I'm not really sure what I wanted to … I didn't necessarily want anything to come of it … like I didn't want him to be like rapped around the wrists – because it is what it is – but I kind of … um … I don't know … I wanted like some acknowledgement … like … yeah … that's not alright, sort of thing … but …

I: … mmm …

P: … but it kind of felt like … again it was … um … kind of funny, and "Oh, what's he like sort of thing" …

I: … mmm …

P: … and I kind of felt like … yeah … I don't know … it's just … it's … that was really odd … I'm not sure what led me on to that … yeah. I was kind of thinking about like (sighs and slight pause) … yeah … yeah … no … so, it's just I didn't really … it never really came up … kind of like diversity or … yeah … anything along those lines I would say … yeah … apart from sometimes … yeah … just say … like I say, as a woman at work sometimes some of the … oh gosh …

25.00

P: … some of the agency male staff were like really inappropriate towards us on occasions …

I: … really …

P: … and I mean they were … to the point where they weren't allowed to work on the ward any more which is a good … good thing in that action was taken but probably there could have been more follow up around stuff like that I guess but it wasn't too important to me but … yeah … I feel like as a … as a woman in that sense, but otherwise … yeah … never really had any discussions around … um … yeah … diversity.

I: And those … those agency workers who were eventually … um … not allowed back on the ward …

P: … mmm …

I: … were you able to bring that to supervision? Was that … you know … those types of discussions … or were they had outside supervision?

P: So, I remember on one occasion, my supervisor did bring it up to kind of just check in that I was OK sort of thing … and that was … that was like useful, I was glad that she did but … yeah, it felt supported in that sense to be fair … yeah … yeah.

I: Mmm … hmm … um … and I suppose, in what other ways did your … your supervisor support you?

P: Um (slight pause) … not really in other ways I'm surprised (gives a bit of a laugh) … yeah … not really any other ways really … err …

I: … OK … mmm … and … and if you could make changes to that supervisor relationship, what would they have been?

P: Yeah, I think that probably it would have been a bit easier if she was … I … I … if it felt genuine that she really cared about me as an employee, and just making sure that I had that work-life balance, and not using me to do bank continuously, you know …

I: … mmm ..

P: … I think that kind of those … those sort of things would have improved the relationship a lot … um … and improved the quality of the supervision definitely … um … yeah … and just … you know, sending me out the notes and stuff would have been … yeah … good as well.

I: Mmm … sure … and … if your … um … supervisor … um … had behaved in a way that upset or annoyed you …

P: Mmm …

I: … how would you feel to raise it with them?

P: (Sighs heavily) … yeah … not at all … sorry … because my supervisor was my team leader, so … I probably should have mentioned that a while ago but … yeah … so, I just felt that … that wouldn't have been … that wouldn't have been possible … I mean she … she did things to annoy me all the time to be honest, but I'd never bring it up with her … it was just like … me and the other nurses would just … you know, vent a little bit to each other … so … yeah …

I: … and … and why wouldn't it have been possible? What … what … would her being team leader have meant … if you had done that?

P: … well, I really wanted to get a promotion so (gives a bit of a laugh) …

I: … right … right …

P: … so I probably would have worried that it would have jeopardised that but also … um … yeah … just (slight pause) … yeah … I don't know like … and … and it would have impacted on my supervision in future I would have thought … like I would have felt … I don't know (sighs) … it just felt like it wouldn't have been a good thing … had I mentioned some of my … like the issues that … you know … the team and myself had had with her

even … if feel … yeah … I don't … I don't know if she would have been able to hear the feedback. I feel that she probably would have (slight pause) … been a bit defensive maybe because that's how she appeared on occasion … and on similar occasions, so … yeah …

I: … so, it would have been a bit … potentially more like a punitive response as opposed to a reflecting …

P: … absolutely …

I: … response …

P: … yeah, I think so … yeah, I think so … yeah.

I: So, the next three questions are looking at what … what you feel are the benefits of your supervision.

P: Mmm …

I: … um … so, I guess, to begin, can you describe a time when you felt supported and validated by your supervisor?

P: (Sighs and pause) … (sighs) … not really (starts to laugh) … not really … honestly, no … but … but again it was potentially my own fault because I didn't open up about … you know (sighs) … how I was really feeling. So, it's not … it's not necessarily her fault I guess but … um … I can't … honestly … no … I can't really … yeah … I can't think of anything in particular.

I: And, I guess just … just for my curiosity, to … and you can step out of in-patient supervision for this, but if I was to ask the same question about ANY supervision that you've had, where you felt supported and validated …

30.00

I: … by your supervisor, what was … what was going on there to make you feel …?

P: Well, so, my supervision now-a-days is completely different and like for the better … um … my … my current team leader, who is my supervisor is just so approachable, and like warm … um … you know she … she's … she asks me like how I'm getting on at work, and is really … what am I doing to look after myself, and I think because the supervision is so structured, it really helps to sort of like tease out any issues at work as well, like just asking me if there's any specific things like safe-guarding with the young people, or social care issues, and stuff like that just … it really helps me to … um … think about what's going on I guess …

I: … mmm … hmm …

P: … but I think just … yeah … those kind of … like communication quality … she's just very easy to talk to and I definitely … um … have opened up a lot more about how I'm really feeling with her … so … err … but I think, as I was saying earlier, having that structure to the supervision is something that's really helps that, and also I always get my supervision notes

now …which is … um … yeah … it's useful to know that things are recorded sometimes I feel …

I: … sure … sure …

P: … I think that really helps as well … yeah … so, it's just … it's a completely different thing but I work in the community now, and I don't know … I feel there's more time for supervision, if that makes sense?

I: Mmm …

P: So, it could be that as well.

I: Yeah.

P: Yeah.

I: Mmm … and we've mentioned obviously having an agenda, having set notes and stuff, are there any other things that are important for the supervisory spaces to feel safe and supportive?

P: Yeah, having … having enough time for the supervision as well … knowing … knowing that you've got the hour, say … because it never felt like that on the ward. I wasn't really sure how long the supervision would last for … like it would change each time, so …

I: … mmm …

P: … whereas, now it's like we really make use of the full hour, so … I feel like a bit more about … you know, to talk and talk … so, it's fine … um … yeah, what was the question again, sorry?

I: Yeah, so … it's just what … what do you feel are important if the supervisory space is to be safe and supportive?

P: Yeah, I think just … you know, with them definitely checking in, asking how are you really doing? Like are you OK? Is there any … anything I can support with like … um (slight pause) … yeah … just … just asking those questions really and asking … I think it's really important to ask about your self-care …

I: … mmm … hmm …

P: … and what the … what … what are you doing kind of outside of work to manage … um … taking care of yourself, considering you work in quite an intensive service, and it's … it's potentially … you know, quite upsetting … some of the things that we deal with … I guess in mental health, so … I think that's a really important question, definitely and it's something that when I supervise myself, that's something that I definitely check in with.

I: Mmm … mmm …

P: Yeah.

I: So, what role does supervision play in your practice?

P: Well, it plays so many roles. Um … I think it's … it's a really important space to kind of ref… … it's really important to reflect I suppose. I think it really helps … um … to make sure you're reflecting on your practice – that's probably like the key thing for me. And then, also, to just feel supported by someone in a very structured way at work, knowing that that space is there to raise any concerns should you have any. I think it's … yeah … it's really important to know that you've got that time and space to do that.

I: Mmm …

P: So … um … yeah, I'd say that's mostly what it does.

I: Sure. And … and then … thinking, you know … um … more with your in-patient supervision hat on now …

P: … mmm …

I: … but in what way did supervision support your skills development?

P: (Slight pause) … (laughs) … not at all! Yeah … no … I wouldn't say that's what … um … no … definitely not. I mean … it's quite shocking really, because I didn't even have my nursing protector-ship … I was promoted to Band 6 … I mean, stuff like that wasn't identified at any point in supervision … and it's just … yeah … I did feel not very valued as a team member, so … I don't think it really helped me in developing my skills … it did just feel like a tick box kind of exercise on the ward.

I: Mmm … so, thinking about what role did supervision play in your practice on the ward …

P: … mmm …

I: … how would you have answered it back?

P: … oh … so … that … I was talking about the ward a minute ago.

I: Oh, you were, were you? OK.

P: Yeah, yeah … oh yeah … so, I don't …

35.00

Appendix twenty – Evidence of stages of data analysis

The following four slides give examples of the phases to TA outlined by Braun and Clarke (2022): familiarisation with the data, initial coding, initial theme generation and theme refinement. The red box highlights how this was done using Nvivo.

Initial coding

Search Project

Name	Files	References
A place to challenge beliefs	1	2
Aspirations & goals	2	3
Burden	5	10
Defence tactics	4	7
Difference	9	15
Don't wish to get others in trouble	7	16
Empowerment	2	4
Environmental	9	33
Expectation	3	10
Fairness	4	8
Feeling safe	7	33
flexibility	1	3
frustration	5	12
Growth	8	16
hopeless	3	10
Impression management	1	2
Invalidating experience	1	7
Lack of role modelling	1	1
My health	5	7
Other support	1	4
own anxiety	5	11
Power difference	8	15
Practical support	5	13
Pride	7	14
reassurance	1	1
Regularity	10	25
Relationship	9	53
Resistance	3	4
Safe topics	6	8

Quick Access
- Files
- Memos
- Nodes

Data
- Files
  - Interviews
- File Classifications
- Externals

Codes
- Nodes
  - Initial coding
  - Secondary coding
  - Theme generation 1
  - Theme generation 2
  - Theme generation 3
  - Theme generation 4
- Relationships
- Relationship Types

Cases

Notes
- Memos
- Framework Matrices
- Annotations
- See Also Links

Search

Maps
- Maps

Output

Environmental

30.00

P: … but on the ward it's finding time to do it (gives a bit of a chuckle) … but, obviously, in the community we have more time to do it – I have one every month …

Reference 5 - 1.09% Coverage

P: Yeah … well … um … sometimes … like our supervisions are probably cut short so, we'll find a slot, like if it's quiet now like "Come on, let's go and do a supervision now" … yeah … but then … um … you can't always guarantee that … um … you'll be able to finish the full supervision session without being called out or disturbed

Reference 6 - 0.84% Coverage

P: Yeah not … not as often as I wanted because it was difficult … because it was not … I don't always work the same shifts as the super… … as my supervisor … so, sometimes, even if it was a good day, then … then I don't have … I don't get to have it …

<Files\\Interviews\\interview1-bill> - § 4 references coded [2.14% Coverage]

Reference 1 - 0.31% Coverage

this acute setting is very busy and to get … err … time, you know, to do something like supervision and do that regularly is (sighs a bit) … sometimes impossible

Reference 2 - 0.81% Coverage

P: Err … I try a couple of times to organise a meeting with her …

I: … mmm … hmm …

P: … and she was always like … err … "Oh … um … you know … um … I'm going home. I've finished my shift now." Or … or … or when I have to … to stay, you know, after the shift …

Theme generation 1

Search Project

Name	Files	References
Expected to be superhuman	3	15
It's an acute ward - It's always hectic	0	0
Impacts of Covid	5	5
Logistical issues	9	24
Unplanned distractions	6	12
Work load pressures	7	16
Nondisclosure	0	0
Positive experience	0	0
Supervisor style & setup	0	0
A variable experience	9	14
Everyone's different you know	5	7
formal	7	12
Informal	8	33
Not prioritised	7	13
Pastoral	4	9
Regularity	9	13
The supervisee	0	0
The team	0	0
Connection	4	5
Looking out for each other	9	11
Sharing skills & Knowledge	2	3
Worrying about the team	4	6
What constitutes clinical supervision	0	0
What I would like to see	0	0
Zresearch	9	12
ZZmusings	0	0

Quick Access
- Files
- Memos
- Nodes

Data
- Files
  - Interviews
- File Classifications
- Externals

Codes
- Nodes
  - Initial coding
  - Secondary coding
  - Theme generation 1
  - Theme generation 2
  - Theme generation 3
  - Theme generation 4
  - Relationships
  - Relationship Types

Cases

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Search

Maps
- Maps

Output

Informal

<Files\\Interviews\\interview1-bill> - § 5 references coded [1.53% Coverage]

Reference 1 - 0.40% Coverage

we always talk, you know, between us … um … between … you know, Band Six's and Seven's, doctors, so in a … in a way that … err … that supervision is quite regular, but it's in a kind of … err … informal way

Reference 2 - 0.07% Coverage

We've … we've got like a kind of form

Reference 3 - 0.14% Coverage

you will follow a certain pattern about … err … what you are going to ask

Reference 4 - 0.49% Coverage

he's very … informal (slight pause) … you know, he like "Oh yeah, yeah … we have to do supervision … um … this … tonight" … and then he asked me two or three questions, blah-blah-blah … and I answer and he's "Oh yeah, yeah, we'll fill out the form later on"

Reference 5 - 0.42% Coverage

you probably think that it's not respectful because it's quite informal … I told you it was informal, yeah, a couple of questions and that's it, you know … um … but, no it works with us. I think it works between the two

<Files\\Interviews\\interview2-danielle> - § 1 reference coded [0.19% Coverage]

Reference 1 - 0.19% Coverage

I honestly … I don't think so. We did bullet points of you know

<Files\\Interviews\\interview3-emily> - § 1 reference coded [0.14% Coverage]

Reference 1 - 0.14% Coverage

Theme generation 4

Search Project

Name	Files	References
A poorly defined space	0	0
Expected to be superhuman	3	14
Relationally unsafe	0	0
Strategies to stay safe	0	0
You work with them more than your family	0	0

Quick Access
- Files
- Memos
- Nodes

Data
- Files
  - Interviews
- File Classifications
- Externals

Codes
- Nodes
  - Initial coding
  - Secondary coding
  - Theme generation 1
  - Theme generation 2
  - Theme generation 3
  - Theme generation 4
  - Relationships
  - Relationship Types

Cases

Notes
- Memos
- Framework Matrices
- Annotations
- See Also Links

Search

Maps
- Maps

Output

Drag selection here to code to a new node

Expected to be superhuman

<Files\\Interviews\\interview6-vanessa> - § 9 references coded [6.91% Coverage]

Reference 1 - 0.84% Coverage

so, when you start talking about staffing issues, you know … err … when you're not happy with your rota, those kind of things that are quite … quite … you know, they take time before you … you are comfortable talking about that … if you have issues like work-life balance, personal issues – those are the kind of things that … you know, that are sometimes quite difficult to talk about

Reference 2 - 0.67% Coverage

but, as you go higher, I think it becomes more difficult to open … to … to open up fully about what you're really going through, and sometimes I think you just … want to put on this brave face, and just carry on really … and you're not really expressing and letting out what's … what … what you are feeling

Reference 3 - 1.49% Coverage

P: … I suppose as you go higher, they expect you … they expect you to handle it, isn't it? You're supposed to … you're expected to … to be this strong person … you're expected …

I: … got you …

P: … to … to … to do the job effectively otherwise you know … who knows, you think maybe I'm apologising for not being able to do my job well, you know … so, you take on a lot really …

I: … right … right …
P: … yeah … as … as you know, from a Band 6 role, I'd say that … you know, taking … taking on … taking on a lot and not opening up as much as you should … should really … you know, when things are not going the way they should be, so … you sort of bear it and go on, I think.

Reference 4 - 1.06% Coverage

when I had the first supervision after a year, really, I questioned, but I didn't question why haven't you given me supervision for a year which is what … I don't know why I … I mean, I

Appendix twenty-one: Thematic map for theme conceptualisation one
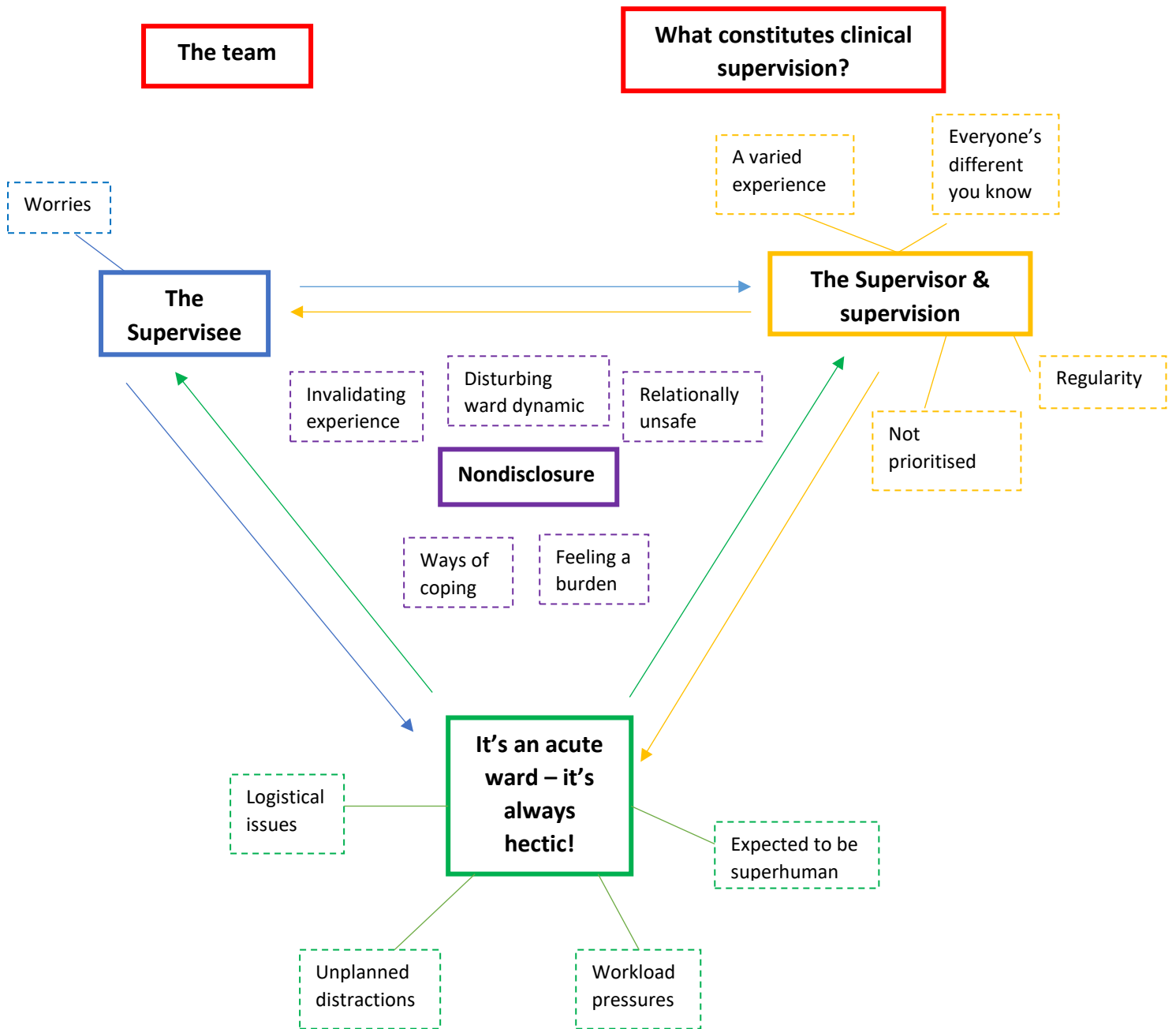
Appendix twenty-two – Excerpts from Reflective diary

Starting position

I have been influenced by my own lived experience, family members and colleagues.

Ultimately, I feel there is an imbalance in the quality of supervision between disciplines who

work alongside one another. When I think about supervision as a trainee and an AP before,

and compare that to the level and quality of supervision I received as a support worker,

there is a huge gap. Speaking to nurse colleagues and my sister I realised my experience was

not unique. I strongly believe that nurses work in some of the most difficult situations and

are not always given the support that can come from clinical supervision. This may be a

cause for burnout and nurses leaving the profession.

I hoped that I could contribute to the supervision literature on nursing to support the

process.

Being humble

Navigating the waters of disciplines judging one another is frustrating as I approach this

research with the mindset of colleagues working together. I can understand why someone

might get defensive but the fact that we have to have the discussion in the first place is

rather disappointing as it implies that we are not all on the same page. I have been trying to

hold in mind how I would feel if the roles were reversed and nursing was looking at

psychological supervision, but I don't think I would feel threatened.

Although what this line of thinking did do was reinforce the need for a nurse on my

supervisory team, as well as, allowed us to come up with the idea of a nurse consultation

group. In this way the research could be much more co-produced, which ultimately I

preferred and sat more in line with my values of working together and not adopting a stance of expert.

Barbara leaving

At the end of December Barbara left the project as lead supervisor and although will stay on as a secondary supervisor it has felt like a real blow to me. She has assured me that she will still be on board with the research and is keen but now I step into another unknown and this feels like it is paralleling my SRP which is currently a walking disaster. Who will be my new supervisor, what will our relationship be like, what expertise can they offer?

Loss of external supervisor

With Andy having to drop out due to personal reasons and Barbara leaving it has been a tough time feeling a bit directionless with the research even with Barbara's offer of continued support feeling a bit unsure and my fears about research and not being going enough have resurfaced.

Emma, Jane & the nurse consultation group

Like a bit of a rollercoaster, off the back of supervisors leaving, Emma joined and her energy instantly got the director of nursing interested (how this will pan out I am not too sure but it was a hopeful sign). Similarly, the speed of which the nurse consultation group has come together has been almost too quick and I have found myself stepping back from contacting nurses as a protection from being overwhelmed and to think about things. This is a familiar defence mechanism to a threat (if I act too quickly, I will get it wrong) but it may be unhelpful here as it can stop me dead when I might not need to be, the nurses are just keen and trying to be helpful. I can slow things down if I need to but I do not need to stop.

UH ethics problems

I found out that as I did not need REC from HRA I will need to go through UH ethics. This has been really annoying as if I had known this earlier, I could have worked on it. It feels that all the hard work I put in to get ahead of the game have been undone. That familiar feeling of ambivalence has crept in and I recognise I am responding like a petulant child. What makes things worse is the fact that the ethics board seem to be asking for adjustments that the HRA, local trusts and UH sponsorship have agreed as ok. This is likely their process but it is leading to resistance in me. Falling over the summer months means increased annual leave and delays in any responses. With everything going on in my personal life as well, I am really losing the will to care for the thesis at the moment.

Success and setbacks

Over Christmas I completed the first draft of my SLR and surprisingly enjoyed putting it all together, after the initial anxiety and worry I was experiencing with it all. Submitting the draft and receiving positive feedback with some amendments felt good and I feel a nice chunk of the thesis is near completion.

However, recruitment still goes nowhere and after speaking to a local collaborator who insinuated that the project it its current form is not feasible, I was left feeling very disheartened and worried, this also came off of the back of a meeting with Emma discussing plan B and C options making me feel a bit sick in the moment. I do not want to submit late and be behind again, I have waited too long for this. I know this pulls on other opinions I hold about being behind my peers and I am trying to let the unhelpful thoughts go. The only positive is that it filled me with some determination to prove them wrong. I have decided to include preceptees and have written off to ethics for amendments and I have spoken to the

preceptee leaders for two trusts and will meet with the preceptees in a couple of weeks to advertise my research. Hopefully this will generate some interest for interviews.

Miracles

It has felt like I've reached out to everyone! Although I have to reflect on the support I have been given, lots of people have tried to support me with this project but I still I feel annoyed that no one wants to take part. I am trying to empathise with overworked nurses who may see this as 'another thing to do' but I also need to pass, and soon, I think this is compassion fatigue.

My sister put me in touch with the head of MH nursing for NHS England who agreed to meet with me, I also got agreement from one trust to go into their hospital, agreement from a ward manager within the hospital and agreement from the consultation team to support with numbers on the ward.

The last weekend, before I gave up on the project, I completed five f2f interviews at the hospital! I didn't feel relief just exhaustion and I slept almost the entire of the next day. I think I did feel relief and it allowed me to see how tired my body was! I've officially started!

Initial coding

It took me some time to get in to the coding and I found myself getting easily distracted and procrastinating. I think this is due to my slight worry about getting this wrong, despite all the reading and 'how to' videos about TA I have watched which say there is no single 'right' way. There is definitely a sense of pressure, mostly placed upon me by me. It took such an effort to recruit these nurses I want to do them and my consultation team justice; this might mean I am in search of 'truth' which is problematic and I need to be mindful of this.

I come to this research with a strong sense that supervision is very important and of great value. It was interesting then to feel myself getting a bit frustrated reading one transcript that spoke to 'just getting on with it'. Was I a bit offended that I am doing this research to benefit nurses and some just don't appear to see it as such a big deal as I do? This narrative on supervision is at odds with my own and I guess I will need to be mindful that I include all voices and not just the ones that fit with my views.

It seems like supervisors are offering spaces to talk within supervision, but I wonder how often/easy it is for these to be taken up? Does the infrequency lead to a feeling of being unsafe? How are both supervisees and supervisors understanding this interaction?

Initial theme generation

It feels like a huge leap going from codes to themes and I am a bit worried I am sticking codes to together with loose links to simply reduce their number. I have re-read Braun & Clarkes book chapter which has made me feel a bit more relieved. The idea of going backwards and forwards and not being too wedded to things is rather worrying as I am constantly worrying about time; how to do the data and participants a good service when you are pressured with time. This is probably not unique to me but with all research.

Evidence of nondisclosure is becoming clear however and three central factors are consistent which is also in line with existing research which is good. I am conscious that I might be looking for a negative picture, I am trying to strike a balance between shining a light on an area of challenge without sounding blaming, but I do keep noticing myself going back to a problem narrative when I describe the data. Why do I need there to be a problem narrative? Because I feel that what is being offered is wrong and not enough which is going against my values of supporting staff. Through this lens however I might be taking aim at

nurses which is not what I want to do and will likely receive a frosty reception. This is another worry, that I am still an outsider as a psychologist looking at nurses and how will my research therefore be received?

I have generated a couple of thematic maps and sent these across to my supervisor to think through with me, not sure how to turn these into themes though…

back to the beginning…

I have been avoiding this part for the last couple of days, as its toying with 'fear of failure' and 'I don't have enough time' narratives. Having taken my thematic maps and codes and shown them to others though I have taken two important notions – don't go beyond the data – and - is this linked to your research question?

I realised I have tried to answer loads more than the remint of my question and lots of my codes are about the experiences of supervision generally not nondisclosure in supervision. Taking the advice of writing my question on a postit and sticking it to my screen, I have gone back to the data and really trimmed large parts of it down. It is tricky as some points speak directly to nondisclosure but others are indirectly linked and I know from the existing research that they can be linked, but am I making a leap here, am I going beyond the data?

Going back to my original themes, they are blurring a lot more and I am wondering how I report them, how I construct my argument around them. I suppose it is a positive thing that I am feeling more confident in my themes to the point that I am asking if I have done enough to construct my argument.

writing up and reconceptualising

I spent the weekend in the library with someone from the cohort and having a change of scene and someone to bounce ideas off of was really helpful. Talking through my themes out loud with someone and having them ask questions and give opinions has been invaluable. It has allowed me to make sense of the data and what I am saying, we were also able to see where some themes might not have been completely discrete and actually blurred across one another. I was able to further reduce and solidify my themes.

Writing up also let me see exactly how my data was matching my themes and I noticed that some of the examples I had created were not as good a fit as others which is interesting as at the time they had felt right. Really interesting how a change of scene and perspective can change how you view the data.

I have been adopting Bruan and Clarke's approach of interpreting alongside reporting in this way I am blending the analysis and discussion. I feel this tells my story better.

Appendix twenty-three – Comments of what participants wanted in supervision

Participants described what they would like to see from supervision. Although not directly

connected to the research question it felt important to include these examples, as if these

needs were met it is likely that nondisclosure would decrease.

I feel that having supervision regularly would boost my confidence for myself … I would feel
confident and empowered to do my daily work without having, you know, any issues.

Danielle

So, definitely … yeah, I think off the ward … time … space … like 'do not disturb' … not … that
the alarm in my pocket keeps going off

Emily

I'd need to be heard when I'm talking … I need to be listened to and acknowledged for what
I'm saying

Danielle

just for the supervisor to just come back and check … to be … just call you aside and say "I
know you had issues with that, how are you feeling? How is it? How's … how's … how's
things at home? How's … how's that situation you were talking about?" … you know, just
having that follow-up really

Vanessa

just having like more allocated time, and having it more often. Then possibly if my
supervisor's attention is on me, not on like the phone or the laptop

Zainab

it was the reassurance that you were … that you … you know … you were doing OK.
Sometimes that supervision can give you a push to … to go ahead with those things

Gina

…like approachable like whenever I needed him … yeah … if I needed help or any support …
yeah … he was always there, yeah. I just felt that I could talk to him about anything.

Tammy

Appendix twenty-four – End of study letter

Introduction

This research employed a qualitative approach to look at mental health nurses' experiences of nondisclosure within their individual clinical supervision. Semi-structured interviews were utilised to gather data before being transcribed and analysed using Thematic Analysis.

This project was conducted for partial qualification of a Doctorate in Clinical Psychology, at the University of Hertfordshire.

Background and previous research

Within clinical psychology, clinical supervision is seen as an integral part of the discipline. It has been described as 'the firm foundation of clinical practice' (Milne, 2003); 'an essential requirement for learning and professional development' (Fleming and Steen, 2005); 'an essential prerequisite for the practice of psychotherapy' (Roth and Fonagy, 1996) and an 'ethical and professional expectation' (BPS, 2017).

Understandably then, there is considerable literature into clinical supervision within clinical psychology, however as Kühne, Maas, Wiesenthal and Weck (2019) observe; supervision research often falls behind psychotherapy research in general.

One phenomenon within the clinical supervision literature is that of nondisclosure by supervisees, which has the potential to negatively impact clinical effectiveness and learning experiences (Mehr, Ladany and Caskie, 2010). The supervisory relationship has been shown to be a key factor in the prevalence of non-disclosure (Sweeny and Creaner, 2014; Mehr, Ladany and Caskie, 2010; Hess et al. 2008). With recommendations put forward to adopt a feminist position within supervision, whereby supervisors explicitly integrate issues of power, activism, diversity, privilege and oppression. Opening up such discussions may foster confidence and manage anxieties around things such as evaluation (McKibben, Cook and Fickling, 2019). The notion of nondisclosure is important not just because of its impact on the supervisee, who hopefully comes to supervision to develop their knowledge and awareness, but also on the clients they are working with.

Existing research into nondisclosure has focused mainly in the therapy and social work disciplines (Hutman and Ellis, 2020). The potential impact of nondisclosure on client risk and

outcomes however, prompts further research to see if the phenomenon exists within other healthcare disciplines.

Mental health nursing is a discipline which values clinical supervision (Severinsson and Kamaker, 1999; Bifarin and Stonehouse, 2017; Driscoll, Stacey and Harrison-Dening, 2019) and has had guidelines for its use for over two decades (Edwards et al., 2006). Similar to clinical supervision within psychology, nursing supervision aims to enhance practice and professional development through the use of reflection (Brunero and Stein-Parbury, 2008). Although supported by stake holders, implementation of clinical supervision has been difficult (Rice, Cullen, Mckenna, Kelly, Keeney and Richey, 2007), with engagement levels of supervision varying from 18% - 86% across the UK (Butterworth, Bell, Jackson and Pajnkihar, 2007). Feedback from nurses suggests concerns with confidentiality, anxiety around admitting difficulties, feeling threatened and supervision being seen as a paper exercise all influence engagement with the process (see Butterworth, Bell, Jackson and Pajnkihar, 2007 for a review). Research has also shown the importance of adequate training for nurse supervisors to maximise both their own practice as well as that of their supervisees (Butterworth et al., 2007). Bos, Silvén and Kalia (2015) in their study with district nurses, found common themes of supervisors feeling 'abandoned' with limited support from management which led to a sense of 'ambivalence' towards their role and uncertainty about how to perform as a supervisor.

These reports from nurses could indicate the potential for nondisclosure as the concerns raised are similar to those expressed by therapists who did not disclose. A review of the literature found no study that had looked specifically at the phenomenon of nondisclosure within nursing supervision.

Rationale for study

As the impact of nondisclosure can have negative consequences on the supervisee, supervisor and service user, it is important to understand whether the phenomenon occurred within nursing.

It is important to acknowledge that the research involved the discipline of psychology analysing the supervision of the nursing discipline. This could be misinterpreted as psychology evaluating or judging nursing; indeed, a discourse already exists within nursing

around the negative consequences of supervision being imposed by other professionals (Royal College of Nursing, 2019). It is crucial therefore, that the purpose of this research is understood to be primarily the search for the nondisclosure phenomenon which already exists within the therapy literature. As an addition, the findings of this research may be of interest to the discipline of nursing, for example clinical governance and in line with the recommendations of the Francis Report (2013).

By adding to the literature in the field, the research provides clinical psychologists with a more detailed account of how the phenomenon of nondisclosure influences nursing supervision. From a research perspective, this will shed light on similarities and differences across disciplines and from a practitioner perspective, it will support clinical psychologists who deliver supervision and training in how to deliver supervision, to nurses.

Research objectives

- To explore whether nurses describe experiences of the phenomenon of nondisclosure within clinical supervision.
- If they did describe experiencing nondisclosure: what factors did they feel precipitate its onset, cause it to perpetuate within the space and what factors do they feel may facilitate disclosure?
- If they did not describe experiencing nondisclosure, what factors allowed them to disclose?
- Are there common trends with what is already known within the therapy nondisclosure literature?

Methods

The study included a nurse consultation team who supported the research at every stage.

Participants were interviewed either remotely or face-to-face using semi structured interviews. Following this the interviews were transcribed and analysed using Thematic Analysis. To improve quality a member checking process was utilised with the themes being returned to the participants to see if their experience had been captured accurately.

Participants

Participants were recruited from a local NHS trust in the South East of England. Participants were recruited via purposive sampling using a range of methods including: a comms advert, information passed from senior nurses (due to the assistance of the nurse supervisor), Twitter and word of mouth.

Inclusion criteria:

- Mental Health nurses
- Accessing Clinical Supervision
- Bands 5/6 nurses
- Permanent (not agency) staff
- Preceptee nurses
- Currently working or experience within the last three years of working, within inpatient settings

Exclusion criteria:

- Community based nurses as they will likely have different pressures in terms of cases, time and environment.
- Band 7 nurses. This is due to the likely differences in type/frequency/function of supervision for example a focus on, leadership and management.
- Dual-trained nurses will not be excluded but the focus will be on their experiences of supervision as a mental health nurse.

Ten mental health nurses were recruited for the research. Eight of the participants identified as female and two as male. The participants ranged in age from 24-66 with a mean age of 37 and a median age of 32. Four of the participants identified as White British, two as Black African, one as White Irish, one as British Pakistani and one as British Asian and one as Chinese. One participant considered themselves to have a disability. Six of the participants occupied band 6 positions and three occupied band 5 positions. Time registered ranged from 5 months to 7 years. Seven of the participants currently worked in inpatient settings and three had worked within inpatient settings within the last six months.

Findings

Five themes were identified from the data, several of which had subthemes; these are outlined in the table below

Theme	Subtheme
Expected to be a superhuman	
You work with them more than your family	- Putting the team first - I'm not a grass
A poorly defined space	- I didn't know that was part of supervision - An invalidating experience
Relationally unsafe	- Impression management - It would do more harm than good - But you always wonder don't you - Everyone's different, you know
Strategies to stay safe	

Expected to be superhuman describes an internalised belief held by participants. The ability to be able to 'carry on' appears to be a cultural narrative held by the nurses. It is also possible that this is reinforced by a narrative held more broadly in society, evidenced perhaps by the popularity of the 'clap for heroes' at the height of the pandemic. The perceived expectation to be 'the strong one' to 'carry the load' and to 'suffer in silence' may imply that disclosing difficulties might feel forbidden

You work with them more than your family talks to the unique role the team plays within the inpatient environment, which is likely different for other disciplines and in other contexts. This theme had two subthemes, the first spoke to participants holding the team and their supervisor in mind which impacted on their ability to be fully present in supervision and also to prioritise attendance over other ward demands. The second spoke to a held belief that raising concerns about their colleagues would lead to the issue being

escalated which might negatively impact on their colleague and potentially disrupt the team dynamic.

A poorly defined space described the challenges brought about by a lack of a definition for supervision within the setting and the resulting impact on the supervisee's experience. This theme also had two subthemes, the first related to the lack of a shared understanding of what supervision is for and what it should look like. This uncertainty appeared present within the supervisee's understanding, the supervisor's construction and wider environmental conceptualisations of what constitutes supervision. The second subtheme talks to the experience of the process of supervision. Participant accounts talk to the challenges of setting up a predictable and consistent space within the inpatient environment.

Relationally unsafe referred the relationship between the supervisor and supervisee. The first subtheme described how participants may have wished to present themselves in a positive light in front of their supervisor. It highlights the power differentials that were felt in the supervision space and possibly a sense of implied consequences of getting something wrong. The second subtheme spoke to their belief that talking about topics linked to the supervisory relationship would at best not be heard and at worst negatively impact on them. Subtheme three related to how confidential participants felt the supervision space was. It highlighted both the lived experience of the participants but also their beliefs. The fourth subtheme spoke to the personal and professional differences between supervisee and supervisor which made participants hesitant to bring up certain topics if they felt there was little common ground.

Strategies to stay safe described several different strategies participants used to help navigate difficult supervision spaces. These strategies may likely be the result of feeling relationally unsafe within a poorly defined environment where a culture of managing other's expectations is perpetuated.

Discussion

This research set out to discover whether the phenomenon of nondisclosure was present within nursing clinical supervision by looking at the experiences of inpatient mental health nurses. The findings indicate that the phenomenon is indeed present and although there are

similarities with how it has been reported in the therapy supervision literature, there are also differences linked to held beliefs, set up and culture. The findings will be of interest to organisations who are advocating for clinical supervision, as well as initiatives such as the nurse advocate programme. Nondisclosure in this study impacted upon nurse wellbeing and team dynamics which was indirectly impacting on patient care. It is hoped that the voices of the mental health nurses who participated in this study will inform policy and practice going forward.

Strengths

This research has for the first time looked at nondisclosure within nursing supervision. The inclusion of a nurse consultation team added to the quality and validity of the methodology and findings. The consultation team informed all stages of the research including designing the interview questions, supporting recruitment and interpreting findings. The use of a qualitative methodology allowed for a deeper exploration of nurse's narratives, and in doing so made their voices heard and emotions expressed. Given the growing acknowledgement of staff wellbeing and the importance of effective supervision for nurses, these accounts will be valuable in current and future planning.

Limitations

A lack of generalisability is an often-quoted problem with any qualitative research. Therefore, it might be more productive to consider the transferability of the data. The richly contextualised reporting of data in this research, aimed to allow the reader to make a judgement as to what extent they can safely transfer the analysis to their own context (Braun & Clarke, 2022).

The recruitment of participants was incredibly difficult for this research. The initial recruiting methods of advertising through the participating NHS Trust communications teams and disseminating study information by senior nurses and the local collaborator, were unsuccessful in identifying any potential participants. The researcher attended preceptee training to advertise the research and also met with the head of mental health nursing for NHS England in an attempt to gain support for the research After three months of attempts to recruit, no participants had been identified and the feasibility of the research was called into question. Recruitment was finally achieved when the researcher and the nurse

consultation team were permitted to access the wards of an inpatient unit, with the consultants replacing the on-shift nurse so that the ward maintained its nursing ratios.

A final limitation was the nature of the study itself; discussing something you have chosen not to discuss. Although the researcher made clear to participants that they only need give broad themes and not specifics, this may have felt too risky or challenging for potential participants. A quantitative methodology may therefore have elicited different results due to participant anonymity.

Clinical implications

A clear understanding of what supervision is and what it should look like, was difficult to identify. This is a known issue within the nursing supervision literature; however, it is likely exacerbated by the numerous clinical and logistical pressures on the ward, which means when supervision is conducted there may be little structure and focus on process.

Participants were unaware of the concept of a supervision contract but did comment on the use of a supervision template. Its purpose however, appears to have been misunderstood; instead of acting as a tool to guide conversations it became the agenda to work through, possibly in a 'tick box' fashion. This is contrary to the recommendations of research into clinical supervision, and has the potential to leave supervisees feeling disempowered within the space and may lead to a silencing effect and the perpetuation of nondisclosure.

In the absence of a clear definition, and a consistent and prioritised space, participants described finding their needs met in other ways, for example in ad hoc 'PRN supervisions' where they can catch their supervisor or manager for five minutes to discuss an issue, or by using other meetings such as handovers and safety huddles.

This has a number of implications, for example participants appeared to perceive ad hoc discussions as akin to supervision. These findings are similar to previous research that found this in-the-moment supervision while beneficial, meant that longer term it reinforced a cautious attitude towards supervision and embedded the belief that it has limited value in-practice. Coupled with the themes identified in this research (e.g. concerns about the teams and expectations to be superhuman) it suggests the creation of an environment that facilitates nondisclosure.

Participants valued this type of quick, readily available 'supervision' space. The meaning behind this preference is interesting; it could be due to the ability to get one's needs met in a practical way, or it could be the result of a lack of understanding of what supervision is and can provide, or it could be relationally safer. An ad-hoc space is time-limited, its agenda is set by the supervisee with a clear task in mind, it can be ended easily and it is not recorded. The theme 'relationally unsafe' was an identified contributor to nondisclosure and this approach can be a way by which supervisees avoid disclosure.

It is important for senior managers and policy makers to be aware of how supervision looked for these participants as the common theme of inconsistency is likely to be applicable to other settings. Recommendations from inquiries like the Francis report (2013) and the Ockenden report (2022) should also be considered alongside these reported experiences.

As research continues to point to the benefits of clinical supervision for nurses, including recent evidence showing that clinical supervision improves retention by improving skills, engagement and satisfaction. In addition to the current NHS Standard Contract which makes clear that all registered nurses should have access to restorative supervision. It is important for senior managers to consider how they implement effective clinical supervision within inpatient environments and how best they support supervisors through training.

A final implication and arguably the most important is the heard voices of the nurses who participated. Nurses described often feeling unheard, not held in mind and not prioritised. This led them to feel unsafe and distrustful within supervision and doubtful that things would change. Ultimately this meant that participants did not feel able or willing to always disclose. New initiatives such as the nurse advocate programme offer exciting new possibilities for change and a refocusing on supervision. As the divide between theory and practice appears considerable within inpatient settings, nurse advocates should hold in mind that their colleagues may feel a need to withhold certain information, the possible reasons why this might be the case and ways they can re-engage and enter into new conversations.