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A portfolio submitted in partial fulfilment of the requirements of the University of Hertfordshire for the degree of DClinPsy including a thesis entitled:

Examining Clinical Supervision with Palliative Care Nurses

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WRITTEN EXERCISE 1

DISCUSS THE IMPORTANCE OF THE THERAPEUTIC RELATIONSHIP ACROSS THE LIFESPAN BUT WITH PARTICULAR REFERENCE TO WORKING WITH ADULTS AND OLDER ADULTS

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INTRODUCTION:

The therapeutic relationship is widely agreed to be one of the most important factors in achieving change through therapy. In 1957 Rogers wrote about the "necessity and sufficiency of the core conditions", referring to the use of acceptance, empathy and congruence (Rogers 1957, cited by Feltham 1999 pg 12). This view has been emphasised over the years and, more recently, Sanders and Wills (1999) described the therapeutic relationship as the vehicle that leads both therapist and client through the issues.

This view of the therapeutic relationship is a common factor among therapies (Beck 1991 cited in Feltham 1999). However, they have their own perspectives on where and how it plays its role in the therapeutic process. Beck stated that the focus should be on developing a collaborative relationship, with both parties working together on solving problems (Beck 1985 cited in Feltham 1999). A psychodynamic therapist will concentrate minutely on the relationship itself (Holmes 1999).

However, the therapeutic relationship is a dynamic force which can change easily, sometimes even in the course of a session. One aspect of its usefulness is how it can adapt to the situation occurring at the time. It also means that, using it across the lifespan, there will be different factors creating its formation. Power differences (Garner) and varying priorities, of both therapist and client (Baltes et al 1999), will mean the therapeutic relationship is slightly different.

Does this have any impact on its importance? Working with younger adults, you may feel more confident because most of the work looking at the centrality of the therapeutic relationship was carried out within this age group. You can assume that it is the important factor within your work as the evidence base for this is substantial (Sanders and Wills 1999).

However, working with older adults, particularly over the age of retirement, this becomes more complicated. There are recognisable barriers to building the necessary rapport when working with an older adult as a younger therapist. Working with older adults is seen to be more complex due to issues such as cognitive difficulties (Knight 1999) and not being psychologically minded (Charlesworth and Greenfield 2004).

Our development continues throughout our life, changing our outlook and priorities as we adapt to different social and environmental factors (PB Baltes 1997 cited in Baltes, Staudinger and Lindenberger 1999). This emphasises the age difference between client and therapist, impacting on their relationship (Garner 2003, Knight 1996). This rift may then be exacerbated by issues such as prejudice (Charlesworth and Greenfield 2004) and environment (Knight 1999).

Are such barriers insurmountable? Research demonstrates that therapies such as Cognitive Behaviour Therapy (CBT) are successful with older as well as younger adults (Crowther and Zeiss 1999, Laidlaw, Thompson and Gallagher Thompson 2004). As the relationship is central to this success, it must be assumed that the barriers are not strong enough to resist the importance of the therapeutic relationship. There are even theories that suggest older adults are better suited to such therapies due to their extensive life experience and knowledge of their own emotions (Garner 2003, Knight 1996).

Are then these barriers actually age specific? As discussed earlier the therapeutic relationship is dependent on the factors brought by each person. This means every relationship must then take on individual characteristics and that there must be some barriers to building rapport, a view supported by therapy models and techniques (Safran 1998, Safran and Muran 2000). This not only demonstrates the importance of the therapeutic relationship, but also how it is different in each case, not just at different stages of the life span.

In this essay we will explore these questions, looking at the evidence for them, attempt to understand how barriers are formed, whether these are insurmountable, and if they are age specific, thus informing our work with older adults at both a therapeutic and a professional level.

BARRIERS TO BUILDING RAPPORT WITH OLDER ADULTS:
Uptake of Services:
Before we begin to examine the reasons behind the changes that may occur within the therapeutic relationship, it is important to recognise one of the most specific differences between ages. Older adults are much less likely than younger to recognise

a problem as psychological (Gurin, Veroff and Feld, 1960, cited in Knight 1996); they are less likely to seek help, believing that a problem is attributable to physical or moral reasons (Knight 1996). This is compounded by older adults being less aware of the available help from appropriate mental health services. (Knight 1996).

The implications of this are twofold. First, fewer older adults seek help from services (Knight 1996), therefore therapists are not trained to work with this group and are less aware of their difficulties and find it harder to appreciate their needs (Knight 1996). Lack of understanding from a therapist makes building rapport with an older adult more difficult.

Second, therapists need to educate their client in the process of psychological therapy before therapy can begin. This creates an initial barrier to the development of the therapeutic relationship (Knight 1996). Younger adults usually can already view their problem in psychological terms.

This difference between older and younger adults in their approaches to seeking therapy is the beginning of the majority of difficulties that exist in building rapport with an older adult. Suspicion, lack of psychological knowledge from the client, (Charlesworth and Greenfield 2004) nervousness, (Knight 1996) and stereotypical thinking from the therapist (Charlesworth and Greenfield 2004), combined with cohort difference (Knight 1996, 1999) and lifespan development (Baltes, Staudinger and Lindenberger 1999), creates misunderstanding and barriers to rapport. These differences, and their implications on the therapeutic relationship, are our focus in this part of the essay.

Generation, Lifespan, and Resulting Differences:
The generational age gap is reported to be one of the main barriers to the development of a successful therapeutic relationship between a therapist and an older adult (Charlesworth and Greenfield 2004, Knight 1999). For therapy to work, much emphasis is placed on the importance of collaboration (Beck 1979, Laidlaw et al 2004). However, for collaboration to occur, there are a number of conditions that have to be met. Beck (1979) stated that these included warmth, accurate empathy and genuineness. Particularly in the case of empathy, this involves the therapist being able

to see the client's experience from their perspective and to recognise the emotional reaction (Beck 1979). If this is not present, and the therapist cannot convey their understanding of the situation, then the client may feel demoralised. In Knight's case example (1996 pg 1), Mrs G goes to see Dr Q and the interaction is mutually difficult. Dr Q's nervousness and doubt are transmitted to Mrs G, leading to her feeling that he thought her senile and that depression is only to be expected at her age. Clearly, in this example there is no evidence of warmth, empathy or genuineness.

This example demonstrates the difficulty of creating a collaborative atmosphere when both client and therapist misunderstand the other's direction. Unfortunately this sometimes happens because of the differences between therapist and client in age and outlook on life.

Priorities, Change and Loss:
According to Lifespan Developmental Psychology, when we become older, our priorities and goals become necessarily different to that of younger adults. As our biological function as humans decrease, we are more reliant on culture and cultural resources (Baltes et al 1999). However, as this occurs, we loose our ability to use those resources efficiently. For example it takes us more time and practice to achieve the levels of learning that we would have reached as younger adults. Even then, in comparison, older adults function at a lower level than younger adults, despite extensive training (PB Baltes 1997, cited in Baltes et al 1999). To reproduce the same levels of functioning would require better and better technology.

Consequently the older adult has to begin to focus their diminishing resources away from growth and towards maintenance and adaptation. This equates to a major life change (Baltes et al 1999). The main focus of a younger adult's life is said to be the pursuit of growth and attainment of higher functioning (Erikson, cited in Baltes et al 1999). As the older adult begins to loose that level of functioning, they have to think in terms of gains and losses. To compensate ourselves for what we have lost, and presumably to assist adaptation, we select specific goals to work on, dependent on resources, and optimize these specific skills (Baltes et al 1999).

In addition to these necessary changes due to reduced biological and cognitive function, the older adult also experiences major life events at a social and personal level. As Garner wrote, "The biological and social realities of the lives of people in advanced years may be very different from their younger days." (pg 540) These events involve loss through bereavement and role changes. These impact on their self efficacy and may lead to isolation (Knight 1996, Laidlaw et al 2004).

These life changes mean that the older adult becomes removed from the younger world. This divide between the two groups has implications on several levels when trying to build a therapeutic relationship between a younger therapist and an older adult.

Stereotypes and Prejudice:
The result of this divide between the two age groups is the formation of stereotypes and prejudices that each group forms about the other. These beliefs, held by either party, then disrupt the collaboration being formed and create a barrier so that an effective therapeutic relationship is impossible (Charlesworth and Greenfield 2004).

According to the Stereotypical Prejudice Model devised by Charlesworth and Greenfield (2004), three systems maintain the prejudicial beliefs, ageism, pessimism towards therapy and psychopathologism. Pessimism towards therapy can be seen from either the perspective of either party. The therapist can be frustrated with ideas that nothing can be done with older adults, leading to a feeling of hopelessness. This is an unpleasant feeling, and can lead to the therapist discharging the client to avoid challenging that emotion. (Garner 2003)

However, probably the most important of these maintaining factors is ageism. This is prevalent in many areas of contact with the elderly. For example Adler, McGraw and McKinlay (1998) found that a patient's age affected how they were approached by physicians treating their breast cancer. Their age had a significant impact on the information given about their condition, and in the physician's attitude towards them. In a therapy situation, communication can lead to ageist interpretations by a therapist. Older adults can sometimes ramble or appear to talk about irrelevant information (Knight 1996). The reasons for this may include the fact that older adults are

frequently not listened to by the younger generation, and sometimes are spoken for by relatives (Knight 1996). However this can sometimes be misinterpreted by a therapist to be 'proof' that the person is dementing which will then block a successful rapport being built (Knight 1996).

The older person can be ageist too. When working with a therapist much younger than themselves, accepting that this person has the relevant experience to help them is hard (Knight 1996). They might feel that someone so young does not have the personal experience to understand their situation. This creates a barrier on both sides. The client, worrying whether the young therapist has worked with someone their age before and the therapist feeling as though their experience is being questioned (Knight 1996).

The older adult can also have a negative stereotype of their own aging (Laidlaw et al 2004). Older adults are aware that they are becoming old. Levy said that "when individuals reach old age, the aging stereotypes internalised in childhood, and then reinforced for decades, become self stereotypes." (Levy 2003 cited in Laidlaw et al 2004 pg 395). The stereotypical belief that the young society holds about the older generation makes adults fearful as they reach that age themselves.

Power

In a successful collaborative relationship, Beck (1979 cited in Feltham 1999), wrote that having two people should make it easier to work at the problem. This implies that the power between the two should be balanced, with each having equal responsibility. However, in a relationship between an older adult and a younger therapist this balance is challenged. Firstly, there is a cultural belief in our society that elders know best and it is hard for a younger therapist to work against this (Knight 1996).

Secondly the apparent hopelessness of the situation may affect the young therapist and make them fearful that the older adult will become dependent on them (Martindale 1989 cited in Pedder 1991). This renders the relationship unequal, the therapist feeling more powerful than the client (Garner 2003), infused with feeling of pity, and means that they would find it hard to work collaboratively.

Environment

The environment of the older adult can negatively affect the creation of a therapeutic relationship. Socially their specific environment may be different, for example they may live in age- segregated housing. Although this may involve the older adult living with a certain number of others, it means that, contrary to younger beliefs that it leads to more friendships (Knight 1999), they can feel more isolated. Their home may be further away from family, and it means very little contact is made with 'the outside world'. Having worked in a Residential Care Facility, I can understand how the shape of the routine of such an environment can impact on the older adult. They have their own chair and mealtimes are set. Decisions are made in the context of the organisation. This removes a feeling of self-efficacy and emphasises to the older adult the loss of their role in life (Knight 1996, Laidlaw et al 2004, Lichtenberg 1999).

Therefore, when encountering a therapist they may not view it as a collaborative equal relationship. Instead they will view it in comparison with the relationships they hold with other professionals and care staff in their lives.

Cohort Differences:

Cohort differences can lead to misunderstanding between all adults. All individuals belong to a cohort based on their birth year and each cohort will have common abilities, beliefs and attitudes. These then define this group as different to those born in earlier and later years (Knight 1996). When approaching treatment it is important to view that person within this context. It has been said that working with someone from another cohort is like working with someone from a different culture (Knight 1999). Expressed in these terms it is possible to contemplate how the two protagonists have grown up in an entirely different world, surrounded by values and experiences that have no resonance for the other.

It is also easier to see how, as Laidlaw et al (2004 pg 393), "cohort experiences produce potential for misunderstanding and miscommunication between generations. Cohort beliefs of older generations can also sometimes clash with the therapist's beliefs." An example is the older generation's beliefs about mental health. As a cohort, when the older generation was growing up mental health was seen very differently. At this time mental illness was a stigma associated with personal failure

and spiritual deficiency (Laidlaw et al 2004). To admit that you experienced depression was shameful and abnormal (Laidlaw et al 2004). It may also mean that you would be sent away to a state hospital to be locked in a ward for a long period of time (Knight 1996, 1999). If we think back to the example that Knight (1996) gave us it is not surprising that Mrs G was so nervous about seeing Dr Q. Such an appointment, in her youth, would have been terrifying and Dr Q, far from being someone to open up to, would be someone to hide the truth from. This will obviously provide a major barrier for Dr Q in trying to build a rapport with Mrs G.

For a collaborative relationship to form, both parties must be able to view the other as an equal (Beck 1979). However, the elder cohort belief may be that a doctor is an authority figure. Therefore, one barrier to forming a collaborative relationship with an older adult is noted to be their being a "passive recipient of care" (Charlesworth and Greenfield 2004 pg. 412).

IMPLICATIONS FOR THERAPY- AGE SPECIFICITY?
All these barriers may have resulted in services for older adults being restricted or changed across the healthcare professions. One possibly ageist view, is that therapy with older adults is not valuable. It has also been reported that older adults prefer medication rather that psychological contact (Crowther and Zeiss 1999).

However, we know, through successful studies, that complex therapies such as Cognitive Behavioural Therapy are possible with this age group (Crowther and Zeiss 1999, Laidlaw et al 2004). Therefore we have to assess whether barriers such as those identified with older adults are age- specific. Are the identified problems really an issue when working with an older adult or do they occur elsewhere in the lifespan?

If we examine the arguments more closely it appears that the main point is the seemingly insurmountable problem caused by the generational gap. This is thought to lead to the younger generation being unable to understand, as the older adult attempts to adapt, and to come to terms with, a significant life event. They are experiencing changing roles, changing environments and learning how to cope with new life goals. Possibly the biological argument remains specific in that they are loosing their potential usefulness as humans (Baltes et al 1999). However, the other examples are

actually experienced across the life span, although in different contexts. Such barriers must be present in every therapeutic encounter. For example, unless therapist and client are born in the same year, there must be some cohort effects. One instance would be when a middle aged therapist is working with an adolescent (Knight 1996).

All humans assess and react to life events in different non age- specific ways. As discussed previously, everyone brings something different to therapy and this alters the therapeutic interaction.

Non age specific factors:
Every human develops with different personality traits and different coping resources that either help or hinder how they react in adverse situations. Using our older adult population as an example, and their transitional events, we will not assume that they will all view it in the same way, despite cohort influence. It will depend on stresses they experienced earlier in their lives and how they have learnt to cope with such situations (Leonard and Burns 1999 cited in Beasley, Thompson and Davidson 2003).

Cognitive Appraisal:
Much of how we react to every situation, either positive or negative, is mediated by how we appraise it cognitively. As Hojat, Gonnella, Erdmann and Vogel said, "an event has no meaning outside of a person's mind" (2003 pg 220). So, as in a panic attack, it is how we interpret information that is important. If we interpret something as threatening, then coping with it is more difficult. However, if we approach situations with the view that they are challenging, rather than threatening, we would be able to cope. It would not be perceived as beyond our capabilities (Hojat et al 2003).

Our appraisal then judges how we respond to the event. Lazarus and Folkman (1984 cited in Hojat et al 2003), as part of their transactional stress- appraisal paradigm, hypothesised that we respond in line with our appraisal and this influences how we view the initial event. In other words, your response makes you reassess the event at a cognitive level. In their project with medical students, Hojat et al (2003) found it is how we perceive the event that influences the outcome.

One identified mechanism of appraisal in the literature is that individuals who try to see the positives in a situation are more likely to appraise it as challenging rather than threatening. Tugade, Fredrickson and Feldman Barrett (2004) found that positivity correlated with an effective coping style, making people more psychologically resilient in the face of adversity.

Personality:
How we appraise a situation might depend very much on our personality traits. As Kaplan reported "Personality is an important factor in disposing the person to view the adverse events in a certain way that can either impair or facilitate the adaptation process." (Kaplan 1996, cited in Hojat et al 2003 pg 220).

To be able to see adversity as a challenge rather than a threat requires cognitive flexibility (Hojat et al 2003). One way this is achieved is through a good coping style and cognitive hardiness. Coping style is seen in different categories. Approach oriented coping refers to situations when the individual actively tries to cope. Avoidance oriented coping refers to emotion focused coping, rumination and emotional response to stress (Beasley et al 2003). A cognitive hardy individual would have belief in their ability to control events, have commitment to this and view change as a challenge. In this way they are flexible in their thinking about adverse events (Kobasa 1979 cited in Beasley et al 2003).

In their study, using postgraduate students, Beasley et al (2003) found that both types of coping style directly impacted on measures of psychological and somatic distress. Having a robust coping style reduces the impact of adverse negative events. Cognitive hardiness was found to act as a 'buffer' against psychological distress when an individual is in a highly stressful situation.

However, it is also possible to possess personality traits that leave an individual at higher risk of experiencing adverse life events. Pickering, Farmer, Harris, Redman, Mahmood, Sadler and McGuffin (2003) performed a study looking at individual's scores on the Psychoticism Scale and relating them to anti-social behaviour traits, e.g. envy and hostility. They hypothesised that these traits would generate an excess of

adverse life events. They proved this through their research and concluded that this makes these people more at risk for depression.

<u>Implications of non age- specific factors on the Therapeutic Relationship:</u>
Having looked at non age-specific factors, it becomes clear that barriers are seen in the therapeutic relationship across the lifespan, dependent on individual factors rather than age. Therefore, rather than being an insurmountable problem just within the older adult population, barriers form some part of every therapeutic relationship, not impacting on its overall importance.

If we are to look at life experience it could be said that older adults may respond better to a therapeutic relationship than younger adults. Leonard and Burns (1999 cited in Beasley et al 2003) proposed that we learn through experience, our protective factors developing as we encounter key turning points in our lives. This theory correlates with the model of maturity.

Maturity:
The differences that maturity gives are age specific. Much research has focused on the cognitive difficulties that develop as we grow older. We are not going to go into these in great detail here further than to say they include slowing of the speed of processing (Salthouse 1985 cited in Knight 1996) and a reduction in working memory (Light 1990 cited in Knight 1996).

What is sometimes overlooked, is the research that shows benefits in some areas of cognitive function as we grow older. It is hypothesised that they can perform better at some tasks when able to take advantage of their knowledge and life experience (Garner 2003). As we loose cognitive function, our pragmatic knowledge, gathered over the years from culture and our own experience, remains constant and is possibly more advanced than that of a younger adult (Baltes et al 1999). It is our pragmatic knowledge that then lets us function despite loosing cognitive power (Baltes et al 1999).

It has also been shown that older adults have a better comprehension and control of their emotions (Knight 1996). Whereas younger adults may experience very intense

reactions to emotions, older adults experience a more complex, but less extreme emotion (Schulz 1982 cited in Knight 1996). This control but with deeper understanding of emotion possibly make them better candidates for psychotherapy (Garner 2003).

THE INDIVIDUAL APPROACH:

From this analysis it appears that working on the basis of trying to place people within a group to help us understand their difficulties is not helpful. Probably the major reason that the Therapeutic Relationship is so important across the lifespan is that it is flexible enough to compensate for all these barriers. Therefore it is more helpful to try to see every relationship as individual, without prejudging information on the basis of age. As Garner wrote, "Assessment for any treatment needs to be clinical and individual, not on the basis of demographics and age" (Garner, 2003 pg 537).

The Cognitive Interpersonal Model:

To redress this balance, and to try to focus more on the individual level, Safran (1990, 1998), has developed a new conceptualisation of Cognitive Behaviour Therapy. The thinking behind this is that up until recently CBT has seemed somewhat mechanistic in its approach to personal difficulties. Instead of considering the learning processes through which we gain knowledge of the world, information processing theory has focused on the mind as a computer. The result is that the relationship between how we acquire knowledge and our behaviour is not fully understood. It fails to compensate for the fact that people do not just process static information, but they actively seek out new information through interaction with others and their environment (Gibson 1966 cited in Safran 1990).

In order to take a more ecological view of how we gather and use information, Safran (1990) has incorporated aspects of Interpersonal and Cognitive therapies. He believes that it is important to investigate how information processing and action in the real world interact.

Within this conceptualisation he defines an 'Interpersonal Schema' as the model through which individual's interactions with attachment figures (Bowlby 1969, 1973,

1980 cited in Safran 1990) begins to predict how they can 'maintain relatedness with others.' Through this we learn what behaviours lead to us being able to maintain relatedness. This goal of maintaining our relationships then continues across the lifespan. Although we may move away as we get older from maintaining relatedness to an attachment figure, we behave in a way which, we believe, makes us attractive to others (Sullivan 1953 cited in Safran 1990).

Therefore, this model suggests that people who are maladjusted psychologically hold beliefs that are negative and rigid in terms of what people expect from them, and how they must act to maintain their relationships (Carson 1969, 1982 cited in Safran 1990).

Working using this model is very different to using traditional CBT. The aim is to focus at a much more individual level, attempting to assess the client's interpersonal schemas which are unique to them (Safran 1998). This is done using the Therapeutic Relationship, emphasising its importance in this area and across the lifespan.

One example of this in action is the 'interpersonal marker' which highlights a useful point for cognitive exploration (Safran and Segal 1990, cited in Safran 1998). To pinpoint these markers the therapist uses their own feelings to judge when specific behaviours or communications are difficult (Kiesler 1982, 1988 cited in Safran 1998). This is done on a moment to moment basis, keeping the therapy in the present and in how the client actually reacts to different cues and lines of questioning (Safran 1998). This then helps the therapist to understand what is triggering the emotion in the client and to help them work with it.

Another technique is the use of meta communication. This state is used when the therapist is aware of something happening for the client through the medium of the Therapeutic Relationship (Safran and Muran, 2000). It invites collaboration in attempting to understand what has happened in that particular moment that has affected the balance between them. It helps the client to begin to be aware of the impact that they have on others from minute to minute (Safran 1998) and to start to change their maladaptive communication style.

Working at this level with someone, a good Therapeutic Relationship is a requirement. However, it is possible to begin to see that barriers within the relationship do not mean that therapy will be unsuccessful. If you approach individuals at this level it is possible to understand how and why they react to life events in certain ways. Only then can you start to help them adapt their style.

CONCLUSION:

This discussion emphasises the centrality of the Therapeutic Relationship and how this is maintained across the lifespan. In relation to working with adults and older adults, there are differences. When working with an older adult it is probable that some of the barriers previously mentioned will be encountered. However, due to personal differences and individual styles, there are barriers that occur in every relationship.

The ageism of our society and possibly fear about end of life issues may emphasise certain elements when working with older adults. This is not to say that these should not be thought of as relevant to a therapist. However, these factors should inform your work, not dictate how you approach that particular relationship.

On a professional level, the role of Clinical Psychology is to educate other professionals in seeing older adults as still developing human beings. Currently, in the NHS there is a perception in some environments that if a person does not speak up, their opinion is not relevant. This means that Older Adult services have been marginalised and therapists are worried about working with their particular issues. However, the same issues occur across the lifespan. But, because younger adults are more vocal their difficulties are more publicised and they are viewed with more respect by both family members and health professionals. Clinical Psychologists need to start to redress this difference through emphasising the many abilities of older adults rather than the hopelessness that is attached to them.

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WRITTEN EXERCISE 2

DISCUSS THE USE OF SYSTEMIC AND PSYCHODYNAMIC APPROACHES WITH LEARNING DISABILITY. WHAT ARE THE POTENTIAL DILEMMAS AND CHALLENGES FACED BY A CLINICAL PSYCHOLOGIST WHEN USING THESE TWO APPROACHES WITH LEARNING DISABLED PEOPLE AND HOW CAN THEY BE ADDRESSED?

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INTRODUCTION:

There is a growing opinion that "the emotional lives and emotional difficulties of people with learning disabilities have been largely neglected and submerged by the behavioural technologies of the 1970's and 1980's" (Arthur 2003 page 25). Until recently there has been an almost complete denial of the internal world of the individual with learning disability (LD). As early as 1936 these individuals were seen as "therapeutically hopeless" (Chidester and Menninger 1936 cited in Lynch 2004 page 399). In trying therapy it was assumed that the clinician would be attempting the impossible, to cure the LD, therefore it was never a goal (Neham 1951 cited in Lynch 2004). Only over the past twenty years has there been an acknowledgement that people with LD experience the same full range of psychiatric disorders as the general population (Hurley et al 1998). Nezu and Nezu (1994 page 34) refer to the "commonly held belief that people with mental retardation are somehow immune to mental illness". An assumption that those with mild LD are "worry free" and that those with severe disability "experience no emotional stress" (Fletcher 1988 cited in Nezu and Nezu 1994 page 34) have created a world in which provision of services for these individuals are judged on such criterion as "is it relevant" (Beail and Warden 1996 page 223).

This omission of emotion lead to purely behavioural techniques or technologies being applied to this client group. The focus of work with these individuals became measuring cognitive function, modifying behaviour and treating challenging behaviour, usually with a variety of psychotropic drugs (Hurley, Tomasulo and Pfadt 1998). The aim was to teach the individual how to 'behave appropriately' using such techniques as reinforcement as they are perceived to have faulty learning and skill deficits meaning they struggle to develop appropriate social skills (Bisconer 1998). As true as some of this may be, particularly considering the vast research into the area (Bisconer 1998), it is hard to understand how such a mechanistic approach has been developed by a group of Psychologists. Even the term 'Behaviour Technology' is telling in its mechanistic associations, conjuring an image of the Psychologist tinkering with an engine in order to achieve proper function.

Evidence has now been published stating that people with LD go through the same life stages, experience the same traumas and show more not less emotional

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disturbance than do the 'normal' population (Lynch 2004, Prosser 1999 cited in Wilner 2005). Even clients with severe LD who cannot communicate verbally experience a degree of stress, although in the absence of overt symptoms (Chaney 1996 cited in Arthur 2003).

Despite this growing evidence base, the provision of Psychotherapy for this client group is still very minimal (Bicknell 1983 cited in Arthur 2003). Nezu and Nezu (1994 page 35) ask the question why, "despite the continually stated need for effective outpatient services for this population, only a few methodological sound investigations have been conducted". This represents the main challenge for any Clinical Psychologist working in this area. After decades of deference to Behaviour Therapy, how can we as clinicians begin to rearrange services and challenge the beliefs of other professionals by presenting another view?

The first challenge then is to develop other therapeutic frameworks and interventions to use with this client group. Both psychodynamic (Gaedt 1995 and Sinason 1992 cited in Lynch 2003) and systemic (Baum and Lynggaard 2006) approaches have been attempted successfully to alleviate emotional stress. However, they themselves present their own challenges and dilemmas to the clinician.

PSYCHODYNAMIC APPROACH WITH LEARNING DISABILTY:
Background:
To a certain extent, the literature has shown that this approach alleviates psychological or emotional distress both for those with mild learning disability and those with more severe or profound difficulties (Beail et al 1996, 1998, 2005). It can be used both as a therapeutic intervention and as a framework. (Hartland-Rowe 2004). Sinason (1992 cited in Lynch 2004) discussed how psychodynamic principles can help us to understand the behaviour of those with severe LD and then to train staff appropriately.

From a psychodynamic viewpoint the emotional difficulties for a person with LD begin at birth. Attachment theory states that even before a baby is born, there is a great drive to make an intimate emotional bond with an attachment figure, usually the mother. Bowlby (1988) describes this as "a basic component of human nature, already

present in germinal form in the neonate and continuing through adult life to old age". This attachment acts as a survival function for the child and it is from this secure base that the child can begin to explore its environment and to find its own independent mind. A child with a secure attachment will be able to regulate their own emotions and have inner confidence and self efficacy (Parr 2007).

When a child with LD is born there is evidence that attachment is ruptured due to the resulting grief of the parents (Hollins and Sinason 2000). The expectation of their perfect child is not realised, to be replaced with a damaged child. As well as having to come to terms with the fact that their child is disabled, the parents also have to mourn for the child that was their fantasy (Emanuel 2004). This is a very difficult process and one that is bound to affect the attachment between parent and child. Emmanuel (2004) talks about the unbearable emotion that this can engender in a parent, and how this sense of disappointment can then be projected into the child. Findings of recent studies suggest an early diagnosis of LD means a higher likelihood that attachment is insecure (Esterhuyzen and Hollins 1997 cited in Hollins and Sinason 2000).

The result of insecure attachment on a 'normal' child may mean increased risk of later psychological problems (Parr 2007) but for a child with LD it is catastrophic. Long term consequences may include separation difficulties, challenging behaviour and pathological grief following significant losses (Esterhuyzen and Hollins 1997). "Where a parent is unable to screen a child from danger, or is part of a dangerous experience for a child, the child's perception of safety and of adult protectiveness can be altered or destroyed" (Pynoos et al 1995 cited in Hollins and Sinason 2000 page 33). Without this sense of security a child would be unable to make sense of its environment and as it gets older be unable to learn, for example the ability to self soothe or to become an individual in the same way. For a child with LD, alongside the cognitive deficits that must make this more difficult the child would have internalised the disappointment and grief of its parents, leading it to feel as if it does not deserve love but that it should be rejected (Emmanuel 2004).

The trauma of this insecure attachment is linked to what Sinason (1986 cited in Hartland Rowe 2004, 1992 cited in Lynch 2004) referred to as a "secondary handicap". This secondary handicap is said to be a possible defence mechanism

against the trauma of being different and damaged by the primary handicap (Sinason 1986 cited in Hartland Rowe 2004). It is this secondary handicap which leads to some of the more visible consequences of LD, for example autistic traits or challenging behaviour (Hartland Rowe 2004, Emmanuel 2004). As Lynch (2004 page 401) stated, "having a 'disabled'…identity can have a substantial impact on an individual which can result in emotional pain. An individual may develop a variety of unhealthy defences and strategies to avoid confronting such pain".

Challenges and Dilemmas of Working Psychodynamically with this Client Group:
Ethical Considerations:
When working with adults with LD there is always a question of consent and capacity to consent (Lynch 2004). This is even more relevant when setting out to explore an individual's emotional responses to their own disability. Working with adults with LD is one of the only areas in which another person, for example a carer or agency, can refer an individual for psychological therapy without their knowledge or consent (Lynch 2004). Even when the individual does consent, it is important to determine whether they fully understand what will happen as in some circumstances they will have learnt to acquiesce with the wishes of those around them (Finlay and Lyons 2002 cited in Lynch 2004). For this reason, "it is sometimes difficult to determine whether full and voluntary consent for treatment has been obtained before psychotherapy is initiated" (Lynch 2004 page 401).

When working with people with profound LD this becomes more complicated as shown in the discussion of how consent was obtained in the study by Hubert and Hollins (2006). It is clear that these individuals have no capacity to consent, but in this circumstance who is then the appropriate person to grant that consent? In this study consent was provided by the hospital management, but if the family are still involved should they be able to withdraw their relative (Hubert and Hollins 2006)? The question should be; who has the right to consent and how might their own motives colour their opinion?

This question is also relevant with ethics involved in setting therapeutic goals (Lynch 2004). It is important that the client sets goals they are comfortable with and are achievable, for example being more independent. However the carer, and the referrer,

may be more interested in the elimination of a certain behaviour (Lynch 2004). In this case the question becomes more about who has the problem with the behaviour, and what is more beneficial for the client i.e. the person with LD.

Ethical considerations have a place in all therapeutic encounters. However, they may seem more relevant when the client is being faced with a therapy that can be both emotionally and physically draining. It is important for any therapist to be aware of these issues for them to be addressed. This will enable them to develop goals in a collaborative manner, listening to the concerns of the staff but also incorporating the client's own preferences (Lynch 2004). When obtaining consent the process needs to be handled appropriately for the client, for example providing understandable information on both positive and negative aspects of the therapy, and then reiterating this several times on different occasions to allow for fluctuating levels of cognition (Beail 1998).

Cognitive Deficits and Fluctuating States of Disability:
Cognitive deficits and related difficulties, such as speech and language problems are used as evidence as to why psychotherapy is inappropriate in LD. Nezu and Nezu (1994 page 35) refer to a therapist bias that individuals with LD were "inappropriate candidates for psychotherapy". This bias was first recognised decades ago (Rogers and Dymond 1954 cited in Nezu and Nezu 1994). However it has endured because of the view that this client group are unable to discuss their difficulties, to understand such concepts and that their over dependency would interfere with transference (Nezu and Nezu 1994). "Psychotherapists frequently assume that limitations in intelligence prevents persons with (learning disability and developmental disorders) from participating in the psychotherapeutic process" Hurley, Tomasulo and Pfadt (1998 page 366). For this reason, and the denial of emotional experience in LD, psychotherapy has never been fully explored (Nezu and Nezu 1994).

Clients with LD do have cognitive deficits making it more difficult for them to access psychotherapy. Common cognitive deficits, undermining their ability to collaborate include; "social desirability, acquiescence, memory problems, recency effects, anxiety and incomprehension" (Stenfert Kroese 1997 cited in Wilner 2005 page 78). These difficulties would impact on the individual's understanding of fundamental concepts,

therapeutic encounters and emotional awareness (Wilner 2005). Specifically in terms of psychodynamic therapy, there is also the possibility that the lack of ability to develop 'insight' or to recognise cause and effect would mean interpretation would be meaningless (Hurley et al 1998).

The level of LD may also alter from hour to hour, dependent on what the individual is doing. Hartland Rowe (2004 page 135) described this as, "a marked and seemingly inexplicable fluctuation between capacity and incapacity" and are important to recognise (Sinason 1992 cited in Hartland Rowe 2004). The consequence may be that what the individual understands of their therapy and what they are able to retain may shift from session to session. This makes it hard for the therapist to be sure firstly that the person can still consent and secondly that they are helping them in an appropriate fashion.

Is this a reason for exclusion from psychotherapy? Although this represents a challenge, there are solutions. The belief that an individual's cognitive deficits would render their account of their experience as useless has been challenged. Although based on self report measures in CBT there has been literature which suggests that with small alterations to language these measures are reliable in LD (Lindsay and Michie 1988, Lindsay et al 1994 cited in Wilner 2005). This suggests that the same alterations in a psychodynamic setting would make it easier to access.

Practitioners are now openly acknowledging that with modifications psychodynamic therapy is of value in LD (Lynch 2004). These include (Hurley et al 1998); simplification of the explanation of therapy (Hurley and Hurley 1987), adjustment of verbal dialogue (Ludwig and Hindsburger 1987), addition of activities (Hurley 1989), assessment of developmental level (Dosen 1990), use of a directive style (Hurley 1989) and a general flexibility (Lindsay et al 1993). With these modifications psychodynamic therapy can offer a more structured, time limited, but still very valuable experience for the adult with LD (Lynch 2004).

As Hurley et al (1998) point out; all psychotherapists alter their treatment plan and techniques for every client. This is not because of lack of understanding but because every individual responds differently in therapy and requires a different approach.

Therefore, in one sense seeing a client with LD and considering how to work with them is no different to working with another client from the 'normal' population. Lynch (2004) agrees, saying that an individualised assessment will help determine how to work with the client, investigating their strengths and weaknesses and then deciding on modifications. As a therapist, this is only normal procedure.

Relationship Issues:

One of the central features of psychodynamic psychotherapy is the use of the therapeutic relationship to facilitate change. Beail and Warden (1996) described the therapy as focusing on the transference and counter transference between therapist and client to build understanding of the client's internal world. The therapist will then use interpretation as an intervention or containment as is appropriate for meeting the client's early developmental needs (Winnicott 1965 cited in Beail and Warden 1996).

Is this type of relationship possible when working with an adult with LD? Firstly there is dispute regarding the ability to be able to respond to transference and interpretation. As we have previously mentioned this was a reason why psychodynamic therapy was not considered a viable treatment option for many years (Nezu and Nezu 1994). This has been challenged by studies that conclude that people with LD can actually experience transference reactions that are, "more rapid, pronounced and primitive than those seen in the general population" (Levitas and Gilson 1987, 1989 cited in Hurley et al 1998 page 373). The result is thought to be that the strong transference could make psychodynamic therapy more effective with this client group (Hurley et al 1998). The consequence is that the therapist may experience correspondingly strong counter transference regarding their own feelings about disability (Hurley et al 1998).

A reason for these strong reactions is the early development in LD and the vital role of others in the ability to learn and retain knowledge (Hartland- Rowe 2004). Hartland- Rowe (2004) discussed the need of these individuals to have an able bodied person present in order to do anything, and the difficulty that they experience in separating themselves from this person to be just themselves. They need contact to give them the motivation to achieve any task, even if they are fully capable of doing it alone. They then lose a sense of identity, merging themselves into the more able person. This resonates with Bion's (1962) work on projective identification. For this

client group, "having someone present, with a mind, is what helps to give sensation meaning" (Hartland Rowe 2004 page 144).

This has an effect on the therapeutic relationship. Instead of meeting as two individuals with their own minds, thoughts and desires, there is a definite power imbalance. The adult with a LD may fall into their previous pattern of relating to others and merge their thoughts with the therapist.

Addressing these issues at the beginning of any therapeutic contact would be vital. The therapist must clarify the situation from the beginning in clear and concrete terms so that the client is aware and feels comfortable with the relationship (Hurley et al 1998). The therapist would also have to be aware of these issues from their own perspective and have regular supervision to work through these dynamics. Common difficulties are said to be "rescue fantasies, over-protection and ridicule of the parents" (Hurley et al 1998). Good supervision will allow them to work through these issues as well as addressing their views on disability.

Evidence Base:
One of the major challenges for a Clinical Psychologist working in this area is the current lack of empirical evidence supporting psychodynamic techniques in LD (Beail, Warden, Morsley and Newman 2005). Unfortunately, despite the rising interest in this area, research has been slow and concerns are being voiced regarding its efficacy (Lynch 2004, Beail et al 2005). In 2003 Prout and Nowat- Drabik (cited in Lynch 2004) conducted a review of the literature in this area and, although they found that psychotherapy was 'moderately effective' they acknowledged that the research was methodologically poor. The issue is that there are no studies that meet the highest standard as set by the NHS, i.e. the Randomised Controlled Trial (RCT Wilner 2005). Without this, and in competition with the highly evidence based Behavioural approach, psychodynamic therapy for this client group has been ignored (Beail 1998).

The result and challenge for the Clinical Psychologist is that instead of using evidence based practice we are using practice based evidence (Beail et al 2005). This process can be more easily challenged by other professionals as, in effect; we are not working as scientist practitioners. In order for Psychodynamic techniques to be accepted in

LD, this process of research needs to continue. In terms of Salkovskis' (1995) 'hourglass' model we are only in the early stages and have a way to go before psychodynamic therapy becomes evidence based.

However, it is clear that the research that has been done clearly supports the use of psychodynamic therapy. Beail (1996, 1998, and 2005) has begun to prove, using stringent methodology that psychological distress is reduced, interpersonal skills and self esteem increase and anger and aggression are appropriately treated. This would indicate that "the treatment warrants the level of investment that further investigation would entail" (Beail et al 2005 page 249).

SYSTEMIC APPROACH WITH LEARNING DISABILITY:

Background:

Similarly to Psychodynamic therapy, the interest in a Systemic approach is a reaction to the unmet needs of the LD population (Pote 2006). However, whereas the focus in Psychodynamic therapy is on the individual and how the trauma of their early life and development has impacted on their functioning, Systemic theory explores the importance of interpersonal factors such as context and relationships (Baum 2006).

In this postmodern era of Systemic theory, LD is viewed, "not as an objective phenomenon but a construction, a label given to certain actions, which consequently constitutes the identities of some people within a culture" (Fredman 2006 page 9). Throughout the person with LD is seen as subject to four layers of context, i.e. themselves, their family and care system, the professional training and service context and the social and political environment (Pote 2006).

 This goes against the medicalisation of individuals with LD which pathologises the difficulties they face as inherent to the person and concentrate of deficits rather than resources and abilities. (Baum 2006). Instead of an individual on their own creating behaviour simply because of their disability, the focus shifts to a circular picture of an individual functioning within a context and as part of a system (Fredman 2006). Relationships at both a family and professional level are seen as interpersonal influences on behaviour and functioning. Therapy looks at the circular patterns of relationships in order to achieve second order change in the system (Fredman 2006,

Rhodes 2003). This is as opposed to Behaviour therapy which only ever achieves first order change (Rhodes 2003).

Therefore, instead of looking at the differences between 'us' and the LD population, a Systemic approach would be to consider the similarities (Fredman 2006). This allows the therapist to look collectively at families and the care systems of people with LD for the first time (Baum 2006). Baum (2006 page 37) states that, "the systemic approach seeks to understand concerns, problems or difficulties within the contexts in which they emerge and in the context of relationships".

Challenges and Dilemmas of Working Systemically With This Client Group:

Although Psychodynamic and Systemic approaches in LD are different in their philosophy, there are similarities when thinking about themes. For example the impact of parental grief on the developing child both in terms of their interpersonal skills (Sinason 1992 cited in Lynch 2004) and in their intrapersonal skills when forming relationships (Baum et al 2001). This similarity extends into the challenges and dilemmas faced by a therapist. It would be expected that the barriers encountered by someone working in a Psychodynamic framework, would also be faced in a Systemic piece of work. Therefore, when thinking about the specific challenges from a Systemic viewpoint presented here, this is not to omit the previously stated challenges presented above but just to avoid repetition.

Championing a New Approach:

The first major challenge as a Clinical Psychologist in using this approach is the fact that it has only very recently been recognised as a potentially useful model in LD (Fredman 2006). As when considering Psychodynamic techniques, the evidence is currently practice based evidence rather than evidence based practice. However some recent studies have been hopeful (Lyngaard and Scior 2002 cited in Baum 2006) and its aims of choice and inclusion do seem to fit with the Government's White Paper, Valuing People (Department of Health 2001).

The difficulty in beginning to use Systemic as opposed to Psychodynamic theory is that it is a multidisciplinary approach rather than an individual therapist's choice. It is for this reason that the application of Systemic theory has been slower (Vetere 1996

cited in Pote 2006). To set up a systemic practice means to go against the contexts in which practitioners work and how they were trained (Pote 2006). There is a definite reluctance for some professional's to change the service structures they work in, possibly due to fear of revealing their working practices to others, for example in reflecting teams. In 1975 Haley warned that family therapy was to be avoided if mental health services wanted to not be over-run. This view is still pervasive in LD services and has led to different arguments against its introduction (Fredman 2006). Calls that the family is not the problem and that systemic therapy is not for the poor or marginalised are still common.

This reluctance has meant that Systemic practice has been beset by, "difficulties in developing co-ordinating, collaborative multidisciplinary relationships" (Pote 2006). Roy Chrowdhury (1992) discussed a number of the barriers he met when setting up a systemic service. Due to the training of other professionals he found it hard to shift their perspective to a circular pattern from the traditional view of linear causality. This led to a resistance in the team and questions being asked about his usefulness (Roy Chowdhury 1992).

To address this there is now growing evidence that this approach is very useful when services can be set up (Baum, Chapman, Scior, Sheppard and Walden 2001). Jenkins (2006) used Systemic theory to set up Network Training which is a structured approach to working with an individual with LD's support structure which is proving to be very rewarding for her team. However it is possible to begin to use Systemic practice without altering the service by using it to facilitate the understanding of care staff (Reed 1997 cited in Arthur 2003). This consultation and training approach, "facilitates emotional development, improves staff- client relationships, decreases symptomatic behaviour and helps improve quality of life" (Arthur 1999 cited in Arthur 2003 page 28).

Maintaining a Curious Stance:
The aim when working systemically is to maintain a stance of curiosity in order to introduce difference and create space for change. (Cecchin 1987 cited in Fredman 2006). This stance becomes more difficult when working with a person with LD and

their family due to the power imbalance created by the effects of societal values and beliefs regarding LD (Fredman 2006).

In a family with a member who has LD it is possible for that person to become a scapegoat simply due to the possibility that they are potentially difficult (Roy Chrowdhury 1992) For professionals working outside a systemic frame Roy Chrowdhury (1992) found that this view would be reinforced by the collusion of the professional with the family and against the individual with LD. The societal and service contexts serve to exclude this individual.

However, working within a systemic frame there is still a risk that the practitioner will collude with the family and the client opposed to the wider professional system (Pote 2006). This collusion is part of a triangulation of protection. Goldberg et al (1995 cited in Baum et al 2001) suggested that the family of someone with LD work together to protect them from the possible consequences of their disability. At the same time the person with LD works to protect their family from feeling responsible or worried about their welfare (Pote et al 2006). The resulting tension means that the practitioner can no longer remain curiously neutral between all elements of the system and hope of change is lost (Pote 2006).

To address this the practitioner has to be aware of their own position and those of the other elements in the system at all times. One way of doing this is for the practitioner to map the 'problem- determined' system (Pote 2006). The aim of this is to develop a clear understanding of all the relationships, how they relate to the presenting problems and then to the practitioner. This can then be shared with all members of the system (Pote 2006). Even then the practitioner has to be aware that each member of the system feels that their needs are being met, allowing the whole family to relax their protection of each other and to develop more positive coping resources (Pote 2006).

Letting Everyone Be Heard:
As with Psychodynamic approaches, one of the arguments used against the introduction of Systemic theory is that the individual with learning disability won't have the cognitive awareness (Fredman 2006) to use it effectively. Burr 1995 (cited in Pote 2006) stated that, "such a focus on language- based change may contribute to

further disempowering them and decreasing their ability to "warrant voice" within society". An anxiety resulted with practitioners believing that they would need specific skills to facilitate inclusion (Rhodes 2002 cited in Pote 2006).

However family therapy research evidence has shown that this process can provide the individual with the, "empowering and novel experience of being heard" (Fredman 2006 page 14). This suggests that, despite cognitive deficits, family therapy can have powerful effects. People with LD rarely get the opportunity to express opinion and this experience begins to shift professional descriptions to individual stories (Fredman 2006). Building on this, Lyngaarrdd and Scior (2002) have developed a narrative approach as an overarching concept to working with people with LD. With some adaptations this is proving useful and they feel it is very accessible. What systemic therapy appears to do is to support families to work collaboratively on the construction of a new story taking into account the person's difficulties (Fredman 2006).

CONCLUSIONS:

The world of those with LD is changing. In the last twenty years normalisation (Wolfensberger 1972 cited in Baum 2006) has meant a move away from institutions and into the community, meaning better housing and access to ordinary health and social care. This is reflected in Government policy with the White Paper, Valuing People (Department of Health DOH 2001) which emphasises main principles of rights, independence, choice and inclusion with an aim that "social inclusion is a reality for all" (DOH 2001 cited in Baum 2001 page 20).

However despite this ever changing and progressive picture it remains true that this population are, "one of the most ignored in terms of mental health services and psychological research into therapeutic techniques" (Reed 1997 cited in Arthur 2003 page 25). Behaviour Technology is still the favoured therapy when working with this group (Sturmey 2005). It is true that there are circumstances in which a Behavioural focus is appropriate (Sturmey 2005).

However it is also true and becoming clearer with more evidence (Beail 2005, Baum and Lynggaarrdd 2006) that there are other approaches that can be just as effective

and that actually take into account not only the behaviour but the person, the emotion, and the environment. Both of these approaches face challenges and dilemmas both in terms of changing services and in the actual work itself. Therefore, possibly because of the social construction of perceived difficulty in working with this client group this has meant that clinicians have avoided such approaches. What seems to be lost in this argument is something discussed earlier. When any therapist starts a piece of work the treatment plan created is done for that individual because it is true that every person responds differently in a therapeutic encounter and will find different aspects useful (Hurley 1998). Why then does it become so difficult to do this when presented with a client with LD? Both approaches present challenges and dilemmas but this is not very different to how they work in the 'normal' population and therefore should not represent a barrier to their use.

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SMALL SCALE RESEARCH PROJECT

HOW TO IMPROVE THE EFFICIENCY OF AN OVERSTRETCHED SERVICE: USING DIFFERENT TREATMENT OPTIONS TO BEST USE THE RESOURCES OF A PSYCHOLOGY DEPARTMENT WITHIN A CMHT

20th April 2007

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ABSTRACT:

The aim of this audit was to look at the referrals made to the Psychology Department, and to investigate viable treatment options in order to improve the efficiency of the service.

It was found that the majority of the referrals made to the Department were for short term therapy, usually CBT, for conditions such as Depression, Obsessive Compulsive Disorder and General Anxiety Disorder. This meant that the Psychology Department is finding it hard to balance the service in terms of providing support for both individuals with short term disorders and those with long term needs.

Group Therapy was proved to be a useful alternative to individual therapy for both individuals with time limited and more severe mental health needs. Options in terms of setting up groups targeting both areas were considered.

Directions for the future were put forward, for example looking at the CMHT's referrals and tracking those who are not referred to Psychology.

INTRODUCTION:

In line with the current climate within Mental Health services across the country, Community Mental Health Team's (CMHT) are undergoing a period of intense change (Department Of Health 1999). Following the unveiling of the new National Service Framework (NSF) in 1999, services are being rearranged with an emphasis on mental health promotion, primary care development, and specialist services for those with enduring mental health problems. The later introduction of the Mental Health Implementation Guide in 2001, made it clear that CMHTs have a central role in this, "CMHT's will continue to be the mainstay of the system. CMHTs have an important, indeed integral role to play in supporting service users and their families in community settings."(Mental Health Implementation Guide, 2001).

However, within this, the function of the CMHT has become two fold. Firstly, they treat people with time-limited conditions who are then handed back to their GP. Their second function is to support those with severe and enduring difficulties such as psychoses, self harm and personality disorder. These service users may need care for

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a number of years (Mental Health Implementation Guide, 2001). Therefore, although the numbers of these service users may reflect a minority on paper, in practice the resources they use are considerable. For example, in the National Institute of Clinical Excellence (NICE) guidelines on Schizophrenia (NICE 2003), it is stated that these service users represent 5% of the budget for Mental Health, 28.4% of the workload of Consultant Psychiatrists (Johnson 1997 cited in NICE 2003) and that 21% have Community Psychiatric Nurses. This dual function can create difficulties for the CMHT in terms of employment of resources and priority setting.

As a part of the CMHT, the Psychological service is involved with the same mix of service users and therefore experiences the same barriers in terms of resources and the need to ensure a balance. Nationally the number of service users referred for Psychological therapies is rising. Looking at the figures for Clinical Psychology services for 2002-3 (DOH 2003), it is noted that the number of new episodes of care was 24% higher in 2002-3 than in 1988-9. In 2001 the government paper on 'Treatment Choice in Psychological Therapies and Counselling' (DOH 2001) highlighted that the evidence supported the use of Psychological therapies, such as CBT, in the treatment of a range of problems including depression, anxiety and PTSD. It went on to recommend that structured Psychological therapy, with a skilled practitioner, can also be effective with people who have severe and complex difficulties such as schizophrenia and personality disorder (DOH 2001). This is supported by the NICE guidelines on the treatment of Schizophrenia and Psychosis (NICE 2003). The need is for practitioners to move away from the traditional use of pharmacological agents to help patients and provide a "more broadly based approach combining different treatment options, tailored to the needs of the individual service user and their families." (NICE 2003 pg 90).

Group therapy has often been thought of as providing less therapeutic benefit than individual, however as Yalom says," a persuasive body of outcome research has demonstrated unequivocally that group therapy is a highly effective form of psychotherapy and that it is at least equal to individual psychotherapy in its power to provide meaningful benefit" (Yalom and Leszcz 2005 pg. 1). There are certainly now many models of group working including Behavioural, Rational Emotive and Person-Centred as well as concepts such as Psychodrama (Corey 2004).

This statement by Yalom and Leszcz (2005) is corroborated by a majority of the research in Roth and Fonagy's 'What Works for Whom' (2006). Investigating effective treatments for time limited conditions such as Depression and Anxiety, they did find that group therapy was as effective as other more traditional individual based therapies. In the treatment of depression, a study by McDermut et al (2001 cited in Roth and Fonagy 2006) who compared 48 studies published between 1970 and 1998. In comparison to no therapy they found that group therapy produced an effect size of 1.03 which is high. In comparison with other individual therapy there was an effect size of -0.15 which suggests that the therapies produced equivalent outcomes. The use of Group CBT in the treatment of depression is also mentioned in the NICE guidelines (NICE 2004), although they do state that there were not sufficient RCT's to compare it to other individual therapies.

Yalom and Leszcz (2005) also emphasise the benefits of group therapy. For some specific disorders, for example substance abuse and those with a medical diagnosis such as Chronic Pain, the importance of social learning, reducing stigma and the opportunity to develop social networks and supports is paramount when designing appropriate therapeutic intervention and this is vastly superior when using groups.

For the same reasons, is also true that group therapy can benefit those with severe mental illness and personality disorder, particularly when the focus is on developing social awareness and appropriate social behaviour. For example Yalom and Leszcz (2005) state the group therapy alongside individual for survivors of childhood sexual abuse can result in greater empowerment and psychological well being.

Group therapy is mentioned in Roth and Fonagy (2006) as a viable treatment option for those with Schizophrenia and Psychosis. They describe three studies, using group based CBT which focussed on delusions (Chadwick et al 2000, Gledhill et al 1998 and Wykes et al 1999 cited in Roth and Fonagy 2006). All three studies found some symptomatic relief for the participants. However as they looked at such a small range of studies this can obviously only be taken as a starting point to finding more evidence of potential benefits. Group therapy for this client group is explored more fully by Schermer and Pines (1999). In a systematic literature review, they evaluated

46 studies involving 57 therapy groups. They found that 70% of patients within therapy groups did significantly better than their counterparts, and that group therapy was as effective, or in some cases, more effective than individual therapy. However within this they mention several factors that impact upon the success of group therapy within this client group. Firstly the group has to be homogenous i.e. made up of people experiencing similar difficulties, for example the same cluster of symptoms (Shermer and Pines 1999). This increases the patient's ability to relate to each other quickly, forming group cohesiveness, and the group leader can employ specific strategies for all members of the group. Finally with this client group, the focus of group therapy is slightly different to one being employed for those suffering a time-limited condition. With time limited group therapy the aim is to reduce symptoms in a point at which the client can re-join the 'normal' population. With a psychotic, or indeed personality disordered group, the aim is to improve their ability to cope with various symptoms and sequalae of their conditions (Shermer and Pines 1999). For example they may learn how to cope better with their symptoms or learn interpersonal skills. These techniques will help them to function within the community, but will not 'cure' them.

This different focus of therapy is clear again in the personality disorder literature. Jacob, Richter, Lammers and Bohus (2006) have developed a therapy designed to enhance the self esteem of those with borderline personality disorder (BPD). This is an essential area with this client group due to instability of self- concept and self-worth leading to self-harm. They have built into this an element to boost motivation as it is recognised that those with BPD devalue themselves to the extent that it is very hard to emphasise their self-esteem. The success of this group is very important in terms of how patients view themselves and the world. Whewell, Lingam and Chilton (2004) have also successfully set up a psychoanalytic group with patients with BPD focussing on their reflective experience. Again they use a group format to increase a feeling of cohesiveness, allowing the participants to feel validated and supported in their experience.

Yalom (2005) supports the importance of the dynamics of a group when discussing the selection of appropriate clients for group therapy, for example the use of

heterogeneous versus homogenous inclusion criteria. They emphasise some criteria that are vital to consider when designing a group.

These features are listed in the Table below:

Table 1: Features identified to assist selection and exclusion of clients referred for Group Therapy (Yalom 2005)

Selection	Exclusion
Motivation to Change	Unable to participate in aim of group e.g for interpersonal or logistical reasons
Predominant difficulty is related to interpersonal problems	Individuals who would be destructive e.g. sociopathic clients
Impulsivity	Clients in acute crisis
Clients who find transference too demanding	Clients who do not show good attendance

The evidence would suggest that group therapy can be effective for both time limited and severe mental illnesses, as long as certain considerations are made regarding inclusion and expectations. A group therefore, would prove both cost and time effective as a method of making a Psychological service more efficient in its provision of resources to both groups of individuals that it serves.

However, before setting up a group it is important to be aware of the complete range and break down of the clients whom the Psychology service has input with. This will enable the group to target any gaps, again increasing the efficiency of the service as well as the purpose of the group.

AUDIT QUESTIONS:

My two audit questions are;

1. What clients have been referred for and how we intervene within this Service, for example what treatment options are currently considered.

    - Who are the Psychiatrists referring to the Psychology service?
    - What are we treating them for?
    - What treatment is used?

- How long is treatment?

2. To carry out a Needs Assessment, looking at what form of group would be of most use for this Service, both for clients with moderate to severe anxiety and depression and more enduring personality disorders?

   - Using Yalom's criteria for selection and exclusion, as in his 2005 book, how many of the referred service users could have been seen in a group?

METHOD:

The design of this audit will be that of a case note audit. Within the service as a whole there are three teams, defined by the area that they cover. All of the case notes of those service users referred to the Psychology service in 2005 will be examined in each of these teams in order to answer the audit questions listed above. In all 45 cases were identified as being referred to the Psychology service across all three teams in this time period.

For the needs assessment, the service users will be assessed by means of a checklist of the features previously listed in Table 1, designed by Yalom (2005) that have been assessed, through research, as appropriate features of a client being selected for, or excluded from group therapy.

To do a case note audit is appropriate in this case as we are interested in the past client activity of the Psychology service. Through the notes we can discover whether there are any trends in referral, whether the Psychiatrists refer more service users for time limited therapy, or more intensive support, and what intervention was used with the client.

Measures:

The aim is to design a series of checklists to guide the investigation. These will be developed in line with current evidence.

1. To check the referral information and the subsequent treatment route
2. To check whether individuals may have benefited from group therapy.
3. What theme of group therapy would be most appropriate for this service

Analysis:

Research Question 1:

- To investigate whether there are themes in the diagnosis- do the Psychiatrists refer more clients for particular difficulties
- To investigate the different types of intervention and how commonly each is used through descriptive statistics.
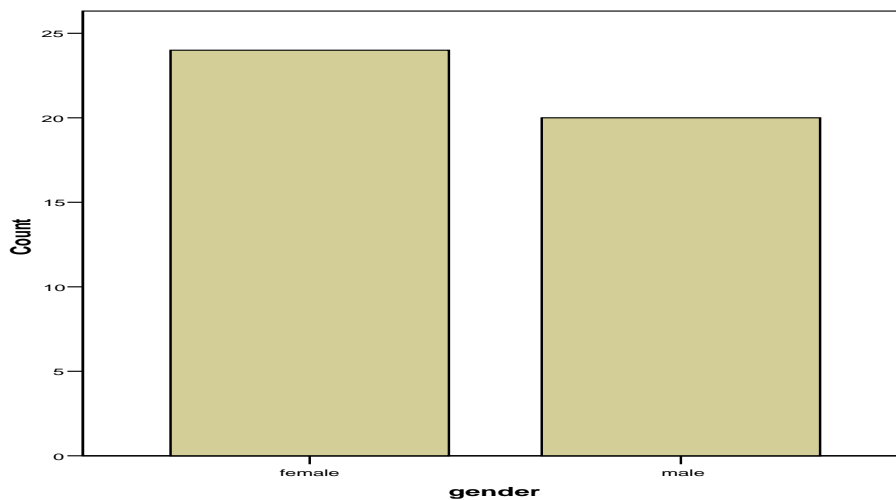
Research Question 2:

- To collate a number of clients who could have benefited from group therapy
- To investigate whether there is one type of group indicated for this Service

RESULTS:

Research Question 1:

1. Demographics:

Graph 1: Gender of clients referred in 2005

Table 2: Age of Clients referred in 2005:

	N	Minimum	Maximum	Mean	Std. Deviation
age	44	20.00	64.00	40.3864	11.57225
Valid N (listwise)	44				

The demographic data of the clients referred for Psychological support in 2005 shows that there were slightly more females to males referred (54.5% to 45.5%) with a mean

age of 40. All referrals were made by the Psychiatrist, although this may have been following consultation with the wider Team.

2. Previous Diagnoses of Clients Referred in 2005

Table 3: Range and Percentage of Previous Diagnoses:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	22	50.0	50.0	50.0
	SADS	1	2.3	2.3	52.3
	Asthma	2	4.5	4.5	56.8
	epilepsy	1	2.3	2.3	59.1
	tourettes	1	2.3	2.3	61.4
	oesophigitis	1	2.3	2.3	63.6
	PTSD	1	2.3	2.3	65.9
	Borderline Personality Disorder	1	2.3	2.3	68.2
	depression	7	15.9	15.9	84.1
	paranoid schizophrenia	1	2.3	2.3	86.4
	pain	4	9.1	9.1	95.5
	psychosis	1	2.3	2.3	97.7
	diabetes	1	2.3	2.3	100.0
	Total	44	100.0	100.0	

From this table it can be seen that the majority of the clients referred in this time period had no previous diagnosis (50%) or a medical diagnosis (11.4%), indicating that they had had no need of prior involvement with the CMHT. The most common previous diagnosis of clients being re-referred was a diagnosis of recurrent or chronic depression (15.9%). Some of these individuals had received Psychological support in the past but some were being referred for an initial assessment. Only 6.9% of those referred had a diagnosis of Personality Disorder, Schizophrenia or Psychosis. Further, some of these diagnoses were tentative and more information was being asked for, rather than referrals being an ongoing plan of intervention and support.

3. Reason for Referral and What was Treated:

Table 4: Reasons for Referral for Psychological Therapy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Panic attacks	7	15.9	15.9	15.9
	OCD	7	15.9	15.9	31.8
	Depression	11	25.0	25.0	56.8
	hypochrondriasis	3	6.8	6.8	63.6
	paranoia	1	2.3	2.3	65.9
	phobia	2	4.5	4.5	70.5
	PTSD	3	6.8	6.8	77.3
	general anxiety	5	11.4	11.4	88.6
	concentration difficulties	1	2.3	2.3	90.9
	agoraphobia	2	4.5	4.5	95.5
	memory problems	1	2.3	2.3	97.7
	chronic fatigue	1	2.3	2.3	100.0
	Total	44	100.0	100.0	

From this table it can be seen that the most common reason given for referral to Psychology was Depression (25%). Sometimes this was accompanied by other disorders, e.g. anxiety or OCD, but was frequently said to be the primary problem. Other common referrals were for Panic (15.9%) and OCD (15.9%). Referrals were also made for Neuropsychological testing due to Memory problems (2.3%) and Concentration difficulties (2.3%). Paranoia only made up 2.3% of the referrals made.

Table 5: Problems Treated:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Panic	3	6.8	8.8	8.8
	PTSD	2	4.5	5.9	14.7
	Depression	11	25.0	32.4	47.1
	Health Anxiety	4	9.1	11.8	58.8
	OCD	3	6.8	8.8	67.6
	General anxiety	7	15.9	20.6	88.2
	phobia	1	2.3	2.9	91.2
	social anxiety	1	2.3	2.9	94.1
	chronic fatigue	1	2.3	2.9	97.1
	complicated grief	1	2.3	2.9	100.0
	Total	34	77.3	100.0	
Missing	System	10	22.7		
Total		44	100.0		

However, from Table 5 it is evident that there is a discrepancy between what clients are referred for, and what they are treated for. Depression still takes up the majority of the group (25 %), but here General Anxiety is the next most common (15.9%), with Panic and OCD only accounting for 6.8% each. Also in this table there is a different range of difficulties treated. Social anxiety and grief are listed as primary problems treated, while not being mentioned in the list of referred difficulties. Whereas agoraphobia and paranoia are listed as referred primary problems but do appear to have been treated as such within an intervention. Further, this means that no psychosis or paranoia is listed as having been treated psychologically.

4. Relevant Information Given to Support Referrals

Table 6: Relevant Information given in referrals

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	15	34.1	34.9	34.9
	previously inpatient	4	9.1	9.3	44.2
	suicide attempt	5	11.4	11.6	55.8
	suicidal thoughts	3	6.8	7.0	62.8
	no motivation for therapy	1	2.3	2.3	65.1
	drug user	3	6.8	7.0	72.1
	previous Psychology input	5	11.4	11.6	83.7
	depression	2	4.5	4.7	88.4
	self harm	1	2.3	2.3	90.7
	recent bereavement	2	4.5	4.7	95.3
	no active psychosis	1	2.3	2.3	97.7
	long term involvement	1	2.3	2.3	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

Relevant Information is given with referrals to highlight any particular risk issue or to emphasise important facts relating to the individual. It would be expected that referrals for those with more severe and long standing problems would contain more relevant information pertaining to previous incidents etc. As can be seen from the above table, most of the referrals received (34.1%) did not contain any such information. However there were issues raised here that indicate previous serious difficulties. For example 18.2% of individuals referred had experienced suicidal thoughts or had actually made attempts to take their own lives. Also 11.4% are said to

have had previous Psychological input, although not necessarily stating what this was for and what form it took. However, only 2.3% were referred on the basis of showing no current psychosis, indicating that this is currently controlled but is a risk issue.

5. Treatment Used and Number of Sessions Completed:

Graph 2: Range of treatments used in 2005.
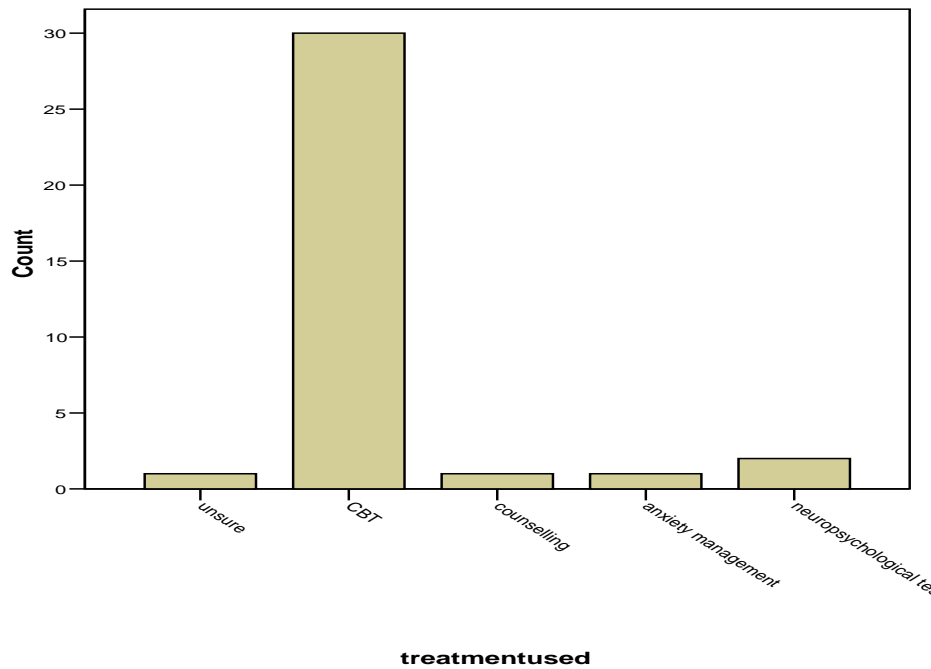
Table 7: Average Number of Sessions per Treatment

	N	Minimum	Maximum	Mean	Std. Deviation
no.ofsessions	28	2.00	30.00	8.5714	5.02165
Valid N (listwise)	28				

From Graph 2 it is clear that CBT was by far the most popular treatment (85.7%), although Counselling, Neuropsychological testing and Anxiety management were also undertaken. Within the CBT, the average number of sessions completed per client was 8.5714. This is close to the recommended treatment lengths in the NICE guidelines for such problems as Depression and Anxiety. However, some of the clients left treatment early and so only the number of sessions they attended is included.

6. Outcome of Intervention:

Table 8: Outcome of Psychological Therapy:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	improvement	21	47.7	50.0	50.0
	stopped attending	6	13.6	14.3	64.3
	referred on	9	20.5	21.4	85.7
	CMHT support only	1	2.3	2.4	88.1
	ongoing	5	11.4	11.9	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

From this table it can be seen that the majority of clients either improved (47.7%) or were referred on (20.5%). However 13.6% stopped attending therapy. It would be interesting to look at which clients were referred on and where to.

Research Question 2:

The aim of this question was to assess how many service users could have been appropriately treated using group therapy following Yalom and Leszcz's (2005) guidelines.

Selection:

Table 9: Success of Previous Therapy:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	unsuccessful	7	15.6	36.8	36.8
	some success	5	11.1	26.3	63.2
	successful	7	15.6	36.8	100.0
	Total	19	42.2	100.0	
Missing	System	26	57.8		
Total		45	100.0		

It is evident in Table 9 that most therapy in what ever format produced at least some success with this sample (63.2%). However, just as many of them found therapy unsuccessful as they did successful. For those who gained some benefit from psychological therapy, they would also have probably improved in group therapy.

Table 10: Motivation to Change:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	10	22.2	22.2	22.2
	yes	35	77.8	77.8	100.0
	Total	45	100.0	100.0	

Motivation to change is key to success in group therapy (Yalom and Lesczc 2005). We found that 77.8% of the sample (Table 10) had this motivation and would have been open to ideas and insightful enough to cope with group therapy. However, this is also an indication of success in individual therapy.

Exclusion:

Yalom and Lesczc (2005) state that clients in the midst of a crisis, in a deep depression or experiencing psychosis or paranoia should not generally be placed within a time limited heterogeneous group. As can be seen in this series of tables (Tables 11- 14) the majority of the sample of clients referred in 2005 were not experiencing these difficulties at the point of referral.

Table 11: Percentage of Sample Showing Signs of a Current Crisis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	39	86.7	86.7	86.7
	yes	6	13.3	13.3	100.0
	Total	45	100.0	100.0	

Table 12: Percentage of Sample with Current Acute Psychosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	43	95.6	95.6	95.6
	yes	2	4.4	4.4	100.0
	Total	45	100.0	100.0	

Table 13: Percentage of Sample with Current Suicidal Ideation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	32	71.1	71.1	71.1
	suicidal ideation	12	26.7	26.7	97.8
	recent attempt	1	2.2	2.2	100.0
	Total	45	100.0	100.0	

Table 14: Percentage of Sample with Current Paranoia

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	41	91.1	91.1	91.1
	yes	4	8.9	8.9	100.0
	Total	45	100.0	100.0	

They also thought that those with a diagnosed Personality Disorder should not be included within a group of clients referred for a time limited intervention. Again, as can be seen in Table 15 the majority of clients did not have a diagnosed Personality Disorder.

Table 15: Percentage of Clients with a Diagnosed Personality Disorder

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	41	91.1	91.1	91.1
	yes	4	8.9	8.9	100.0
	Total	45	100.0	100.0	

DISCUSSION:

In this audit we have investigated viable ways to make more effective use of limited resources, what specific areas of our service would be best targeted for change and whether previous referrals would have been appropriate when considering new treatment options.

Investigation into the Psychology service has highlighted some already apparent information about the set up of the team, as well as uncovering new factors which have increased our understanding. There were no surprises about the general make up

of the clients referred to us in terms of age or gender, and all referrals came from the Psychiatrist as expected, although it wasn't always stated whether this was in partnership with the CMHT or an individual decision. The fact that CBT is overwhelmingly the treatment of choice in this service was also expected.

The interesting information starts when looking at reasons for referral and the treatment backgrounds of those referred to Psychology. In the introduction it was clearly stated that the aim of a CMHT, as set down by the Department of Health, is two-fold; to provide care both for those suffering from a time limited depressive or emotional difficulty and for individuals who have been diagnosed with a severe, long term disorder which leads to chronic difficulties. For Psychological services, recommendations made about effective treatment options also state that Psychological therapy should be incorporated into the care of both groups. Therefore, both as a part of a CMHT and as a separate professional body, the Psychology service should expect referrals of both a time limited and a long term nature. However, the results of this audit suggest that this is not the case. This is evidenced by both the reasons for referral, for example depression being the most commonly referred difficulty, and by the history of the individuals referred. From the information given regarding previous contact and diagnoses, 50% of the individuals had had no previous contact with the team, suggesting a short term problem. Only 15.9% had been treated before for depression and just 4.6% had a diagnosis such as Borderline Personality Disorder or Paranoid Schizophrenia. Of course, services could have been wary about making definitive diagnoses, meaning that there would be less evidence, although the team would be aware of someone's difficulties through team discussion. However, you may still expect them to have had previous contact. This referral pattern can also be seen in the information given to support referrals. Here 34.1% of referrals had no relevant details given, for example regarding any known risk issues. This may be a result of the type of referrals made, with the Consultant giving little information in writing but discussing it more fully with the Team.

These findings would suggest that the Service is experiencing difficulty creating effective treatment options for such a varied client group. The need to balance short term therapy using a maximum of 16 sessions, a recommendation made within the NICE guidelines, with long term support of someone with complex needs is very

difficult. This is possibly made harder by the CMHT misunderstanding the role of the Psychologist when organising the care of an individual with severe mental health issues.

These results indicate that the Psychology service needs to consider different ways of using their limited resources in order to meet the demands of the CMHT. Group Therapy has been proved by the evidence presented in the introduction to be an effective intervention, as beneficial if not more so in some cases than individual therapy. In terms of which area should be targeted in order to create the necessary changes there are options. Firstly, to improve the service provided for those with more severe mental health needs, groups could be set up specifically for these clients. From the research these would be homogenous groups that focus on specified areas for change, for example self esteem. Rather than expecting the client to improve to such an extent so as to enter the 'normal' population, the therapy would provide life skills that would help the individuals to function better alongside others.

The second option would be to create a more heterogeneous group that is aimed at the more common referrals, for example Depression and General Anxiety Disorder. These groups should be more short term and their aim would be to return the client as much as possible to their previous functional level. This option would mean that the Psychology service would then have more resources to focus on those who require long term support.

The information gathered in the second research question suggests that those individuals referred in 2005 would have been appropriate in terms of being potential group members following Yalom and Lesczc's (2005) selection and exclusion criteria. For selection, most of those referred were psychologically minded enough to be open to therapy having found it successful before (63.2%), although if they were not thus, it may be expected that they would also have found individual therapy difficult. Also the majority (77.8%) were motivated to change. In regards to exclusion, all categories considered, for example levels of paranoia and suicidal thoughts indicated that the vast majority of those referred would not have been excluded as a potential group member.

This audit does have limitations and these should be taken into account. Firstly the small sample size means that some of the conclusions drawn could be exaggerated. Secondly the audit has been limited due to the differing level of information contained within referral letters which were one of the main sources. This is a point for the future in itself as at the moment this may limit the Psychology department's ability to prioritise cases. Perhaps something more standardised, such as a referral form would direct the Psychiatrists more in providing the information needed to make decisions.

However, this piece of work's main limitation has been the fact that it has not answered some important questions in terms of the individuals who are not referred to the Psychology service. An assumption could be made that there is a number of people, particularly those with more severe difficulties, who are being supported by the Team without input from Psychology. Due to the Medical model that this Team works in, often more physical treatments are attempted first, for example there is a large ECT department. However it is difficult for the Psychology department, with the issue of their limited resources, to be aware of these people and to keep track of their involvement with the Team. A useful follow up in the future would be to look at all the referrals to the CMHT, rather than just to the Psychology department, to follow all the treatment paths taken and to look at outcome. This would provide a bigger picture of the CMHT as a whole, the choices that are made in terms of intervention and the levels of success for the individual.

From this point options in terms of which would be the most beneficial group for this team would also be extended. For example we will have a better idea of the mix of individuals involved and not just necessarily the people who are directly referred to the Psychology service. Then, referrals could be made by the CMHT to the group, rather than have to select from those firstly referred to Psychology.

This audit has provided a good picture of the types of disorder referred to Psychology, where the gaps are and what could be done in order to make the Service more effective. The next step in this process is suggested through looking at referrals to the CMHT, overall treatment choices and levels of outcome.

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LITERATURE REVIEW:

THE POTENTIAL ROLE OF THE CLINICAL PSYCHOLOGIST IN PROVIDING SUPERVISION FOR THE PSYCHOSOCIAL ASPECTS OF A PALLIATIVE CARE NURSE'S ROLE: A LITERATURE REVIEW

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Word Count: 5040

INTRODUCTION:

The aim of Palliative care is the provision of both physical and psychological support for the patient and their relatives as the individual approaches the end of their life. In cancer care particularly, it is well recognised that the physical state can lead to psychosocial difficulties (Uitterhoeve, Duijnhouwer, Ambaum and van Achterberg 2003). Recent figures suggest psychological distress is evident in between 20-60% of cancer patients with 12- 30% experiencing clinically significant anxiety problems and up to 40% experiencing clinical depression (Botti, Endacott, Watts, Cairns, Lewis and Kenny 2006). As the decision is made to cease curative treatment these rates of distress understandably rise and affect both the patient and those around them.

The Palliative Clinical Nurse Specialist (PCNS) therefore has a very demanding role requiring them to use not only their medical skills to alleviate symptoms but also to be able to respond effectively to emotional distress (Keidel 2002). This level of involvement has been shown repeatedly in the literature to lead to personal emotional consequence (Vachon 1998, Kendall 2007, Blomberg and Sahlberg-Blom 2007). It appears to be both the breadth of the role and its inherent expectations that cause this stress (Kendall 2007), in spite of the skills that the PCNS possesses.

Several programmes have been discussed in the literature that are designed to support the nurses and reduce their stress levels. These include the introduction of 'Clinical Supervision' (Jones 2000, 2003, 2006), 'Communication Training' (Heaven, Clegg and Maguire 2006) and instruction in self care techniques (Witt Sherman 2004). However there are still significant stress levels found in PCNSs working in this area (Skilbeck and Payne 2003). This suggests that this support is not yet adequate to ensure the PCNS can function, confident in her own skills and aware that she is backed up by her colleagues.

As clinical psychologists, we are now being employed in these teams to work alongside PCNSs in an interdisciplinary format (Haley, Kasl- Godley, Kwilosz, Larson and Neimeyer 2003). One role within this team may be to use our insight into such areas as stress and relationships in order to begin to understand the position of these nurses and to reflect on why they are becoming stressed. With this information we may then be able to offer more directed support to reduce their stress.

In this literature review we will begin to explore some of the literature pertaining to the above factors and start to formulate some important questions (see Appendix 1 for search strategy): How confident are PCNSs in being able to provide such complex support? How does it affect them emotionally? How effective is the support that they are offered? Where can the clinical psychologist fit into this picture?

Nursing: A Stressful Profession:

On a 'stress league table' (Rees and Smith 1991 cited in Butterwoth, Carson, Jeacock, White and Clements 1999) nursing is in the top three jobs leading to stress. As more responsibility is placed on nurses and their working conditions deteriorate, ever greater numbers have to take time off due to stress, prompting concern and research into the area (MacLeod 1997 cited in Severinsson 2003, Edwards et al 2000). 'Burnout' or 'Stress' are terms used widely in the research. Although there is no standard definition, one used in Maslach et al 1986 (cited in Edwards, Burnard, Coyle, Fothergill and Hannigan 2000) states that burnout is "a syndrome of emotional exhaustion, depersonalisation and reduced person accomplishment that can occur among individuals who work with people in some capacity". The symptoms of burnout and stress include emotional difficulties such as depression and anxiety as well as more physical problems such as appetite disorders and memory disturbance (Baumrucker 2002).

Burnout in nurses is thought to be particularly dangerous as, in some cases, it has been found to impair not only their psychological well being, but also how they actually function in terms of the quality of patient care they provide (Severinsson 2003, Keidel 2002). Due to the understandable focus on patient care in the NHS, this fear of reduced performance appears to outweigh the more personal risk for the nurse's psychological well-being (Davey, Desousa, Robinson and Murrells 2006).

The Particular Stressors of Being a Palliative CNS:

Background:

The role of a PCNS is recognised as being one of the most challenging and potentially stressful within the nursing profession (Barnard, Street and Love 2006). The reason for this higher risk is believed to be within the unique nature of the role (Keidel

2002). The primary role that a nurse would expect to hold is the provision of health care to their patient aimed at reducing their symptoms. However recently the focus of care for this client group has shifted and emotional care and support for both patient and family is seen as a key component of the role (Skilbeck and Payne 2003). This has lead to the position in which the one professional is expected to provide both physical and emotional components of a patient's care. Keidel (2002) referred to this resulting in these nurses having a 'Special Vulnerability' in terms of being at risk of developing stress due to the complexities of balancing these two very different roles.

This is also in the context of the PCNS having to work closely on a daily basis with those who are dying. This can understandably provoke an emotional reaction (Botti et al 2006, Vachon 1998) and it is widely recognised that working with this client group can lead to intense personal pain for the nurse (Rich 2005). This experience of pain is contributed to by both the repeated loss of patients and the constant reminder of death and therefore their own mortality (Rich 2005). Kendall (2007) talked of the nurses' recognition of the intense tragedy of a patient's experience. Perhaps because of this emotional intensity, heightened within the close relationships nurses are encouraged to have with patients, PCNSs form close attachments to patients (Kendall 2007). In terms of the patient's experience this may be beneficial and we will discuss this later, but it can have a high emotional cost for the nurse. When that patient later dies the nurse may feel an "acute sense of loss, both professionally and personally" (Rich 2005 page 141). The process or acknowledgement of grief is largely denied to the PCNS as she has to move on to the next patient (Rich 2005). This can be dangerous as the PCNS can become stressed and acutely aware of the fact of death which leads to anxiety around their own and loved one's mortality (Rich 2005). This heightened awareness and fear can lead to the development of "death anxiety", which can have an impact on both the PCNS's emotional state and her ability to function as a nurse (Rich 2005, Boyle and Carter 1998).

The Basis of the Emotional Support Nurses are Expected to Provide:
The development of a 'therapeutic relationship' with a patient is becoming seen in the literature as the main vehicle of the PCNS being able to provide the emotional component of their role. An expectation is forming that nurses have the knowledge

and skills that equip them to be able to intimately understand each patient's experience of their illness (Kendall 2007).

This therapeutic relationship is now seen as a crucial part of the role of a specialist PCNS (Canning, Rosenberg and Yates 2007). Within the literature there are many definitions of a therapeutic relationship in this context. Canning et al (2007 page 223) use the description of Cutliffe et al (2001) when they proposed that "the therapeutic relationship is demonstrated in the establishment and maintenance of a partnership between the SPCN (Specialist Palliative Care Nurse) and the client and their carers, and by 'knowing' the patient". Bernard, Hollingum and Hartfiel (2006 page 6) refer to Pusari (1998) and state " the care associated with terminal illness demands…the qualities and skills that arise from communication, reciprocity, professional commitment and the ability to communicate with patients and their families". Wallace (2001 page 86) states that "The uniqueness of this communication of care in nursing lies in the components of knowledge, honesty and trust which form the basis of the therapeutic relationship".

Research shows that nurses do develop very good relationships with patients and that this is very important. This process appears to evolve from the interpersonal communication that occurs between PCNS and patient (Skilbeck and Payne 2003). From the very first time that they meet, nurses will try to engage with the individual and connect with their experience leading to the establishment of a rapport (Davies and Oberle 1990 cited in Skilbeck and Payne 2003). This therapeutic relationship is further enhanced by the use of comfort, touch and empowerment (Skilbeck and Payne 2003).

It is clear from the literature that the development of a relationship with the PCNS is vital for some patients and can improve symptom control as well as lead to reduced anxiety (Wallace 2001, Canning et al 2007). The ability to talk openly about their experience and related fears has been shown in research to be very important and makes the patient feel safe (Skilbeck and Payne 2003). This extends to the family who respond well to having a relationship with the PCNS who can provide them with the information they need as well as giving emotional support and understanding (Canning et al 2007).

However it is also clear from the literature, that it is mainly the process of building this relationship that leaves the PCNS vulnerable to stress (Canning et al 2007). The skills required to develop this type of relationship with a patient appear to be expected of the nurse as a pre-existing personality trait (Barnard et al 2006). It is reported that this mixture of personal qualities and caregiving skills is the quality that makes palliative care nursing such a speciality (Canning et al 2007). In discussing communication skills as the foundation of building rapport, Wallace (2001) states that far from communication being a complex art, the nurse just needs to have good interpersonal skills and to have awareness of her own attitudes to be able to initiate, maintain and close a therapeutic relationship (Chauhan and Long 2000 cited in Wallace 2001).

This view appears to ignore the collaborative nature of such a relationship and the complexity involved in initiating such an interaction, particularly in the context of such an emotionally intense time (Skilbeck and Payne 2003). Instead there is an assumption that all patients in this position will freely and obviously provide cues that they wish to discuss their feelings and that the nurse, despite her workload, will easily recognise these signs (Skilbeck and Payne 2003).

This assumption extends to the idea that this 'special' quality of palliative care nurses also protects them from stress and allows them to cope with their role. Barnard et al (2006) discuss the understanding that the personal values that the nurse holds creates meaning in such circumstances and that this helps them to work with this client group.

Therefore the literature regarding therapeutic relationships appears to be too simplistic and makes assumptions that are not held up by the research. The relationship is an important factor but can the nurse do this role simply by virtue of her own personality traits?

Difficulties Involved in Meeting Emotional Needs of Patients:
It appears within the literature that PCNSs struggle with the emotional side of their role and feel that they do not have either the skills or capacity to be able to perform it (Botti et al 2006). In terms of capacity nurses refer to the difficulty in balancing the medical aspects of their role with the psychological in the wider context of their heavy

workloads. Botti (2006) reported that nurses struggled with the fact that the times that they had available to talk were inconvenient for the patient. For example often they noted that patients wanted to talk during the night when the nurse had other patients to attend to.

Building Boundaries:

It is the nurse's struggles to define a therapeutic relationship, and her anxiety about her skills that can lead to stress. In defining this type of relationship, a crucial aspect is the need for the nurse to set up personal boundaries, for example limiting the personal information that is divulged to the patient (Botti et al 2006). This is designed to protect the nurse in terms of defining the relationship as one that is professional as opposed to a personal friendship. However it is reported in the literature that nurses still find this very difficult and feel that they are drawn into the emotional world of the patient (Barnard et al 2006, Botti et al 2006). The nurses interviewed by Barnard et al (2006) spoke of sharing more information and developing deeper relationships with both patients and families than was appropriate. They referred to this as 'journeying with the patient' through their illness and recognised that this intensity can lead to the nurse becoming very vulnerable and experiencing profound grief when that patient inevitably dies (Barnard et al 2006). Despite this and the attempt to build boundaries the nurses spoke of it being just the cost of being a PCNS. Botti et al (2006) referred to this as some patients getting 'under the barrier' and reflect that this is hard to avoid.

'Blocking':

'Blocking' refers to the behaviour of the nurse when she feels inadequate to deal with emotion and blocks the attempt of the patient to talk, either by becoming too focussed on the medical role or leaving the situation prematurely (Blomberg and Sahlberg-Blom 2007, Uitterhoeve et al 2003). It has been found in the literature that this is quite common and is used by nurses as a strategy to avoid having to have emotion- laden conversations that they feel unable to contain. An example would be prioritisation where a nurse would attend to symptoms that they considered easy to alleviate rather than talk to a patient about their worries and anxieties (Blomberg and Sahlberg- Blom 2007). In one study by Wilkinson (1991 cited in Skilbeck and Payne 2003) they found that blocking behaviours were used 50% of the time.

Possible reasons given for this avoidance behaviour were fear of death, anxiety, lack of time and lack of skills training (Wilkinson 1991 cited in Skilbeck and Payne 2003). It appears to indicate both a lack of confidence in being able to deal with consequent emotion, and a way of protecting themselves from thoughts of death.

This evidence from the literature appears to show that nurses actually do not feel confident in providing what is said to be a crucial part of their role. But why is this? As was mentioned earlier researchers have previously made assumptions that these nurses should be able to instinctively develop these relationships, maintain them and then deal with the inevitable death due to their personality traits. If this is not the case, what training and support do the nurses receive to assist them in their work and how useful is this to them?

Self- Care, Communication Training and Supervision As Support:
Self Care:

Within the literature, alongside the idea that the PCNS possesses special personal qualities that enable her to fulfil her role, there is also a belief that they can protect themselves from any emotional stress as a result of their work (Barnard et al 2006). Therefore the idea of promoting self- care strategies to enhance this ability is discussed in the literature (Baumrucker 2002). Witt- Sherman (2004) discussed such a self-care strategy she terms 'Insulation against Stress'. She states, "Nurses must recognise their stress reactions and symptoms and employ self- care strategies to replenish themselves in physical, emotional, mental and spiritual ways in order to overcome the various sources of stress" (Witt- Sherman 2004 page 53). This programme is based on ideas from meditation, contemplation and visualisation. For example she suggests that nurses, while washing their hands, visualise that they are washing away their stress and uncertainty (Witt- Sherman 2004).

These strategies or programmes are highlighted as being useful in terms of being able to separate work from home and creating a balance to life which is very important in lessening the impact of stress (Byrne and McMurray 1997 cited in Keidel 2002). In the literature it is stated by Keidel (2002) that there are actually only two ways for a nurse to cope with stress within the workplace. The first is to change their practice and the second is to accept that they can't do anything in certain situations and

adapting to this. Therefore they require self-care skills in order to acknowledge this and to move on with no adverse emotional reaction.

Obviously it is important for a nurse to be able to be resilient and to be able to look after herself within these situations. However, relying on nurses to monitor their own functioning in this way seems to place the responsibility for not becoming burnt out onto the nurse (Baumrucker 2002). As a measure to protect the well being of the nurse this seems to increase stress rather than to reduce it. As both Baumrucker (2002) and Keidel (2002) admit, when an individual is stressed they are usually so involved with their work that they lose the insight to be able to acknowledge this fact. This has been highlighted in the literature when we discussed how nurses admit that they struggle to separate their work and home life and allow some patients in under their barrier (Botti et al 2006).

Communication Training:

It has been recognised in the literature that initiating and maintaining a therapeutic relationship relies on the nurse having good Communication skills. In their literature review Kruijver, Kerkstra, Ada, Bensing, van de Wiel and Harry (2000 page 25) state that, "the communicative behaviours of nurses seem to play a crucial role in meeting the cognitive and, more especially, the affective needs of patients with cancer". When working with patients with cancer an emphasis is placed on the emotional needs of the patient with the nurse being empathic and facilitative in order to help the patient cope with their diagnosis (Kruijver et al 2000).

However, as previously discussed it appears to be this communication that is most difficult for the nurse to realise, leading to a gap between the patient's need for support and the nurses' ability to provide it (Kruijver et al 2000). This discrepancy appears to be acknowledged by the nurses. McCaughan and Parahoo (2000) found that nurses feel that they need more knowledge and skills in providing psychosocial care and communication.

In an attempt to support the nurses in closing this gap a programme of providing communication training was devised (Heaven, Clegg and Maguire 2005). PCNSs attended eight three day communication skills workshops over a two year period.

Immediately after the course the nurses had become more competent with some aspects of communication, for example recognising patient cues. However, over time this was found to diminish and there was no transfer of behaviour. In other words, despite initial improvement, this was not sustained and the nurses returned to their previous strategies of blocking and distancing.

The reason for this failure in generalising skills from training to practice was discussed by Skilbeck and Payne (2003). They reflected on the fact that an assumption made when devising these training programmes was that these skills can be defined behaviourally and then reliably taught and assessed. They fail to consider the communication style of the patient and the intense emotion which may make the communication at this stage more complex. As with the literature on developing the therapeutic relationship, the research in communication skills appears to provide too simplistic a picture in relation to the complex task expected of the nurse.

Interestingly however, Heaven et al (2000) did find that if the nurses were then simultaneously given clinical supervision this facilitated their development in providing effective communication. Being able to discuss a case on a regular basis and reflect on the process and content of the conversations they had had with patients enhanced their confidence and ability to offer the emotional support that was needed.

Clinical Supervision:

Clinical Supervision (CS) has only recently started being introduced into some specialist areas of nursing. The Nursing and Midwifery Council stated in 2003 that CS is important in terms of clinical governance and the appropriate delivery of patient care (NMC 2003 cited in Jones 2006). This is also reflected by the Department of Health who are becoming increasingly aware of the value of CS (DOH 1999 cited in Edwards et al 2006).

In the general literature CS is also being thought of more as a valuable preventative measure against burnout (Hawkins and Shohet 2000) as well as a tool that can both improve nursing practice (Jones 2000) and the emotional health of nurses (Bond and Holland 1998). Research into the area has shown positive effects of CS both for PCNSs and nurses in other specialist areas such as Mental Health.

In his series of studies, Jones (2000, 2003 2006) provided psychoanalytically informed group supervision for PCNSs. The basis of his ideas was the work of Bion (1962) and Klein (1942) on projective identification. His theory was that patients going through the palliative process would unconsciously project their negative emotions onto the nurse caring for them. Therefore the purpose of CS would be to help the nurses to not feel overwhelmed by these complex feelings (Jones 2003). The nurses in CS were given the opportunity to reflect on the process that was occurring between them and the patient and come to an understanding of their own internal world and what Jones terms the 'life- world' of the palliative experience (Jones 2000). The nurses described supervision as providing them new and experiential ways of looking at their jobs (Jones 2006), to voice their experiences of palliative care (Jones 2000) and to gain a more psychological perspective of the process that they witness daily (Jones 2003). However it was also reported that nurses found CS itself stressful due to having to share very personal information with groups of their peers (Jones 2006).

These contradictory findings reflect much of the research on CS in a nursing context. There is little agreement regarding the extent to which CS is helpful and effective in reducing stress (Edwards et al 2006). Part of this confusion is because of a perceived methodological weakness within the early literature (Teasdale et al 2001) due to a concentration on individual research and the dependence on subjective opinion (Hyrkas, Appelqvist- Schmidlechner and Haataja 2006). This contradiction is seen in a variety of research findings, from the positivity of Jones (2000, 2003, and 2006) and Butterworth et al (1999) to the negative findings of Teasdale et al (2001) who found no change in stress levels after CS.

This confusion and contradictory research appears to extend from the basis of how CS has been defined in Nursing and how it's perceived benefits have been set out to the nurses.

The main concern is that there has been no clear definition of CS for nurses (Cleary and Freeman 2007, Davey, Desousa, Robinson and Murrells 2006). This means that there is no consensus on how CS should be organised and operationalised within

nursing. Therefore a 'patchy' pattern of the use of supervision has appeared using models which, Cleary and Freeman (2007) reflect, may not be appropriate for the differences within the care context. It also means that CS has become a non-mandatory requirement for nursing which is in contrast to the way CS is set up within other professions, for example clinical psychology (Cleary and Freeman 2007). Again this sends the message that CS is not a useful resource to provide regular support but something that you may only need when in difficulty.

This uncertainty has lead to a great deal of anxiety and suspicion amongst nurses regarding the 'actual' purpose of supervision. When supervision was first developed as a strategy within nursing one of the key elements identified was its potential to improve patient care (Johns 2004). This appeared to have come before a desire to improve the working lives of the nurses. This decision has confused the role of CS as a facility to share and learn through experience with the idea of supervision being used as a managerial control over the nurses. Davey et al (2006) discuss how quickly nurses can perceive CS to be, "an invasive managerial tool used for performance monitoring, assessing 'coping abilities' and managerial discipline" (Davey et al 2006 page 239). The anxiety that this provokes in the nurses leads to them resisting the implementation of supervision due to a misunderstanding of its aims (Bishop 1998).

The choice of model used is also something that has possibly reinforced this anxiety of a managerial focus on the nurse's abilities and resources. In nursing, supervision is set up as a reflective process (Johns 2004). It concentrates very much on the nurses lived experience and their internal processing of a situation. Johns (2004) refers to the concept of "reflection-within-the-moment" wherein the nurse will be able to attend to their own thoughts, reaction and emotion at any given moment. This is then enhanced by being given opportunity to reflect afterwards on that moment, using it as a tool to develop self-awareness (Johns 2004). The nurse can then use this awareness to develop their clinical practice. Nursing supervision also usually occurs within a group situation rather than on an individual basis which is common in psychologists. This adds the concept of group dynamics to the process of the nurses' reflection.

Although this can be useful for the nurse in order to understand a situation from her perspective, shaped by her beliefs, this again places the responsibility within her. It

does not acknowledge the external factors at play and the complexity of the patient and their emotional state and the impact that this will have on the situation (Skilbeck and Payne 2003). Using these models, Davey et al (2006) spoke of an unmet need for Nurses in being able to further their skills through supervision.

This suspicion and uncertainty have created a situation in which nurses are unsure about the aims and value of CS. With the higher risk of stress involved in palliative care nursing this can create a barrier in terms of them being able to receive adequate support, particularly in the psychosocial aspects of their role.

Why Study This Psychologically and the Potential Role of the Clinical Psychologist:
In the latest NICE guidelines (2004) a new model was devised to think about the psychosocial skills expected of those working with patients with cancer and palliative care. Within this model there were four levels of competence. Level 1 refers to those who have contact with patients but who are not expected to provide emotional support. Level 4 is the highest level where there is an expectation that the professional will be fully trained and competent in discussing difficult topics with these vulnerable patients. Based on this model a PCNS would generally be at Level 2, therefore expected to have some communication and possibly counselling skills. A clinical psychologist would be expected to be at Level 4, able to use a variety of models and skills to provide effective emotional support.

As a part of this model there is an expectation that clinical psychologists and PCNSs will work together as an interdisciplinary team (Haley, Kasl- Godley, Kwilosz, Larson and Neimeyer 2003). The aim will be for the clinical psychologist to 'filter' their specialist psychosocial skills to the rest of the team. This will provide a framework in which the clinical psychologist will both supervise the psychosocial work of the Nurses and provide support for both their emotional health and the well being of the patient (NICE 2004).

As clinical psychologists we have a firmer belief in the value of supervision and a more definitive idea of its aims. As a psychologist, our professional body, the British Psychological Society (BPS) recommends regular supervision with a peer, a minimum of once a fortnight. The aim of the supervision we receive is to keep

perspective on the 'big picture' as well as providing space to reflect on our own emotions and reactions and an opportunity to develop our understanding of the therapeutic relationship, and the process and function of it. The British Association for Counselling and Psychotherapy (BACP 1996) defines supervision as, "…a process to maintain adequate standards of counselling and a method of consultancy to widen the horizons of an experienced practitioner". The crucial aspect of supervision is this multi purpose; it gives the practitioner space to think about the process of therapy, to explore the psychological impact of their work on themselves and to develop working hypotheses while also protecting the best interests of the client in the relationship (Fleming and Steen 2004).

Gaps in Research:

To summarise, from the literature concerning the role of a PCNS and the supports that they receive I have found a number of discrepancies which provide the basis for my research. Firstly the PCNS is expected to fulfil an emotionally focussed role for the patient using a therapeutic relationship. However she is assumed to be able to do this by virtue of her existing personality traits rather than by having had extensive training in developing these complex relationships. This we have seen the PCNS does not feel confident to do, and indeed within the NICE (2004) guidelines she is not expected to have these skills as defined by the Level she is placed at.

Secondly, in terms of support we have seen that the PCNS either does not receive adequate training for their role or is anxious about the purpose of the supervision offered. Instead assumptions are made regarding their pre-existing 'people- skills' being adequate for the purpose of building relationships which are more complex than the literature allows.

Therefore the focus of my research will be to explore the support needs of PCNSs (Barnard et al 2006) in an attempt to use the role of the clinical psychologist to provide directed and useful support. As a result we will hopefully be able to think of a model that adequately boosts the confidence of these nurses in providing the needed emotional support, but in a way that does not dangerously increase their stress levels.

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APPENDIX 1: SEARCH STRATEGY

Initial Ideas:

The initial ideas for focussing on the role of the clinical psychologist within a palliative care team came through discussions with my supervisor who had recently taken up such a post. She voiced concerns regarding both the amount and complexity of work that the PCNSs she was working with were expected to do and the minimal nature of clinical supervision and practical support that they were given.

In order to explore these issues my initial reading focussed on what was understood by the term clinical supervision in a nursing context. This mainly relied on general textbooks that provided a background perspective. I also began to explore literature that described the stress and burnout that these nurses were experiencing within their jobs. From both of these angles I gained some key names and information which I then used to dictate a more detailed literature search.

Focus of Ideas and a Systematic Search:

After having gained a general knowledge of the area, I then began a more detailed search. Using the names and papers I had already identified I looked for relevant research specifically around the role of the PCNS, the expectations placed on them, the stress they were experiencing and the support that they received. It was through this process that I began to identify gaps in the literature. Having identified gaps, I then searched more in these areas to determine whether these had been filled since the publication of earlier articles. In effect I went through this process twice, once early on in thinking about the project and again very recently while writing this review.

Databases Searched:
- PsychInfo
- PubMed
- Cinahl (Cumulative Index to Nursing and Allied Health Literature).
- Web of Science
- Dialog Datastar
- Cochrane

Search Terms:

Below are some examples of search terms used:

- Nursing and Clinical Supervision, Supervision of Nurses
- Models of supervision in nursing, themes of nursing supervision
- Burnout and palliative care, burnout and end of life care, burnout and Macmillan nurses
- Roles of Macmillan nurses, emotional care and Macmillan
- Stress risk and Macmillan, stress risk and palliative care
- Therapeutic relationship and Macmillan, therapeutic relationship and nursing

Some terms were also combined to search the databases for relationships between themes, for example therapeutic relationship and stress. When this was done Mesh and Boolean techniques were used.

Website Searches:

As well as searching databases I also used websites such as Google and Google Scholar to explore other relevant information on the internet. I accessed Government websites such as the Department of Health and NICE to explore recommendations that were related to my research area.

Reference Searches:

I used the reference sections of all the articles I read to identify any other relevant research which I then found through the databases or search engines. I also identified relevant authors who I then searched for. This helped to ensure that I had not missed any literature.

I also searched through the citation indexes of research that I found on the databases and in search engines. This helped to identify more recent relevant research.

General Comments:

It is interesting to note that most of the research I found for this project comes from the UK, Australia, Finland and Sweden. I have used papers from these countries throughout my research as all were relevant to the questions I was asking and were consistent in their outlook on the topic.

THESIS

Examining Clinical Supervision with Palliative Care Nurses

A thesis submitted in partial fulfilment of the requirements of the University of Hertfordshire for the degree of DClinPsy

Elizabeth Mary Dixon

July 2008

CONTENTS

METHOD

RESULTS

ABSTRACT:

This study focuses on the current issues regarding the provision of clinical supervision for palliative care nurses. NICE (2004) recommendations stated that the task of supervision should be undertaken by 'Level 4' practitioners such as clinical psychologists or psychiatrists. Palliative care nurses are recognised to experience high levels of stress due to the emotionality of their role. However there appears to be little understanding of how they cope with this aspect of their role. Self care is promoted as a useful strategy; however this is thought to have limitations due to the questionable ability for an individual to objectively and accurately assess their own mental and emotional state. Clinical supervision has been attempted with palliative care nurses but this appears to focus on the internal world of the nurse rather than the interaction between nurse and patient.

This study employed a staff survey, including a demographic questionnaire, the Copenhagen Burnout Inventory and the General Health Questionnaire, followed by individual interviews and focus groups analysed using thematic content analysis. Participants were recruited from two teams within one cancer network.

Results showed that there was an incidence of both high stress and psychiatric morbidity within the sample. Provision of clinical supervision was shown to be inconsistent across the two teams. Although there was recognition that clinical supervision would be beneficial, there was a certain amount of confusion regarding the concept as well as suspicion about the 'real' agenda. These factors appeared to work together to produce a situation in which clinical supervision was not being provided or accepted in a way that would maximise its efficacy as its application was inconsistent with the theoretical basis.

In conclusion, in order to better support palliative care nurses with the difficult aspects of their role, it was suggested that a more structured and consistent picture of clinical supervision was provided. This would enhance their practice, support their emotional needs and protect the patients under their care.

CHAPTER 1: INTRODUCTION:

1.1 Service Context:

In recent years cancer services and palliative care have become one of the most complex areas of the NHS (NICE, 2004). Current figures suggest 230,000 people are diagnosed with cancer each year and cancer accounts for around a quarter of deaths within the United Kingdom (UK). The aim of services provided for these patients is to cover all their needs from diagnosis to either remission or the point where curative treatment has ceased and they enter palliative care. The needs identified for this patient group include not only symptom control but also social, spiritual and psychological care both for the patient themselves and their families.

However the National Cancer Patient Survey (2002) showed that quality of services was inconsistent across the country. It suggested that poor inter- professional communication and co-ordination led to sub-optimal care. To address these issues the National Institute of Clinical Excellence (NICE, 2004) laid down guidelines which aimed to both centralise and streamline cancer and palliative care services. Cancer Networks were developed to act as partnerships of organisations that stretch across counties. Their aim is to ensure effective planning, service delivery and monitoring of care (NICE, 2004). Within this framework different professionals from both health and social care can work together creating better co-ordination of care for all needs of the patient (NICE, 2004).

This move towards a multidisciplinary model of working is in line with shifts across the NHS. It is seen as a move away from the hierarchical structure prevalent within the NHS since its conception. Instead of decisions made by doctors in isolation, teams of varied health professionals are asked to reach joint decisions that best meet the needs of the patient. The aim is for the whole team to work as one unit. Nolan (1995, cited in Wilson and Pirrie, 2000 page 306) stated, "Interdisciplinary care, although not denying the importance of specific skills, seeks to blur the professional boundaries and requires trust, tolerance, and a willingness to share responsibility." However there are drivers that can determine its effectiveness in practice. The most important, as discussed by Wilson and Pirrie (2000), are the clarity of roles within a team and their intercommunication. To achieve maximal functionality and the sense of the team

operating as one unit, all relevant responsibilities have to be shared between professions with each profession also taking the lead in roles that match their particular skill set.

1.2 Three Roles of the Clinical Psychologist within a Palliative Care Team:

When NICE (2004) revised their guidelines regarding cancer services and palliative care, there was an increased focus on provision of specialist psychological care. Previously there was recognition that dying patients needed emotional support, but it was felt that this could be adequately met by the doctors and nurses in the team (Payne and Haines, 2002). More recently clinical psychology is becoming seen as a necessary component of palliative care teams. The biopsychosocial model moved away from a purely medical understanding of illness and began to appreciate the impact of both psychological and social factors on the illness experience (Haley, Kasl-Godley, Kwilosz D.M., Larson D.G. and Neimeyer, 2003). At the same time research suggested that provision of psychological support is a core component of good quality care (Payne and Haines, 2002). This led to the Department of Health (DOH 2000 cited in Payne and Haines, 2002) recommending increased psychological provision when designing care packages in cancer services.

It was proposed that clinical psychologists have three roles to play as part of the palliative multidisciplinary team. The first was provision of specialist psychological care for the patients and their families. The other two roles refer to the structures of personal support and clinical supervision within palliative care multidisciplinary teams. It was suggested that the clinical psychologist in the team would be an effective facilitator, both in terms of clinically supervising the psychosocial work that nurses do as well as providing more personal emotional support in this difficult role (NICE, 2004).

This study will focus on the process of how the clinical psychologist can best provide these services within a multidisciplinary team, and whether this is currently happening within palliative care teams.

1.2.1 Specialist Psychological Patient Care:

It is recognised that at the time of diagnosis approximately half of all cancer patients experience significant levels of anxiety and depression (NICE, 2004). Recent figures suggest psychological distress is evident in between 20-60% of cancer patients with 12- 30% experiencing clinically significant anxiety and up to 40% experiencing clinical depression (Botti, Endacott, Watts, Cairns, Lewis and Kenny, 2006).

Clinical psychologists bring a thorough understanding of complex psychological theories to palliative care and the ability to then translate these into specific interventions for either patient or family (Payne and Haines, 2002). As well as reactions such as anxiety and depression, areas clinical psychologists may cover include abnormal grief reactions, adjustment disorders, relationship and communication difficulties and symptom management (Payne and Haines, 2002). These interventions can occur across the patient's journey, from the point of diagnosis to preparing for death and supporting bereaved relatives (Haley et al, 2003).

1.2.2 Providing Case Related Supervision to Other Professionals:

Within cancer and palliative care services professionals from both health and social care backgrounds assess for and provide elements of psychological support (NICE, 2004). However in their report NICE (2004) suggest that some professionals may feel overwhelmed by this role and lack confidence in their decision making. The result is either patient's symptoms going unnoticed or inappropriate referrals being made for specialist help. This can lead to failure to provide adequate psychosocial support (Botti et al, 2006). Further, the report suggested that there were insufficient professionals with the skills to offer more specialist intervention as quickly as it was needed. In order to create a system in which all professionals felt supported enough to carry out their psychological role NICE (2004) made several recommendations regarding training, support and supervision. This would both boost confidence and mean that less referrals were made for specialist intervention. The main mechanism for this was the Model of Professional Psychological Assessment and Support (NICE, 2004).

In this model there are four levels of professional psychological support:

Level 1: Reflects the general ability of all health care professionals to recognise distress and provide appropriate support to both patient and family.

Level 2: At this level are professionals such as nurse specialists or GP's who are able to meaningfully assess the level of distress and the impact on patient and family and then provide some intervention in order to manage situational crises.

Level 3: Here specially trained professionals (such as social workers) are able to differentiate between moderate and severe distress and intervene using skills such as anxiety management and solution- focused therapy. They can manage mild to moderate anxiety or depression.

Level 4: Represents specialist intervention for complex difficulties from a highly trained professional such as a clinical psychologist.

Within this model professionals at lower levels receive support and supervision from those at higher levels, for example clinical psychologists. The aim is that this will ensure their confidence to provide adequate psychological support under the supervision of someone with more specialist skills. The result being that more patients will receive appropriate care from a confident and supported practitioner rather than having to be referred for specialist help that may not be required.

1.2.3 Providing Personal Support for Palliative Clinical Nurse Specialists (PCNS):

NICE (2004) propose the third role of the clinical psychologist within a palliative care team is to provide emotional support for the nurses. Being a PCNS has been described as one of the most challenging and potentially stressful roles within the nursing profession (Barnard, Street and Love, 2006). The research suggests that the major reason for this stress appears to be the emotional impact of the role (Barnard et al, 2006). The consequences of working so closely with dying patients and their families on a daily basis are beginning to be recognised and these are discussed fully. NICE (2004) have also recognised that they need to ensure nurses are given space to think about some of these issues.

Therefore the aim of clinical psychologists developing these two roles would be to both enable and support the nurses professionally and personally with the psychological work that they do (Payne and Haines, 2002).

1.3 Stress and Burnout Within the Nursing Profession:

The primary reason more effective ways of supporting nurses need to be considered is the rising incidence of stress and burnout within the profession. A stress league table (Rees and Smith, 1991 cited in Butterworth, Carson, Jeacock, White and Clements, 1999) found nursing to be in one of the top three professions at risk of stress. Taylor, White and Muncer (1999) stated that stress in nursing is a current global problem.

The current focus on targets and care outcomes in the NHS means more responsibility is placed on the nurse with a consequent deterioration in their working conditions. This has led to ever greater numbers taking time off sick, placing more pressure of the remaining staff and the NHS as an organisation. As a result research into the area has risen over the last few years (MacLeod, 1997 cited in Severinsson 2003, Edwards et al, 2000).

This research appears to reflect not only managers' worries about the well- being of their staff, but also the perceived danger to patient care posed by an over- stressed nurse (Keidel, 2002, Severinsson, 2003). Research by Severinsson (2003) has shown that stress can lead to an impairment of practice in the nurse which could be dangerous to both patient and organisation. At the current time Davey, Desousa, Robinson and Murrells (2006) are of the opinion that this risk outweighs concern regarding the psychological cost to the nurse.

1.4 The Specific Stress of a Palliative Care Nurse:

The role of the PCNS is seen as particularly demanding and one that can have significant emotional consequence for the nurse (Vachon, 1998, Kendall, 2007, Blomberg and Sahlberg- Blom, 2007). Due to the pressures of the role Keidel (2002) in her review of the factors associated with stress and burnout in hospice caregivers stated there is a "high risk" of stress for the PCNS.

1.4.1 Confusion as a Cause of Stress:

In 2002 Macmillan Cancer Research conducted a UK wide evaluation of different aspects of cancer care. One section focussed on the role of the PCNS, looking at their remit and the boundaries of their work (Seymour et al, 2002). The conclusions suggested a mismatch between the nurse's and manager's perception of the role

leading to ambiguity and confusion. One nurse interviewed in the study described it as a conflict, with expectations and pressure pulling in each direction. This paradoxical position meant that the nurses felt that they could not complete any aspect of their multifaceted role adequately which could lead to stress.

The clinical role of the PCNS presents further confusion due to the dual focus of medical intervention and psychological support. Recently the balance between medical and psychological in palliative care appears to have shifted towards the latter. One study estimated approximately two- thirds of all new referrals to the palliative multidisciplinary team were for psychological support (Skilbeck et al, 2002 cited in Skilbeck and Payne, 2003). Skilbeck and Payne (2003) reflect that it now appears to be the psychological role that the nurse provides which is most valuable as the patient nears the end of their life.

However this may represent a further conflict for the nurse. Kendall (2007) conducted a study exploring the impact of nurse- patient encounters on clinical learning and practice. As a nurse the aim is to protect and nurture towards cure; however in palliative care this aim is impossible due to the disease and its course. This view is shared by Keidel (2002, page 201) who suggests that nurses can, "struggle to straddle the medical world with its emphasis on cure and the hospice world of caring and providing comfort". McCaughan and Parahoo (2000) discussed the need for nursing in this area to redress the balance in terms of care and treatment away from the physical and towards the psychological needs of both patient and their family.

1.4.2 Nurses Lacking Confidence in Psychosocial Care:

Despite the increasing focus on psychological care, PCNSs have been shown to feel inadequate to deliver this type of service. McCaughan and Parahoo (2000) looked at nurse's self- reported levels of competence in various areas of care for cancer patients and their perceived educational needs. They found nurses felt they had only moderate psychosocial skills and wanted education in communication and helping the patient come to terms with their diagnosis. There was a perception that they were not given the time or the education to deal with the situations they found themselves in. It was also acknowledged that it is not easy to have conversations with patients about some

issues and that nurses need supervision to cope with this work (McCaughan and Parahoo, 2000).

Although this research was primarily done with surgical nurses, the findings are still of value as many of the issues listed as barriers to them providing effective psychosocial care mirror those seen in research done with PCNSs. Botti et al (2006) found that PCNSs struggle as their workload created an impediment to the delivery of psychosocial care as they did not have the time to have meaningful conversations with patients.

Further, research with PCNSs has suggested that this lack of confidence can be seen in aspects of their clinical work. Building boundaries refers to the need to define the relationship between nurse and patient as professional, for example through limiting the personal information that they divulge (Botti et al, 2006). Although nurses are found to recognise the importance of this boundary for their own sake, they still become drawn into the 'emotional world' of the patient (Barnard et al, 2006, Botti et al, 2006).

PCNSs were also found to use 'blocking' behaviours. This occurs when the nurse feels inadequate to deal with the emotion and therefore blocks the attempt of the patient to talk, either by becoming focussed on medical matters or by leaving the situation completely (Blomberg and Sahlberg- Blom, 2007, Uitterhoeve et al, 2003). In one study by Wilkinson (1991, cited in Skilbeck and Payne, 2003) they found that blocking behaviours were used 50% of the time.

However there appears to be a level of expectation that the PCNS can use their experience to cope with these issues. This is observed within research examining the therapeutic relationship between the PCNS and patient. There is an expectation that the nurse will quickly develop an intimate understanding of the individual's response to their illness and be able to communicate with them in a "highly skilled, sensitive, timely and person- centred way" (page 227 Barnard, Hollingum and Hartfiel, 2006). The ability to use therapeutic communication is central to this role and is said to be the primary medium of care (Wallace, 2001).

However, no clear picture appears of where the nurse gets these skills. Instead the ability to use therapeutic communication is thought to be an extension of the nurse's personal qualities. Barnard et al (2006) interviewed ten PCNSs in order to better understand the meaning of their role. The authors state that PCNSs need personal characteristics such as compassion, commitment and the ability to communicate with others. This view is shared by Canning et al (2007) who concluded in their study that the PCNS needs to have highly tuned communication skills and a genuine preparedness for difficult conversations. In both of these papers there is no explanation beyond that of experience as to how the nurse learns these difficult skills. Wallace (2001) in discussing the use of communication as a therapeutic tool states that there is actually "no mystery" (page 87 Wallace, 2001) involved in good communication and the ability to initiate, maintain and close a therapeutic relationship. All that is required in her opinion are good interpersonal skills.

This position fails to recognise that both nurse and patient contribute equally to the resulting interaction. As Skilbeck and Payne (page 524 2003) state, "there is an assumption that all patients give cues about how they are feeling, and that all nurses can recognise and act on these cues". This places an unrealistic expectation on the nurse (Kendall, 2007) and can leave them in a position for which, Keidel (2002 page 202) writes, "their nursing education and life experiences have left them ill prepared".

Research on the efficacy of the training that the PCNS does receive demonstrates insufficient support for this difficult task (McCaughan and Parahoo, 2000, Kruijver et al, 2000). Research into communication training was carried out by Heaven, Clegg and Maguire (2005). Although there were found to be initial improvements in the way the PCNSs used communication with patients, for example by recognising more patient cues, this was not sustained over time.

Skilbeck and Payne (2003) reflected on the fact that an assumption made when devising these training programmes was that skills can be defined behaviourally and then reliably taught and assessed. They fail to consider the communication style of the patient, the intense emotion and the environment which all may contribute in making the communication at this stage more complex.

1.4.3 Emotional Consequences for the PCNS:

The literature on the psychosocial role of the PCNS readily acknowledges that this position creates a risk for the emotional health of the nurse (Vachon, 1998, Canning et al, 2007, Burnard et al, 2006, Botti et al, 2006, Keidel, 2002).

Continual exposure to dying patients and the requirement to develop close relationships can result in "death anxiety" (Rich, 2005, Boyle and Carter, 1998). Boyle and Carter (1998) cited Tomer (1994) describing death anxiety as corresponding to fears concerning life after death, ceasing to exist and the fear of the dying process itself. This occurs when surrounded by death, reminding the nurse of their own mortality and that of their loved ones. It is reported to have an acute impact on both the nurse's views of themselves and the world as well as their ability to function as a carer.

PCNSs are also said to have to cope with feelings of intense personal pain and an acute sense of loss. Rich (2005) discussed the difficulties of not having space to grieve for patients, hypothesising that repeated loss and failure to acknowledge their feelings may result in "bereavement overload" for palliative care nurses. Kendall (2007) reflected on the danger of nurses beginning to recognise tragedy in patients and beginning to identify with their experiences. Kendall (2007) reported that this is even more prevalent if the patient is younger. For example the death of a child can produce immense emotional stress for a nurse; it is very hard not to view such an event without personal significance.

However, the process or acknowledgement of grief is largely denied to the PCNS as the system decrees that she has to move on to the next patient (Rich, 2005, Vachon, 1998).

1.5 The Current Stress Discourse and its Role in the Importance of Self Care:

In their study McCaughan and Parahoo (2000) suggested that nurses needed supervision in order to cope with the difficult situations described above. However in the literature there appears to be more of a focus on self care to avoid stress (Baumrucker, 2002, Keidel, 2002, Vachon, 1998, Canning et al, 2007).

In recent years it has become the responsibility of the individual nurse to monitor her stress levels and ensure that she does not become burnt out. Keidel (2002) states that there are two ways to cope with stress, either by trying to change their practice (problem focussed coping) or by accepting that they can't and adapting to that (emotion focussed coping). In another study it was found that the nurses who coped best were those taking care of themselves, keeping work in perspective and maintaining sufficient emotional distance (Byrne and McMurray, 1997 cited in Keidel, 2002).

This individualised view of nurses having to cope with their stress fits with the stress discourse examined in both the academic and social worlds. Currently there appears to be an inevitability regarding the presence of stress. It is something in life with which we must learn to cope (Mulhall, 1996, cited in Donnelly and Long, 2003). In fact it is seen as a 'good thing' in some cases, driving our ambitions and desires.

However if this stress becomes too much we are told it is likely to be harmful, leading to both physical and psychological illness. The responsibility for ensuring that this is not the case lies with the individual (Newton, 1995, cited in Donnelly and Long, 2003). This view has been used widely within the self help literature on stress. People are told clearly to "deal with stress" and that the way to do this is to alter some aspect of their self (Brown, 1999, Harkness, Long, Bermbach, Patterson, Jordan and Kahn, 2005).

In a work context, individualism has meant that managers are increasingly denying their responsibility for their staff, stating that stress is for the individual to monitor and manage (Kinman and Jones, 2005, cited in Harkness et al, 2005). This has lead to certain beliefs and practices regarding stress in the workplace (Harkness et al, 2005). Harkness et al's (2005) study with administrative workers discussed the dichotomy regarding expression of stress. If the worker does not come across as stressed to their colleagues, an interpretation is sometimes made that they are not working hard enough. The 'good employee' is the one who is giving their all while holding off stress through good stress management techniques. However despite this perception of stress as normal, there is a reticence to admit to it openly in the workplace

(Harkness et al, 2005). It is considered unacceptable to say that you are unable to cope with your stress levels as this may be construed by others as a personal flaw.

For nurses these beliefs about the stress discourse can be very difficult to manage because of the position it places them in. As employees of an organisation such as the NHS they are expected to conceal their emotions and stress levels in fear of being thought unable to cope and having a personality flaw. However they also have to use their feelings every day in order to be empathic to their patients. A 'good nurse' is the one who can be emotionally open and empathic with patients but also be in control of their own stress (Donnelly and Long, 2003).

1.6 The Use of Clinical Supervision to Reduce Stress and Enhance Practice:

1.6.1 Self care is Not Enough:

From this evidence regarding the stress discourse and the focus on individualised self care, the question has to be raised whether it is a realistic expectation that nurses manage their own stress? This question becomes particularly pertinent when considering the difficult environment of the PCNS and the constant emotional stimulus.

It is acknowledged that self care is an important factor in how nurses manage their emotional workload and that some individuals can monitor and reflect on the impact that this is having both personally and professionally. However it has been reported by Baumracker (2002) and Keidel (2002) that nurses suffering from burnout lack the insight enabling them to objectively assess their own level of stress.

It is also possible that it is difficult for the practitioner to identify their own reactions and emotions to the patient while with them. From a psychoanalytic perspective Jones (2003) discussed the ability of patients and families to generate powerful anxiety and to make unconscious appeals that may influence the professional working with them. Working in an environment filled with such strong feelings may lead to the nurse struggling with their own reactions to situations. For example Jones (2003, page 443) reflected on how nurses reported that they found it hard when "a dying person turns his or her face to the wall".

The argument that self care is not enough to protect nurses from the emotional impact of palliative care leads us to consider the use of clinical supervision as suggested by McCaughan and Parahoo (2000).

1.6.2 What is Clinical Supervision?

Clinical Supervision (CS) has many definitions as different authors have sought to explain the task and the factors that impact upon it. The British Association for Counselling and Psychotherapy (BACP) definition states that, "the task is to work together to ensure and develop the efficacy of the counsellor/ client relationship. The agenda will be the counselling work and feelings about that work, together with the supervisor's reactions, comments and confrontations" (BACP, cited in Fleming and Steen, 2004 page 2).

Scaife (2001, page 2) reflects on the difference between purpose and function within CS saying "the primary purposes of supervision are defined here as ensuring the welfare of clients and enhancing the development of the supervisee in work. In order to affect these purposes the supervision should perform the functions of education, support and evaluation against the norms and standards of the profession and society".

Finally Hawkins and Shohet (2006, page 3) focus on the supervisory relationship in stating that "the 'good enough'…helping professional can survive the negative attacks of the client through the strength of being held within and by the supervisory relationship."

As is demonstrated by the differences within these definitions there are many different understandings of how and why CS is useful. However the similarities point to CS providing a different environment in terms of the supervisory relationship in which the practitioner can consider their work with the client and begin to process both the client's and their own reactions to session material. Although it is a multi-faceted concept with different aims and objectives, core ideas include the need to protect the client (Scaife, 2001), to improve or enhance the skill of the practitioner (Hawkins and Shohet, 2006), learning (Holloway, 1995) and the exploration of the emotional impact of psychosocial work on the practitioner (Hawkins and Shohet, 2006).

1.6.3 What is Understood By the Concept of Clinical Supervision?

In order to explain further the functions and process behind the art of CS (Holloway, 1995), different authors have attempted to conceptualise it with theory. These models come primarily from general research looking specifically at CS, rather than 'belonging' to any particular profession.

1.6.3.1 Inskipp and Proctor (1993, 1995)

Inskipp and Proctor (1993) were interested in defining the purpose of CS. Their model describes three components which together make up what we understand to be the aims of CS. They term the components 'formative', 'normative' and restorative'. The formative purpose relates to the learning and development of the supervisee.

The normative considers the managerial responsibilities of the supervisor. In any supervision context the supervisor has to hold a moral and ethical stance in relation to the work being attempted with the client. It is here that the supervisor has to protect the interests and safety of the client. Working within an organisation such as the NHS the supervisor also has to hold in mind the requirements of that setting. For example what therapy represents the best outcome in terms of NICE guidelines and how many sessions should the client be offered. This role is problematic for the supervisor as they need to balance their responsibilities to the organisation against their relationship with the supervisee.

The restorative purpose of CS refers to the work done within the supervisory relationship to understand and acknowledge the emotional impact of work with people, particularly people in distress. Scaife (2001) discusses the different sources of emotional impact for the individual. These can be political, coming from the managing organisation, from relationships with colleagues, relationships with clients and in the individual's relationships with those outside of the work context. Inskipp and Proctor (1993) considered the need to explore each of these areas, although the focus was strictly on how these relationships influenced the work of the practitioner. They likened the restorative nature of supervision to the request of miners to be able to wash off the dust of their labours before returning home (Inskipp and Proctor, 1993).

1.6.3.2 Hawkins and Shohet (2006)

The Hawkins and Shohet (2006) Double- Matrix or Seven- Eyed Supervision model looks at the process of supervision. Taking the supervisor, supervisee, client and work context as essential elements of supervision they look at various modes that occur between these protagonists in any supervisory situation. These are a focus on the session content, exploring the specific strategies used by the supervisee, the relationship between the supervisee and the client, a more emotionally driven focus on the supervisee, the supervisory relationship itself, the supervisor themselves and finally the wider work context. Although all of these modes may not occur in each session, Hawkins and Shohet (2006) state that good supervision must contain elements of all seven different modes. They concentrate of training supervisors to be aware of each angle so that they do not become stuck in one mode and therefore limiting the benefit of the supervisory process.

1.6.3.3 Holloway (1995)

Holloway's System's Approach to Supervision (SAS) combines an understanding of the functions, tasks and context of supervision while holding the supervisory relationship at the centre as the core factor. The principles at the centre of the SAS are related to assumptions regarding empowerment and relationship. Therefore the goal of supervision is for the supervisee to learn in an effective and supported manner, within the context of a mutual professional relationship that involves the supervisee which gives power to both the supervisor and supervisee. In this manner the supervisee is said to be empowered by acquiring skills and gaining knowledge through experience (Holloway, 1995).

In the Holloway (1995) model the overall task of supervision is the teaching of the supervisee. Within this the functions are that of monitoring progress, instruction, modelling, consulting and supporting. The process of supervision is explained as the interrelation between these two points.

Although each of these models is based upon a different perspective of CS, there does appear to be some basic tenets that are central to each theory. Firstly, for 'good practice' in CS to exist there are a number of core issues including learning, development, client protection and emotional support that need to be addressed. These

do not necessarily have to be explicitly stated in each session but do have to be held in the mind of both supervisor and supervisee (Scaife, 2001, Hawkins and Shohet, 2006, Holloway, 1995).

Secondly that although personal matters are discussed within the CS context, this should strictly be in relation to the work with the client (Scaife, 2001, Hawkins and Shohet, 2006). Scaife (2001, page 41) makes the point that, "the exploration of personal issues and of self when undertaken with a lens that consistently focuses on relevance to and implications for the work is an essential component of an ethical approach. It may happen that such exploration is more generally beneficial to supervisees… this is serendipitous and not the purpose of supervision".

<u>1.6. 4 Issues That Can Impact on the Efficacy of CS:</u>
1.6.4.1 Supervision vs. Therapy:
One issue that Scaife (2001) states may adversely affect the success of a supervisory relationship is the blurring of the boundary between supervision and therapy. Due to the similarities between the role of supervisor and therapist, there is a risk that this line may be crossed. This is dangerous as moving from one position to the other may impact on the supervisory relationship as the supervisor would have gone into territory not permitted within the contract (Scaife, 2001, Hawkins and Shohet, 2006).

1.6.4.2 Trust and Suspicion:
The issue of trust is reported to be central in the development of a successful supervisory relationship. Hawkins and Shohet (2006, page 65) are of the opinion that a "good working alliance is not built on a list of agreements or rules, but on growing trust, respect and goodwill between parties". Without this level of trust between supervisor and supervisee it is unlikely that the supervisee will feel able to share either details of their personal life or encounters with patients. In their study, Ladany, Hill, Corbett and Nutt (1996, cited in Scaife, 2001) found that one of the main reasons for nondisclosure in supervision was the absence of a positive and trusting relationship between supervisor and supervisee. They went on to suggest that lack of trust within supervisory relationships was unsurprising due to the common power differential between parties. If you are being supervised by someone who is also a manager then it is difficult to overcome this in the interests of supervision. Further to

this they also found that the supervisee was more likely to discuss troubling matters with a peer, i.e. someone who may be considered less threatening.

One of the criticisms of CS is the very use of the word 'supervision'. Supervision gives the impression that someone is observing your work and monitoring your progress (Johns, 2004, Bond and Holland, 1998). As Holloway (1995) points out to supervise literally means 'to oversee'. It has been suggested that this can lead to the assumption that CS is a managerial tool designed to monitor effective practice (Bond and Holland, 1998). If this is the case then trust would be very hard to achieve which, Butterworth et al (1998) suggests, means there is no basis for effective supervision.

1.7 Clinical Supervision in Nursing:

CS is still seen as a relatively new concept in nursing although Bond and Holland (1998) make the observation that CS has actually been around for a number of years in nursing but that conclusions regarding its usefulness have yet to be made. This is not to say that various nursing bodies have not recognised the benefits that CS can have, reflected by the DOH who are becoming increasingly aware of the value of CS (DOH, 1999, cited in Edwards et al, 2006).

However there appears to still be confusion and disagreement within the nursing literature about the abilities of CS to reduce stress. On one hand it is thought to be a valuable preventative measure against burnout (Hawkins and Shohet, 2000) as well as a tool that can both improve nursing practice (Jones, 2000) and the emotional health of nurses (Bond and Holland, 1998). As Butterworth et al (1998, page 3) states there is a, "need for 'support' for the clinical nurse faced with dealing not simply with the patient's psychology, but also her own". On the other there is concern over a perceived methodological weakness within the early literature (Teasdale et al, 2001) due to a concentration on individual research and the dependence on subjective opinion (Hyrkas, Appelqvist- Schmidlechner and Haataja, 2006).

This confusion is intensified as there appears to be no clear definition of what supervision is in the nursing world (Cleary and Freeman, 2007, Davey, Desousa, Robinson and Murrells, 2006), leading to no consensus on how CS should be pursued within nursing. Therefore a 'patchy' pattern CS has appeared using models which,

Cleary and Freeman (2007) reflect, may not be appropriate for the differences within the care context. It also means that CS has become a non-mandatory requirement for nursing which is in contrast to the way CS is set up within other professions, for example clinical psychology (Cleary and Freeman, 2007). This could send the message that CS is not a useful resource to provide regular support but something that you may only need when in difficulty.

Bond and Holland (1998) suggest that one of the underlying reasons for this reluctance to provide CS for nurses as an obligatory package is a fear and misunderstanding around nurses discussing their emotions. It is thought that if these emotions are given a voice, nurses will be unable to function and patient care may be compromised as nurses struggle to contain their own feelings. Bond and Holland (1998) refer to an ever present fear that emotion will negatively impact on both patient and the other nurses (Bond and Holland, 1998). This creates an environment in which nurses cannot use CS to safely discuss their emotional reactions and trust that this will not adversely affect their position.

Relating this back to the previously discussed models of supervision, this reluctance appears to be creating a situation in which CS may be difficult to achieve. Firstly, on entering CS, Davey et al (2006) suggest that nurses may feel that they are being evaluated thereby meaning trust is unlikely. Secondly the infrequent and non mandatory aspect undermines the purpose of building a joint understanding that incorporates all the necessary components of CS as discussed by Scaife (2001).

1.7.1 Clinical Supervision for Palliative Care Nurses:
These cultural issues regarding nursing and CS have negative implications for PCNSs. The research above discussed CS and its position within nursing as a whole. Reflecting on the role of the PCNS and the particular stresses, both professional and personal, that they experience on a daily basis, it is clear that their need for good supervision is significant.

Currently there is CS offered to some PCNSs. In his series of studies, Jones (2000, 2003, 2006) provided psychoanalytically informed group supervision for PCNSs. The basis of his ideas was the work of Bion (1962) and Klein (1942) on projective

identification. His theory was that patients going through the palliative process would unconsciously project their negative emotions onto the nurse caring for them. Therefore the purpose of CS would be to help the nurses to not feel overwhelmed by these complex feelings (Jones, 2003). The nurses in CS were given the opportunity to reflect on the process that was occurring between them and the patient and come to an understanding of their own internal world and what Jones terms the 'life- world' of the palliative experience (Jones, 2000). The nurses described supervision as providing them new and experiential ways of looking at their jobs (Jones, 2006), to voice their experiences of palliative care (Jones, 2000) and to gain a more psychological perspective of the process that they witness daily (Jones, 2003).

However it was also reported that nurses found CS itself stressful due to having to share very personal information with groups of their peers (Jones, 2006). These negative findings reflect the issues of trust and the importance to remain work focussed as discussed above. It concentrates very much on the nurse's lived experience and their internal processing of a situation. It is clear from the findings that some of the nurses interviewed found these personal issues difficult to discuss not just with a supervisor but also with a group of peers. This could create a barrier in terms of them being able to receive adequate support, particularly in the psychosocial aspects of their role.

In relation to the effective models of supervision presented above, it does not acknowledge the contextual factors, the complexity of the patient and their emotional state, the impact of this on the nurse and the discussion within the supervisory relationship (Scaife, 2001). This reflects the individualisation observed within the stress discourse that seems to permeate through the nursing culture. The PCNS is learning to control from within herself rather than to reflect on other psychological factors that come from the direction of the patient and their family and to be able to openly discuss the emotional impact of this experience.

1.8 Aims of the Current Study:

This study seeks to explore further the use of clinical supervision with palliative care nurses, including how it is currently structured and how it is received and perceived by the nurses themselves.

The rational of this is that, from the presented literature, there appears to be barriers that prevent clinical supervision from being effectively provided for this staff group. These barriers are possibly constructed by such issues as the culture and expectations behind the nursing profession and society generally interacting with the type of supervision currently being proposed and practiced.

However there is a clear need for these professionals to have clinical supervision to aid their management of patients and their own emotional reactions to such intense situations.

As clinical psychology become more involved in providing input into CS with these nurses as level 4 practitioners, following the recommendations by NICE (2004), some of these issues and concerns need to be examined. Something that appears to have been missed in the literature presented is the nurse's own views regarding their understanding of their needs in this area, whether they value the supervision they have, whether anything is being missed and what might be beneficial in the future.

This study proposes to focus on two teams within one cancer network attempting to address the issue of CS for PCNSs and ask the following questions:

- What are the current stress levels present within each team and what is the impact on their psychological well being? For example how do nurses believe they function on a day to day basis?
- What supervision are they currently receiving and how is this structured and delivered?
- How effective do they find this supervision, what do they see as strengths and weaknesses, what do they think their needs are in this area, what would mean they would not attend and what else would be useful?
- How do they view some of the issues raised from the literature and what would the most useful supervision package for them look like?

Using this information the aim is to consider what is currently happening in terms of the provision of clinical supervision for this group and how this can be taken forward in the future by clinical psychologists in this role.

CHAPTER 2: METHOD:

2.1 Design:

The participants for this study were all part of the same Cancer Network although they represented two teams from different counties which I will refer to as Area A and Area B. Both teams were of similar size and composition and based primarily within high density urban areas although one of the teams (Area B) covered a wider area involving more rural settings. Each team consisted of approximately twenty nurses although in both cases this did not represent twenty full time roles as the nurses worked varying hours. Across teams, the nurses were split between working within an acute hospital setting, the hospice and the community.

The teams differed in the amount of contact that they had with each other. Due to the wider distribution of the nurses and different employing agencies, Area B had less frequent meetings and existed more independently than nurses within Area A. The teams also differed in the amount and type of supervision offered. Nurses in Area A were required to attend a group supervision session on a monthly basis attended by both management and nurses. They also had access to case related supervision provided by the clinical psychologist employed by the team in smaller area focussed groups. Area B had less organised supervision which was not available for nurses within the acute sector. As this study progressed the clinical psychologist recently employed within the team began to provide case related supervision for all nurses at Band 6 and above.

Each team employed nurses across bandings determined by Agenda for Change, for example from Band 5 to Band 7. However within this study we only included nurses at Band 6 and above. We excluded nurses below a Band 6 as they are currently not seen to have the competencies of a Clinical Nurse Specialist, and therefore supervision is not a recognised need.

In terms of research design, this study employed a mixed research design using both quantitative and qualitative methods. This enabled the examination of both the wider picture, in terms of obtaining a baseline of current stress levels within these teams, as

well as a more detailed representation of participant's views regarding their supervision needs.

The study entailed a three stage process. The completed questionnaires presented an illustration of the teams involved and gave a baseline measure of stress and psychological distress. The interviews explored the use of supervision and the participant's views on their needs in this area. The focus groups provided a forum in which some of the issues from the literature were raised and future possibilities for supervision were discussed.

2.1.1 Stage 1: Quantitative:

The quantitative element entailed the participants filling in a range of questionnaires, some standardised and some designed by the researcher. They sought information regarding the participant's stress levels and current emotional state, their experience of supervision and demographic information. The questionnaires are discussed in more detail in section 2.5 below (see questionnaire pack in Appendix 1). This information provided a picture of participants current functioning, allowing comparisons with previous research. The quantitative phase of the research was carried out as a staff survey with each participant being asked to complete and return the questionnaires.

2.1.2 Stage 2: One to One Interviews:

Following the staff survey four participants from each team were asked to participate in a face to face interview with the researcher. Interviews were carried out at a location specified by the participant thereby reducing the impact that the research had on their time and resources.

The interviews were planned for approximately fifty minutes and were semi structured by design (see Appendix 2: interview schedule). This allowed similar information to be gathered from each participant without restricting what they could bring to the discussion. It was felt that a more structured interview would close down discussion on what was a wide and sensitive topic for the participants. The areas discussed were decided by the researcher in consultation with the supervisors. The interviews were recorded by two separate devices to ensure that the conversation was

captured. Participants were aware of this and gave consent before the interview commenced.

2.1.3 Stage 3: Focus Groups:
The focus groups took place after all the interviews had been completed and the coding process begun. The first aim was to present some issues raised from the literature and expressed during the interviews, opening them up for further discussion. The second aim was to begin thinking in more detail about the needs of the participants in terms of supervision and how this could be best structured to meet those needs (see Appendix 3: Focus Group prompts).

There were two focus groups, one in each participating team. This served to reduce travel time for participants. All participants from each team were invited to attend the focus group. Both focus groups were lead by the main researcher and the issues discussed were planned in consultation with the supervisors. Both focus groups were recorded by two devices and the nurses were aware of this before commencing.

2.2 Participants and Selection:
As mentioned above, nurses within each team were based in different settings, acute hospital, hospice and community. This was accounted for in this study by using a stratified random sample design. All participants regardless of primary role were asked to participate in the staff survey. However, in the interview stage, the researcher ensured that each group was represented by using a stratified random design, interviewing at least one participant from each setting. This approach was recommended by the Ethics committee and approved by the supervisors. Beyond this participants were chosen randomly where possible. In some cases only one participant with a particular role completed the questionnaire so this individual was interviewed.

In Area A a total of 20 nurses were asked to participate in the staff survey with 13 responses being received giving a response rate of 65%. However one of the participants was found to be highly stressed and therefore, in line with the ethical procedure, it was decided in consultation with the supervisor that it would be unwise to interview her and this individual was removed from the list of possible interviewees. Following this four nurses were approached to do an interview with four agreeing, giving a response rate of 100%.

In Area B 20 nurses were invited to participate in the staff survey with 14 responses being received giving a response rate of 70%. Four nurses were approached and asked to do an interview with four agreeing, giving a response rate of 100%.

For the focus groups an open invitation to attend was extended to all of the nurses in each area. In Area A four participants took part in the focus group while in Area B, three attended the focus group.

2.3 Ethical Considerations:

2.3.1 Ethical Approval:

This study was granted ethical approval by the relevant Ethics Committee and then Research and Development approval by the departments covering each team (see Appendix 4: approval letter).

2.3.2 Informed Consent and Freedom to Withdraw:

Informed consent was ensured by presenting the study at multidisciplinary meetings and then providing the participants with an information sheet detailing the background and aims for the study. These were distributed with the questionnaires and the participants were asked to read this and then return a signed consent form to the researcher (see Appendix 1: questionnaire pack). The information sheet was designed so that the potential participant had enough information without attendance at the general presentation.

As instructed by the Ethics Committee guidelines, participants were not asked to sign a consent form immediately on receipt of the information but were given at least 24 hours to consider their position.

The participants were also informed at this stage that they were free to withdraw their participation from the study at any point in the process.

2.3.3 Potential Harm to Participants:

Due to the nature of the questionnaires, the researcher was aware that stressed individuals may be identified and considered how these participants should be responded to. Following discussion with supervisors it was felt that it would be

appropriate to inform the individuals if they appeared to be experiencing stress, providing signposts to relevant sources of support such as the GP or Occupational Health. This would be done in a written format (see Appendix 5: letter to participants).

Further to this, the feedback from the Ethics Committee was that there should also be a contingency in place whereby the Lead Nurse would be informed if a highly stressed individual was identified.

It was felt that telling the manager would contradict the confidentiality of the study. However, it was agreed that this may be done in extreme circumstances, for example if the participant appeared to be at risk of self harm. This fell in line with professional standards for clinical psychologists in terms of the need to inform in such a situation.

2.3.4 Confidentiality:

All of the information from this study was kept confidential and anonymous. Although the researcher asked for the nurse's name in the questionnaire, this was due to the above safety concerns regarding identifying potentially highly stressed individuals. This was explained to the participants fully as part of the presentation when questionnaires were distributed. If there were no concerns then the names of the nurses were removed and replaced by a number.

Any quotes used from the interviews or focus groups within this study have had identifying features removed and remain anonymous. No identifying features of either area have been used.

2.4 Procedure:

2.4.1 Contact:

After achieving ethical approval from the relevant NHS ethical committee and agreement from the research and development departments in each area, contact was first established with the Lead Nurse in each of the areas.

Due to the research and development process taking longer in Area B, the researcher distributed the questionnaires and interviewed the nurses in Area A first, before moving on to Area B when approval was granted.

With the agreement of the area Lead Nurse, the researcher attended multidisciplinary team meetings to present the background and aims of the study. In total three meetings were attended, one in Area A and two in Area B as here the community team were privately employed by a hospice. Following this presentation the researcher distributed the questionnaire packs which contained the consent form, information sheet and the questionnaires. The packs were in stamped addressed envelopes for easy return. The nurses were asked to read the relevant information and then complete and return the packs along with the signed consent form, if they wished to participate in the study. They could keep the information sheet for their own records.

When the questionnaire packs were returned, they were scored, identifying information was removed, the participants were given a number and the data entered into the database. In order to maintain interest the researcher attended a second multidisciplinary meeting in Area A as a reminder. In Area B one reminder phone call was made.

For the interviews the researcher identified the participants and then called them at their workplace to arrange a meeting at their convenience. The interviews took approximately 45- 50 minutes. Prior to the interview commencing the researcher restated issues regarding consent and confidentiality and participants were reminded that they could withdraw at any point. Following the interviews the researcher transcribed the recordings.

For the focus groups, when the analysis of the interview data was underway, the researcher contacted the lead nurse in both areas asking them to forward an email extending an open invitation to all participants with the details of the two focus groups. To protect confidentiality, the email was sent to all of the nurses in each team rather than being sent solely to those taking part.

In order to alert the researcher of their intent to participate in the focus group the participants were asked to reply to the email. In Area A one reminder to the lead nurse was necessary for her to convey this message. However in Area B several reminders were necessary.

The focus groups were conducted two weeks apart. The opening statements and questions followed the same pattern in each. The focus groups lasted approximately one hour in each area.

2.4.2 Analysis:

2.4.2.1 Quantitative:

The results from the questionnaires were analysed using SPSS. Descriptive statistics gave a baseline indication of the amount of stress and psychological distress present in the participants.

2.4.2.2 Qualitative:

Grounded theory is one of the best known qualitative research methods. It was first used by Glaser and Straus (1967 cited in Barker, Pistrang and Elliot, 2002) as a response to the scientific methods of theory development of the time. Instead of the creation of abstract grand theories and hypotheses tested using large scale quantitative studies, they wanted to be able to "ground" a theory within data. Therefore, rather than research designed to confirm preconceived ideas, grounded theory lead to the development of ideas initially found within the data (Potter, 1998). Following the gathering of data through open interviews, the researcher then 'codes' the responses looking for information that could lead to a theory that may account for the issue being examined. Although this meant moving away from the grand positions of other theorists, the resulting studies could be more meaningful in terms of thinking about how different people understood and interpreted the world. Grounded theory focuses more on making sense of the experiences of different people by looking for relationships and patterns within the ideas and concepts expressed. The method therefore has to be open ended and inductive in order to create the flexibility required to begin to make viable conclusions (Potter, 1998).

Inductive coding is a process in which the data is not made to fit a pre- existing coding framework but instead evolves naturally from what has been said. As a result the derived themes may not match exactly what the participants were originally asked but may be a truer representation of the data (Braun and Clark 2006).

Grounded theory has developed since its conception and in this study data from the interviews and focus groups was analysed using thematic content analysis, similar to Grounded theory. The themes presented reflect the content of the entire data set in order to create a rich overall description of the participants' thoughts and experiences.

However, it needs to be stated that the researcher cannot code in a vacuum, freeing themselves of their research commitments, leading to there being some influence on the themes produced (Braun and Clark, 2006). Finally the themes presented in this study were identified at a semantic level, reflecting the explicit meaning of the data, rather than looking beyond into what may have been beneath the statements made.

The data from both interviews and focus groups was coded and organised into themes following the above qualitative method. Themes were then discussed with the supervisor and refined.

2.4.3 Feedback:

Feedback was given in the form of a presentation in each area. Due to issues involving confidentiality and anonymity this was planned carefully and separate presentations for the teams and managers were considered.

2.5 Measures:

2.5.1 Demographic Questionnaire:

The Demographic Questionnaire was designed by the researcher in collaboration with supervisors Dr. Alex Harborne and Dr. Anne Lee. It consists of a series of both closed and open questions covering several issues. It starts with details regarding the participant, for example their place of work, area, years of experience and training and then focuses on whether the participant has access to supervision, if they have had supervision in the past, whether this was group or individual and the profession of their supervisor. The open questions ask for more information about their views on

the positive and negative aspects of supervision (see Questionnaire Pack in Appendix 1).

The aim of the demographic information was to give a more detailed picture of the participants, where they work and their level of experience. Although the interviews were designed to explore participants' perceptions of supervision in detail, the questionnaire included questions regarding whether or not participants currently received supervision or had ever done so in the past; this enabled the researcher to gain an overview of the patterns of supervision provision within the targeted areas.

2.5.2 The General Health Questionnaire 12 Item (GHQ- 12)

The General Health Questionnaire (Goldberg and Williams 1988) is a widely used research tool assessing psychiatric morbidity among participants. It was first designed in order to differentiate between individuals in terms of whether they met 'caseness' by scoring above a predetermined threshold. The short version of the GHQ, the GHQ (12 item), was chosen due to the speed of completion. The GHQ (12 item) was designed to be used in research for this reason, although it has comparable psychometric properties to the longer version.

There are different methods of scoring the GHQ (12 item). The method advocated by the author is referred to as GHQ scoring (0 0 1 1). This method is generally used when trying to determine whether an individual falls above the 'caseness' threshold in line with the original intention of the instrument. However there is also a Likert scoring method (0 1 2 3) which is primarily used as an indicator of severity. The Likert scale is reported to have a wider and smoother distribution curve for this purpose.

In this study the GHQ was scored both by the GHQ and Likert scoring. This enabled the researcher to examine firstly how many of the sample achieved 'caseness' (using the GHQ scoring) as a descriptor. Secondly Likert scoring was used to provide a severity score for correlation with other variables.

2.5.3 The Copenhagen Burnout Inventory (CBI)

The Copenhagen Burnout Inventory (CBI) was developed in 2001 by Borritz and Kristensen, based on the results of their Project on Burnout, Motivation and Job Satisfaction (PUMA). It consists of three subscales that explore personal burnout, work burnout and client burnout. The participant obtains a scaled score with high burnout being defined by a scaled score of 50 points or more (Borritz and Kristensen 2004).

The CBI has been shown to have good reliability data. Cronbach alpha scores of 0.87 (Personal Burnout), 0.87 (Work Burnout) and 0.85 (Client Burnout) were achieved. It also has high inter-item and item-scale correlations.

CHAPTER 3: RESULTS

3.1 Questionnaire Data:

The questionnaire data provides a picture of the sample with information describing the demographics as well as a baseline measurement of the amount of stress present across both sites.

3.1.1 Demographic Data:

As stated in the Method a total of 27 nurses employed across two teams took part in this study.

3.1.1.1 Setting:

Participants worked in three different settings, acute hospital, hospice and in the community. The breakdown of this can be seen in Graph 1. The majority of the participants worked in the community which is an accurate representation of the sample as there are more PCNSs employed to work within the community setting.

Graph 1: Different Settings in Which PCNSs Are Employed

Percentage of PCNSs in Sample (y-axis: 0, 10, 20, 30, 40, 50, 60, 70, 80)

Settings (x-axis): Community, Hospital, Hospice
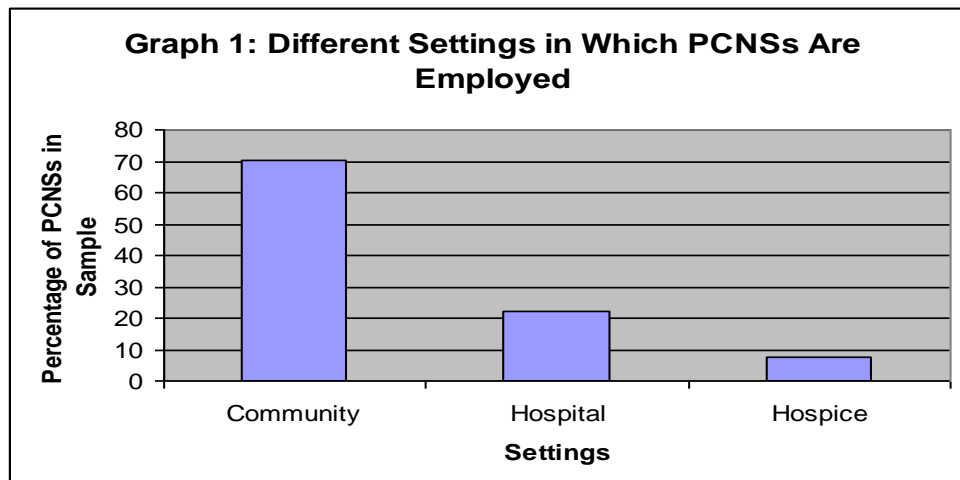
3.1.1.2 Experience:

The experience and level of responsibility required to be a CNS was reflected in the demographic data by looking at the age of the participants and the number of years that they had been qualified (see Graph 2). The majority of the participants had been qualified for over twenty years although it is acknowledged that this may not mean

that they had only been working in palliative care. As we excluded nurses working at lower than Band 6, this result was expected.

Graph 2: Experience Level of PCNSs in Sample
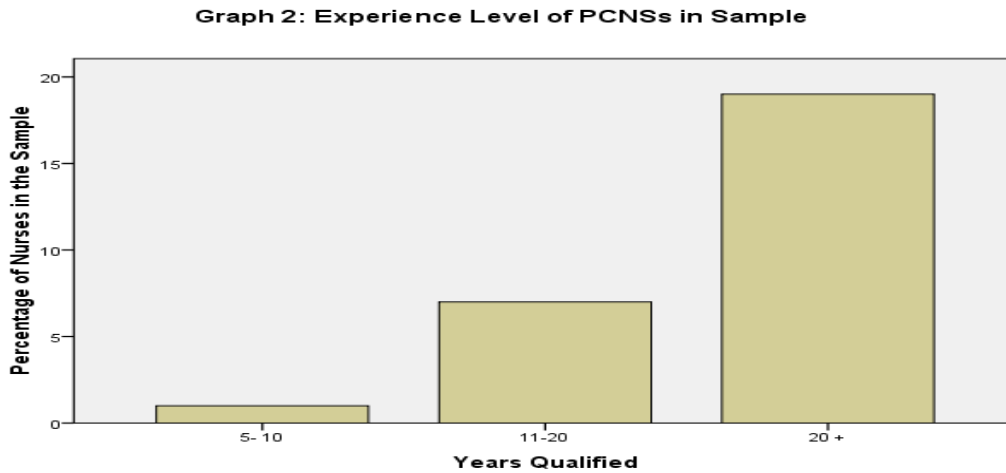
3.1.1.3 Current Supervision:

The majority of the participants reported currently having supervision (Graph 3). However there was some disagreement among the participants' responses as to what constituted 'formal supervision'. In response to the open ended questions, some participants noted that they did have support sessions with a facilitator but that they did not believe this was supervision. However, other participants used the same support sessions as evidence of supervision.

Some of the participants were only beginning to have some supervision at the time of filling out these questionnaires. Therefore these new developments may or may not have been included.

Graph 3: Current Acces to Supervision within Sample
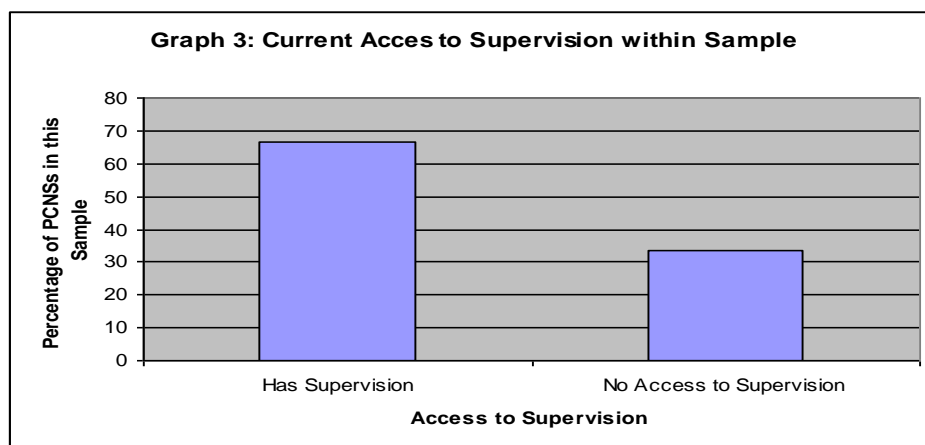
In Graph 4 it can be seen that, out of the participants stating that they do have supervision, the most common length of time between sessions was a month or approximately four weeks. Only one participant had supervision more regularly. Again during this period some of the participants were beginning to have more frequent supervision but this may not have been the case at the point of them completing these questionnaires.

Graph 4: Frequency of Supervision Sessions Offered
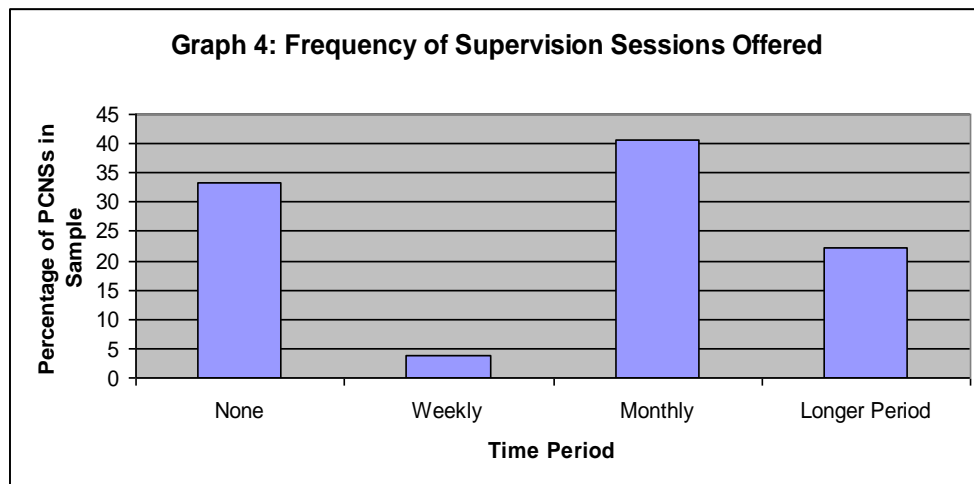
Within the supervision sessions provided for the participants, the most common facilitators are the psychologist employed to work in the team and outside professionals (Graph 5). From the space given for comment on the questionnaire this outside professional was described by the participants as being either a counsellor or a social worker.

Graph 5: Facilitator Professional Background
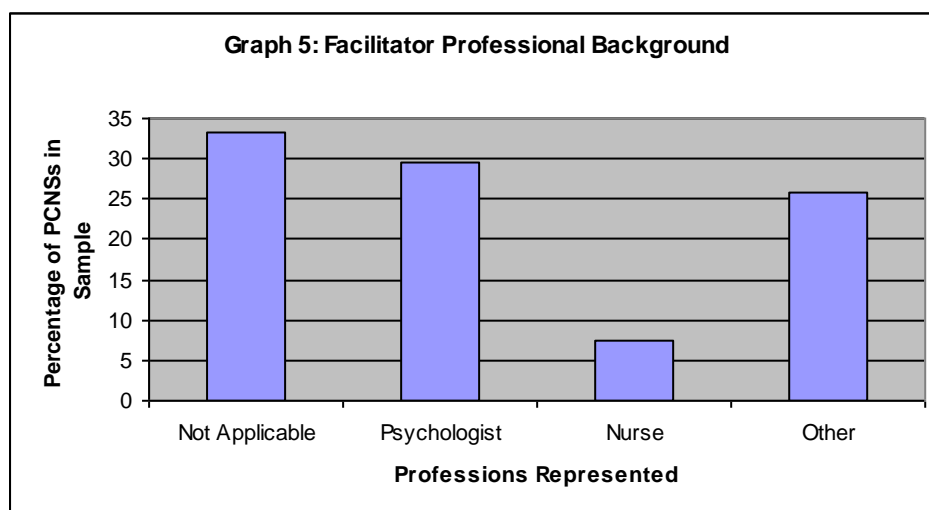
Finally it can noted that the supervision provided for participants is usually group based (55.6%). From the comments of the participants on the questionnaire the group size can vary from approximately 6 people to 9 people in one session. Only a minority of the participants were currently receiving individual supervision (11.1%).

3.1.2 Copenhagen Burnout Inventory (CBI):

The Copenhagen Burnout Inventory (CBI) indicates whether an individual is currently experiencing symptoms of burnout. It is divided into three scales which explore burnout relating to personal factors, work factors and patient factors.

The boxplot shows the distribution of scores on each subscale. Although there is a spread of scores, there are no outliers or extreme cases.

Boxplot Showing Distribution of Scores on Copenhagen Burnout Inventory
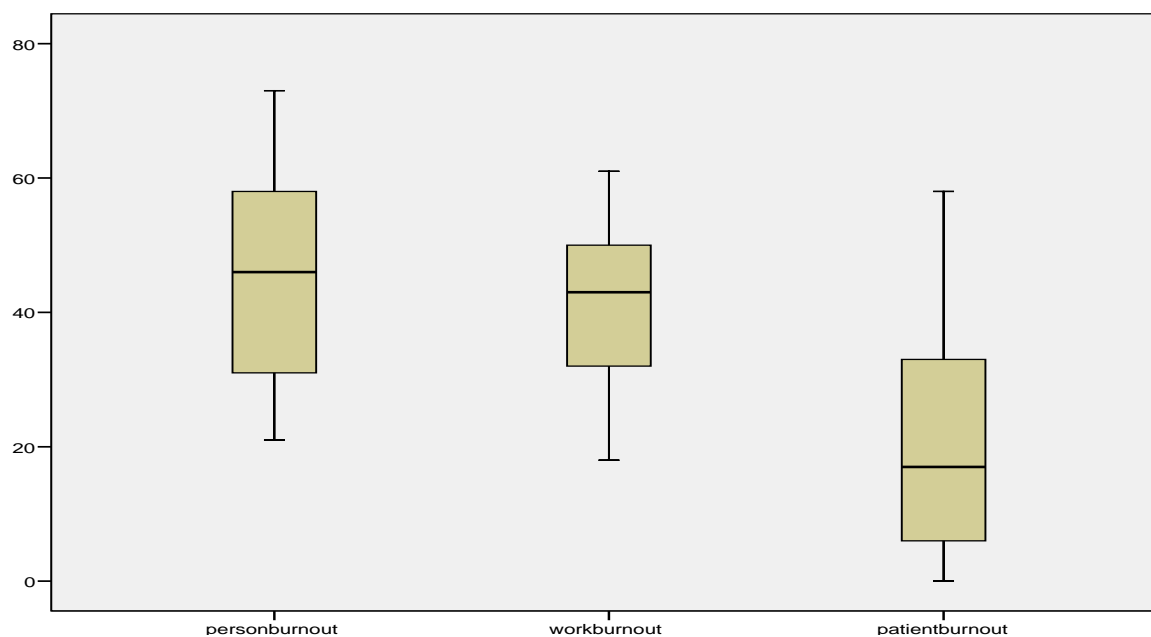
Participants scored higher on both the Personal and Work elements of the questionnaire than they did on the scale examining burnout in relation to patients. However the distribution is seen to be wider on this subscale.

In each case there were more participants falling below the threshold of 50 than there were above it, although the numbers were very close in relation to the Personal Burnout Scale (Graph 6).

Graph 6: Percentage of Participants Falling Above and Below Threshold on CBI
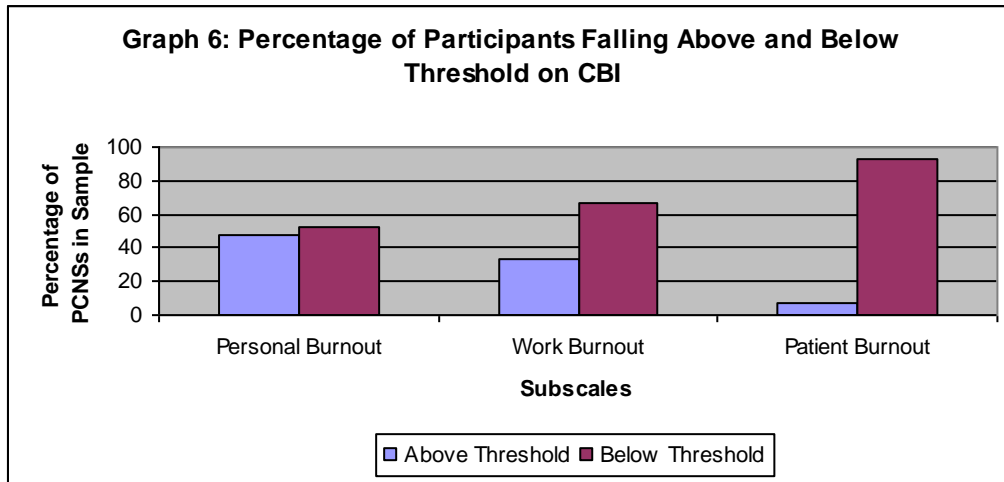
3.1.3 General Health Questionnaire (GHQ 12 Item)

The GHQ was originally designed to define whether an individual had reached 'caseness' in terms of their current level of distress. The boxplot displays the distribution of scores. Although the median and the majority of the scores fall within or just above the threshold, there were participants scoring very highly. However none of these appear to be outliers or extreme cases. The number of participants scoring above the threshold (48.1%) was slightly lower than the number below (51.9%).

Boxplot Showing Distribution of Scores on GHQ
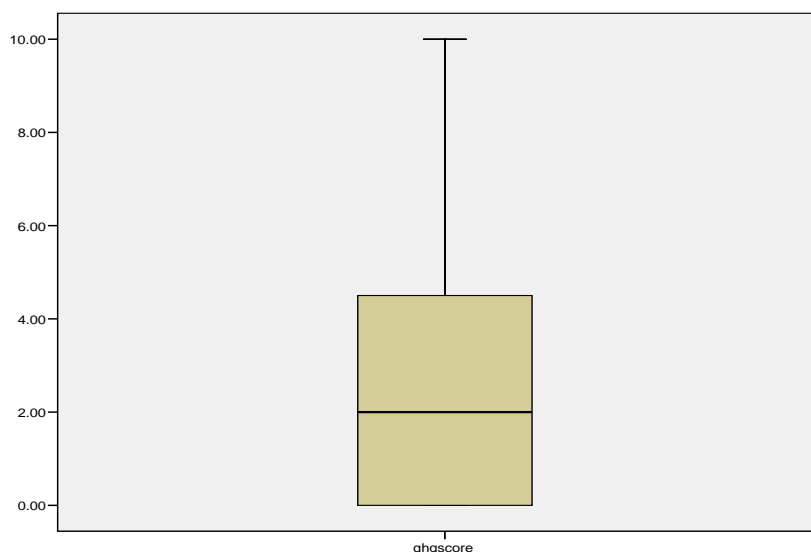
However most of the participants indicated on the Demographic Questionnaire that they were also having difficulties outside of work which they felt could also be impacting on their current well being. Therefore it is hard to differentiate the cause of the distress of the participants.

3.1.3.1 Independent T tests:

In order to determine whether there was a correlation between work related issues and psychiatric morbidity, a T test was run looking at possible links between having supervision and the scores on the General Health Questionnaire. However the correlation proved to be insignificant (see below).

T-Test Descriptive Data

	Current sup	N	Mean	Std. Deviation	Std. Error Mean
Ghq score	Yes	18	12.7222	6.05665	1.42757
	No	9	12.1111	3.95109	1.31703

T- Test Data Showing Insignificance

	t-test for Equality of Means						
						95% Confidence Interval of the Difference	
					Std. Error		
	t	df	Sig. (2-tailed)	Mean Difference	Difference	Lower	Upper
Ghq score	.274	25	.787	.61111	2.23383	-3.98955	5.21177
	.315	22.940	.756	.61111	1.94230	-3.40742	4.62964

3.2 One to One Interviews:

Once completed the interviews were transcribed and then analysed following the procedure described in the method. The data was organized into four main themes which are described below in detail, using extracts from the interviews.

3.2.1 Theme 1: The Psychological Role of the Palliative Care Nurse:

This theme reflects the thoughts of the participants on the psychological role they play in the care of their patients, how it is manifested in their daily experience and how competent they feel to fulfil it.

3.2.1.1 Psychological care versus symptom control:

The participants were unanimous in their belief that their clinical role involved both the elements of psychological care and symptom control.

My job has three main parts that is to make sure that the patient is comfortable- so symptom control...so that the patient themselves are physically comfortable and then...to make sure that they are comfortable in their head and their heart...enough information, are there things they need to talk about... (P 7)

It's providing an initial assessment and then go on to provide appropriate support, either symptom control or psychological support (P 1)

Further to this, the majority felt that the psychological element of their role, either directly or indirectly, was their primary task. In many instances this would be the given reason for their visits to that family.

A huge amount of it is emotional support... so dealing with the families and with the patient (P 3)

I see a bigger part of my role as being the supportiveness of the role to the family and to the patient, listening to them really, seeing what their concerns are and then trying to unpick them... (P 4)

Indirectly, the participants talked of their role in helping patients make decisions regarding treatment, for example when to cease chemotherapy. This could be seen as a medical intervention, however the participants reflected on the role they play within the medical team in thinking about the best option psychologically for the patient at that point.

In this way the palliative care nurse can become the emotional link between the family and the medical world. Participants reflected that sometimes the feelings of the patient can become secondary when the doctors discuss treatment. Therefore they need to be able to understand and represent the hopes, wishes and fears of the patient and their family in their absence. This can mean them becoming an 'emotional container' for these very intense and important thoughts. As well as the difficulty of being the liaison and holding split loyalties, this increases the need of the nurse to quickly develop a close relationship with the family in order to understand their position. However again there is a perception of the nurse being able to contain these emotions without a concept of how this may affect them personally.

Liaising with the doctors… actually getting the team to listen to what the families, the patient and families want… actually if they asked the person in the bed they would realise that's not what they wanted…they just want good therapy, it doesn't always occur to them to ask…that's where we facilitate (P 8)

Some of the participants also acknowledged the link between the psychological and the physical and the impact that the one can have on the other. In some situations, the symptoms need to be controlled to enable a conversation about more emotional matters.

It's always going to be about maybe pain or nausea, but also about "I'm scared" and it's always mixed and it's almost finding a way of separating them in a way that you can manage them (P 2)

You can't sit down next to somebody's bedside and say how do you feel about the fact that you're dying if they're actually vomiting their guts up…you have to deal with that first (P 7)

The participants reflected that symptom control and psychological care required different approaches and this appeared to impact on how comfortable they felt in managing each factor.

Symptom control was described as a structured system in which they knew what changes to make in response to side effects and where to go if they have difficulties, for example the consultant.

There are always patients that the symptoms baffle you and you think "I don't know where to go now" but yeah- it's probably the easier bit because you can have quite a structured action plan…and we would take it to the MDT meeting if we had problems and seek advice from the consultants- so you know where to go… (P 1)

The psychological care seemed to be viewed as unpredictable. The participants spoke of the difficulties of having to make quick judgments about people based on very short relationships and the need to try and establish those relationships very quickly. There was also a feeling that they were very alone with the psychological work and there was recognition of the need to look after themselves in these situations.

You are jumping in and having to make relationships very quickly…you might be jumped into talking about very scary things with people because they become real at the point of meeting them…you've got to make huge judgment calls…you haven't had the chance to build up a relationship… (P 2)

I think the psychological bit has lots of grey areas…if you think of someone's pain you know that you start them on a tablet and then you feel that doesn't work you move onto the next one…the psychological support doesn't feel like that…I sometimes feel you take two steps forward and three steps back (P 1)

You carry that yourself and you have to unpick it yourself and worry about it and decide what you are going to do about it and whether you've said the right thing and how you take that forward is the more challenging side of the role (P 4)

It was also recognised by some of the participants that this is possibly made more complicated by management not understanding the extent of the psychological role that they do an a daily basis and the relevance of this part of their work.

I don't think that even the management…recognises the level of counselling that is necessary, I think they would say that counselling isn't essential to the role (P 5)

This perception of the management's misunderstanding of the value of the psychological role in relation to symptom control may result in the nurses believing that they are not doing their job by concentrating on psychological care. This fear was demonstrated by some of the participants.

I do put more value on the symptom control because I'm feeling when I'm not doing that, that I may be not doing my job (P 6)

Despite this the majority of the participants noted that, despite its challenges, the psychological part of the job was the most interesting and rewarding to do.

I find it very interesting I have to say. Sometimes it is the bit of the day that makes it fascinating and you get to know people and are quite privileged… (P 5)

I love it actually…you see the patients straightaway so the family can actually see what goes on with whose doing what and how its all fitting in and I find it fascinating (P 4)

3.2.1.2 Competence Anxiety:
Despite the interest in the psychological aspects of care there does appear to be some anxiety regarding the competence required to fulfil their role. The majority of the participants reflected on their doubts about their ability to support such distressed people. This lack of confidence seemed to encompass issues such as moving people forward. There was also an element of recognition that sometimes you have to let people cope in their own way and that stepping back and allowing them to do this was hard. There was a continuing theme of the nurse being alone with these decisions.

It's the patients who you sit alongside who actually don't want to hear the bad news, you do sometimes go away with "have I pushed them too far?" or sometimes there is this feeling of my best intention has been to do the best but have I done that?(P 2)

It's all very well to get the information…they tell me stuff…but whether I can then help them deal with it, I think that's probably my difficulty (P 5)

Sometimes I'm valuable from an emotional support angle as well and I think that patients probably enjoy seeing me but I, I don't know, I suppose I come away thinking have I really done anything… (P 6)

The participants reflected that this had led to some nurses standing back altogether from their emotional role and just keeping their work on a very practical level. Some of the participants spoke of their sadness at this but others felt that maybe these nurses were simply better able to cope and therefore doing a better job than themselves.

In a role play… breaking difficult news and exploring how somebody felt about the news… and it was like a revelation to them, "oh do you do that everyday" you know, I thought we should all be doing this (P 8)

Some of my colleagues seem to be really detached from the emotions of it all…that makes me feel bad sometimes…because I think they're obviously managing better than me… (P 5)

3.2.1.3 Training/ Support:
The participants further reflected that they felt that they did not have the training to enable them to cope with some of the situations they were left with. Generally the participants felt that they had to rely more on experience than formal training.

I suppose because we've never had any formal training in how to deal with psychological issues you know, it's all just done as an add-on (P 6)

They (the management) don't feel that (counselling training) necessary because we're classed as symptom control and they see symptoms really in a more medical drug-related way (P 5)

Its personal experience really (P 4)

3.2.2 Theme 2: Emotional Impact:

The second theme reflects the participants' thoughts on the emotional impact that their role has on themselves. The majority spoke of the difficulties involved in working in such close proximity to death and dying.

I often describe it to friends and family, it's like watching sometimes a weepy movie that makes you cry but actually that's your life, you're in that (P 2)

Some days I'm really, really sad and very stressed and you know you're doing that day in and day out; it's affecting my energy levels…I'm mentally exhausted at the end of every day… (P 8)

3.2.2.1 Building Intense Relationships:

Following on from the previous theme, the relationship that the participants have to build with the patient and their family appears to be the main source of the emotional impact that their work can have. Because of meeting at such a significant point and the role they then play in the families' journey, these relationships can become very intense both for the family and the nurse. The majority of the participants discussed becoming close to families and the impact that this has on them. Some spoke of the conversations that they had had with patients which also affected them. Others spoke of their feelings on the death of a patient.

You've completed your part of their journey almost… we do so much with like, we've got to look after this patient, we've got to care for this family and you do get so involved sometimes and when they're gone its just like, oh they're gone now and whilst you're busy doing something else you do still think… (P 3)

Sometimes you'll find that in a day you'll spend three hours with just one family… because there's an acute problem, the whole family are distressed and the person is dying…and each time you go back people grab on to you and ask questions… (P 7)

You feel sad- someone dies and you can sense the sadness I have to say…you have become attached to some of them. I had one girl that died and I have to say I still

think about her bizarrely, almost miss her strangely because we got on really well for quite a long time and then she just went downhill very quickly (P 5)

There was a lady who was exactly the same age as me and I'd known her for about two years…I struggled over that…firstly the fact that I had known her for such a long time and we had some very open and honest conversations (P 1)

Some of the participants spoke of how the types of conversations they feel compelled to have with patients can add to the intensity of the situation. The participants reflected on how they feel they have to be the one who asks whether treatment is appropriate and thus take away hope of recovery.

That can be difficult sometimes because you don't want to burst people's bubbles, you don't want to appear someone that's negative but you want to give some honesty and some people need to hear that and some people don't want to hear it (P 2)

A patient who has been very challenging in her behaviour… she has seen the Macmillan nurses as a black cloak really and hasn't wanted to be there…they were talking about a holiday and I'd suggested that perhaps they went… a bit sooner and she really didn't like what that meant (P 4)

The other factor that the participants discussed in terms of making the relationships more emotionally painful for the nurse was the age of the patient. The majority of the participants acknowledged that it was the younger patients or those the same age as themselves that had more impact.

A young girl literally covered in tumours…that was very difficult for everyone (P 1)

I find it harder with some of my younger patients…people with young children (P 5)

Some of the participants reflected that the intensity of their emotional reaction is just too difficult to cope with and therefore they may avoid having these conversations.

There are times I know that I don't go there for whatever reason, just because either I'm a but too busy or too you know- I think that's only human…sometimes you feel that if they're not forthcoming then I won't… (P 6)

It never ceases to amaze me how detached from the emotional side of things a lot of nurses are…I think they see patients as patients and not people…although they think things are sad they don't engage at an emotional level (P 8)

3.2.2.1 (a) A Need to Protect:
The participants also spoke of their need to protect both patient and family from the inevitability of the situation and consequent emotions.

Sometimes when a family leaves after a death you do feel quite helpless because whilst they're here you feel like you could sort of cocoon them a bit really and protect them from everything (P 3)

I think the bit that does have an impact on you is when things are very sad for people- sometimes there just aren't answers, you can problem solve to a certain degree and offer support but you know… (P 8)

3.2.2.1 (b) Building Boundaries:
The participants reflected on the difficulties they experience in establishing appropriate boundaries between them and the families while also maintaining a good therapeutic relationship.

Its about finding the boundary between you're not their friend and you are the professional but how you build that relationship but still keep it on a very professional boundary really… (P 1)

It's quite a fine line between supporting them and getting involved and actually feeling like you're bereaved yourself when they've died. That can be very difficult sometimes… it's trying to protect yourself from that happening…but still being able to work properly and to show empathy and compassion and do your job without getting hurt in the process (P 3)

The participants spoke of themselves then taking a lot of their worries about particular patients home and this then impacting on their lives outside of work.

You're very aware that this is real life that you're dealing with, these are real situations and you can't just switch them off when you leave, it doesn't always work like that (P 3)

It can sort of stay with you and you worry about it and get concerned about it (P 8)

I mean occasionally there are times but yeah, I mean you have some very very difficult situations and families and things are very sad and yes you wake up at 3 'o' clock in the morning thinking about them but I suppose I think as long as that doesn't happen on a regular basis (P 1)

3.2.3 Theme 3: Expectations of the Role:

3.2.3.1 Responsibilities:

The role of a palliative care nurse involves direct clinical work with an equally important focus on education, and supporting less qualified staff. All of the participants reflected on the complexity of their role, the tight time schedule and the difficult decisions that they have to make on a daily basis.

One of the biggest difficulties which probably causes me quite a lot of stress is being realistic with your time scales (P 4)

Sometimes there's a lot of responsibility on you and it's always what your perception of the situation is…sometimes it can be quite stressful …there's quite a lot of responsibility and people look to you for answers (P 4)

3.2.3.2 Autonomy:

The majority of the participants spoke of how they are required to work autonomously. This may be reasonable given their level of expertise but the participants reflected on how this can mean that they feel very alone, are left to deal with difficult situations and feel that they should always be busy meaning that it is

sometimes possibly to the detriment of their own needs. As a result the participants spoke of feeling the necessity to protect themselves.

I think you've got this real prestigeness among CNS's about autonomy and you've got to be these autonomous beacons of virtue that carry a caseload around…I think to a certain extent you've got to be autonomous in the decisions you make… but the emotional stuff you carry around, you don't become superhuman because you're a CNS (P 2)

We're often the glue between a lot of teams… and that's quite a hard place to be… it can be quite lonely… really because you could go all day and not see any other professionals (P 4)

3.2.3.3 Expectations Regarding Relationships:

The participants also discussed their perception that they are expected to create as close a relationship as possible with the patient. This follows from the previous theme which demonstrated the participant's difficulties when trying to establish a boundary between themselves and the patient.

You're taught to deal very closely with people here and to give everything but then how do you protect yourself…so that can be very hard (P 3)

I suppose being a nurse anyway I think you are that sort of a person that is very- it's expected… it's just a part of who I am to give I suppose… that's what I do isn't it? (P 5)

3.2.3.4 Feeling Unsupported:

Perhaps because of the level of autonomy and the requirement to seemingly deal with the emotional impact alone, some of the participants indicated that they sometimes felt unsupported.

Very stressed nurses running around thinking that nobody was bothered… you know we're dealing with death all the time and nobody cares (P 3)

I think the team often feel very, very overworked, stressed and don't feel supported and I think a lot of it is to do with the role that we're doing... (P 6)

The participants stated that they gain support from colleagues, being able to discuss and reflect on difficult and emotional situations. However there was also recognition from some of the participants that this can only be effective when the team is working well. In a team with difficult dynamics it can be hard to ask for support and in some instances this can even create more stress and make their role feel lonelier.

I think often what I've found is that just sharing that with my colleagues at the end of the day or you know if there is anyone to share it with...just talking about it and I think just helps you know you feel that you're not on your own with it (P 6)

When the team's not working well that's actually non- support in a sense because if- when you feel that you can't go to your team for support- that makes it harder- and there have been occasions in the past... (P 7)

3.2.4 Theme 4: Concept of and Need for Supervision:

3.2.4.1 Need for Supervision:

In the interviews all of the participants spoke of their need for supervision and recognized its usefulness as a concept and as a way of coping with stress and perhaps preventing burnout.

I think supervision is so important, um, I think if you have people working with very raw emotions and do not have in place something that, um, prevents burnout, um, then its naïve (P 2)

I became really really stressed I have to say and I think really it's because we don't have that clinical, we don't have formal clinical supervision and I just think that, I think it should be mandatory (P 5)

I think it's something I wish that I had had you know when I look back on lots of times I've been very stressed and yeah, I think it (supervision) would be very valuable (P 6)

There was recognition from some of the participants that provision of clinical supervision for their role was not seen as necessary by some of the management perhaps because they were expected to cope alone.

I just don't understand why they wouldn't go to it…there seems to, this isn't from management, this is from the feeling in the team… they don't see it as a priority…the general feeling is that…I don't know why, you've got the support, don't know why you need clinical supervision- they don't recognise what the difference is (P 5)

I can't talk for other… nurses, but… I do a huge amount of psychological work with my patients, um… and I think if you were a counsellor or a psychologist you would be having supervision around your case load but because you are a CNS and you're somehow differently or godly you don't need that and I think that is awful (P 2)

Most of the participants for whom supervision was provided reflected on how much they valued certain aspects of their supervision.

I think that's a small team ~ we're a very supportive team of each other ~ I mean ~ there could only be the four of us and we've sort of known each other quite well over time ~ and it's not ~ we tend to bring very psychological things obviously to… and that works ~ I think that works very well (P 1)

Sometimes I do come out of supervision and think… I could have been writing those notes up or something- and then another day you'll go and you think that was really good I feel better for having discussed that I feel supported…I did do that right and it has been worrying me or I listen to someone else and I think phew that was really hard… (P 4)

3.2.4.2 Provision of Clinical Supervision:

Although the majority of the participants spoke of valuing supervision and believing that they need it because of the stressful and emotional aspects of their role, many saw it as a 'luxury' and not something that should be provided as a matter of course. Most referred to it as something that can be asked for, or that is provided for a specific issue but not routinely.

I mean the PCT provides formal clinical supervision if you wished to go and access it and that's usually done with regard to a specific thing, or you would ask to be referred to the supervisors and they usually offer so many weeks of supervision to deal with a particular issue (P 1)

I'm very very lucky really I think because I have…for caseload supervision once a fortnight…then we have a clinical supervision from an outside person as a team once a month…it's very very good (P 4)

Some participants reflected on the fact that supervision is something that is not stable. It is something that would be the first thing to go if a crisis occurred. The participants discussed whether it should be mandatory which involved some disagreement.

We did look at it being mandatory but I think if you make something mandatory people decide not to go… some people are just not interested and therefore you cannot force them to do things that they don't want to do (P 3)

I think it's good that we have a regular 'must go to' slot…if you had supervision that you sort of went to when and if you felt like it I don't think you would have as effective supervision (P 4)

3.2.4.3 Concept of Supervision:

The participants had different ideas regarding what they thought clinical supervision should provide. They reflected on the importance of learning and development and having somewhere to be able to discuss some of the situations they had with patients.

Supervision- it's allowing me to speak with somebody with skills about patient scenarios or anything really- anything to do with my work be it from a team or whatever point of view or clinically- to try and unpick what it is that's bothering me about that particular scenario (P 4)

Because I think of my own health…and to prevent, help you not get over- involved with people, to be able to leave it somewhere else…and it helps you to have more boundaries somehow I feel (P 5)

Development of your practice…by helping you to examine what you do and unpick it and see where you need to learn and helping you to reflect on what you do and develop your skills (P 7)

However some of the participants also reflected on the confusions involving the definition of clinical supervision. They referred to the aims of supervision as quite separate and discrete tasks that may be dealt with in different contexts. For example supervision looking at the daily management of patients, supervision to look at the emotional impact and then supervision in which they may look at team dynamics, with little cross over between tasks. The participants discussed how this can also be very confusing as they are not sure what was appropriate to take to each discrete session.

Again I mean I do find the meetings with…very helpful but I would take a patient very specifically to her and seek her advice and you know she would say why don't you try this or why don't you try that but I potentially wouldn't say ~ I don't know ~ perhaps I'm really struggling emotionally with this family and I don't know whether I would take that to that meeting (P 1)

Sometimes I do really get a little bit confused with them because I'm never quite sure what to bring to what really sometimes. I tend to take the cases that I need some psychology support to…whereas I suppose the ones I take to the clinical supervision monthly session is perhaps some ongoing block or problem that I'm having within a family perhaps about any particular issue (P 4)

I think some structured clinical supervision would be…I think there are two aspects…I mean I think some clinical supervision about dealing with patients would be fantastic- dealing with their psychological issues but also as a team I feel that we still have other things that aren't patient related…(P 6)

The participants' confusion may arise from the fact that some of them do currently have different supervision sessions which have separate aims and approaches. While they referred to caseload supervision as being specifically based around patient issues,

the participants spoke about the group supervision or support they receive as having a different focus on team dynamics and functioning.

We obviously meet with (the psychologist) which I find very useful to take specific issues… how do I get through this? (P 1)

I think its called- support it's called- basically what it is we have a lady who comes to the meeting…but I would say that is more about the politics of work, what is going on in the team and how we are all feeling…its really helpful because it makes you think "Oh God it's not just me then" but it's not about specific patients, we don't have time in that meeting to talk about specific patient issues (P 5)

The different aims also seemed to inform what the participants felt that they benefit from in each situation. For example in the caseload supervision the participants reflected on the value of being able to formulate a plan of action for a patient.

My caseload supervision with…allows me to do some of that work and that's given me confidence to try those things and take those forward… (P 4)

I went in there and I said I've got this girl that's dying and I just cried- and then my colleague here cried…and we just all had a cry…it was quite a bonding process actually, I felt…actually it's normal, normal but it's hard (P 5)

However some of the participants spoke of how they had found the approach and aim of the sessions with a focus of team dynamics anxiety provoking. Some of the participants also felt that these sessions did not meet their expectations in terms of what clinical supervision should include.

We would have to take it in turns and it would be your turn you'd be thinking ~ or you'd almost be thinking something up to take to supervision which completely defeated the object of the whole process and then you'd sit there thinking you know you'd done something wrong or you know somebody else would challenge you… it was horrendous (P 1)

It is much more my impression of it (group supervision) so far is about politics. So who sits where and who brings what and to me I haven't got time for it…it's more about conflict and politics and, um, and it doesn't meet my supervision needs remotely (P 2)

We do have a support session which is I think is about once a month…I mean if I'm honest I don't particularly find those sessions very helpful (P 6)

3.2.4.4 Complicating Factors:

The participants also reflected on their worries regarding the beliefs that exist in the nursing culture about the motives and meaning behind supervision. They talked about how this makes it harder for them to accept supervision and can mean that they are wary of it. Some of the participants spoke of the suspiciousness that still appears to exist regarding the 'motives' or 'agenda' behind supervision.

The issue of trust appeared to be very important, particularly in entering group supervision. The need to trust both the supervisor and their colleagues was something that could impact on their ability to feel comfortable to share information and use supervision effectively.

Trust is a major, major thing. Trust, environment, making sure that you are not interrupted…that they haven't got their own agenda either (P 3)

I think if you were going to talk about things that were very personal- I think that's the danger- so I think in order to feel safe people would want to talk to somebody who was completely outside the team (P 7)

I don't know how helpful group supervision is…you know if I'm going to be completely honest about something and how it's affecting me and what I need to do I think that's something that I would rather deal with one to one. You need to feel comfortable in a group (P 8)

Supervision is what your manager does to make sure that you're working properly and I think years ago when clinical supervision was brought out there was a lot of

people that thought it was a way of management knowing whether you were performing or not... I think there are people that worry that yes if they say certain things that that will be fed back (P 1)

Participants reflected on their anxiety about what it meant to admit that they needed to share and discuss things. This can be reinforced by the fact that, in some instances, supervision is supplied for a nurse who is seen to be struggling to cope.

I think it (autonomy) gets in the way of them saying actually its good to talk about things because if you need to talk about things is there a question that you're not managing your case load. It might become, do you need to talk to me because you need advice? (P 2)

I think formal supervision, that, that actually gives permission, right the idea of this is that you are going to bring your case load and its ok to do that, its almost permission giving (P 2)

3.3 Focus Groups:

Two focus groups were used, one covering each site. Four nurses participated in the first group and three in the second. Only one nurse who had been interviewed participated in the focus groups although all had completed the questionnaires.

Following the focus groups, they were transcribed and then the data was analysed, again using the procedure described in the method. Three main themes were identified and are presented here.

3.3.1 Theme 1: Mismatch in Expectations and Consequences:

In the focus groups the participants reflected on the expectations that are placed on their role from different directions, for example patients, their management and the Macmillan organisation. As their role has developed over recent years a mismatch has appeared to develop between what they do and what these three groups perceive that they do leading to confusion and the nurses feeling that their role is not understood.

I've seen the expectations change and I do think years ago it was the twinset and pearls, you went in…you'd have a little chat with them… but now I think for lots of people the expectation is you're coming in, you are going to be the expert… going to make it all better… they expect you to know everything about everything

I think the Trust expects things differently from us than Macmillan and that's sometimes different to what the public expects so you sometimes feel a bit caught in the middle of this

The participants felt that neither their patients nor their managers really knew what their role entailed and that sometimes their views were in opposition with each other. The participants discussed how their patients can expect anything from full time care to provision of equipment while the management can be preoccupied with targets and statistics, missing the human element of the role.

What the public thinks we do and what management think we do is sometimes a bit different

I had a relative and they thought that a Macmillan nurse came in a navy blue uniform with a navy blue coat, with a packed suitcase, and stayed for the duration of the patient's illness, at home… then I went to see this gentleman… he wanted to go home and his wife said could I sort out the commode because that's her main problem…

From the management side there's also this business of having all the boxes ticked… I think sometimes the timings wrong for that, you can't impose that on a person at that time… so you could come out with very few boxes ticked

(Management thinks we should) have a very structured approach to how we interact with people… without having an understanding of what people's needs actually are. You can't just get to the nitty gritty with someone within three minutes, it takes time for some people to build up a relationship with you and for them to feel able to trust you with things…

The participants reflected that there are several consequences for them because of these discrepancies. The main one that they discussed was that they sometimes feel that they have to choose between the needs of the management and the needs of the patient.

You think you're there to give them information… but then if they're not ready to hear it it does all backfire, but if you don't give it to them you feel you're not doing your job properly

You just end up feeling you haven't really quite done your job properly because you know you should be perhaps addressing, trying to address some of these things… but he's just not having any of it, didn't want to know

This can then impact on them as they question what their 'agenda' is when they visit a patient and actually is that what the patients needs or wants from them?

Whose agenda, whose needs are we fulfilling? Because we look upon it… to be able to assess somebody's needs, to be able to talk things through… but I'm not… it's back to whose needs, and is it what the patients want from us?

It can also have an impact as the misunderstanding of the role, particularly by management, means that sometimes people can come into the role without a clear picture of their job will be.

Not understanding and not being clear of the role of a palliative care nurse… is reflected when people are employed into post sometimes by management, because they don't have the necessary skills… some management don't understand what the role is about and so have a different expectation of it and therefore… that poor person comes into post but there's very little support mechanism there to help them develop in the role

Although it was recognised by the focus groups that the competency based roles will help to alleviate this difficulty and mean that the management will have a better understanding.

People's expectations, particularly management expectations, will be clearer of what they can expect of their palliative care nurse

3.3.2 Theme 2: What do They Need in Terms of Supervision?

The participants in the focus groups discussed their need for supervision because of the difficult and possibly emotional consequences of their role. They reflected that, while they found it useful and indeed vital to be able to share some of these things with their teammates more informally, supervision that was more formal and involved a facilitator was important.

We do informally… if someone's come in and had a really awful experience or a bad day then everybody will down tools… and will just listen won't we

I think you have to have something, with the sort of job we do, you know, day to day, facing people one after another, you've got to have… you've got to bring it somewhere…

It's almost like having, offloading it, in a way, you need somebody to offload it onto don't you…you're taking on people's problems all day long…. You need to be able to… offload them onto somebody sometimes and just discuss them… because you can be quite isolated if you're not careful because you're out there all day on your own.

However this overall need for supervision, when discussed further by the participants, seemed to involve different elements. The participants reflected that sometimes the supervision they were provided with did not cover everything that they needed.

Whilst the supervision that we get at the moment I think is great… it makes you think about how you manage your patients and manage their problems, but actually there is no supervision for actually how you manage the role…

The participants spoke of having different forms of supervision to help support them with the various areas of their role. The two main areas appeared to be support with their caseload, thinking about patient related matters, and an arena in which they could discuss team or management issues. The latter was also discussed as being set

up either as an open forum, with more reflective based sessions, or more as a team focused management meeting.

There's something about the difference between something like caseload supervision and supervision in terms of the other aspects of the job as well and how you actually manage the job…

We have an outside facilitator that comes in and that is with all the team, and that covers anything and everything, so we don't bring one specific thing, we just sit there and someone will start talking…

Rather than just having a team meeting but actually have like management supervision where somebody actually said, you know, right what have you brought for the agenda…

Therefore, while the participants definitely regard supervision as an important concept, they may see it as a series of discrete tasks which each focus on a certain area of their role.

3.3.3 Theme 3: How Should Supervision Be Set Up?

Following on from the previous theme, the participants went on to discuss the different possibilities in terms of how supervision should be structured in order that it meets their needs.

At the current time it appears that in some cases they have different supervision sessions and this seems to have created an element of confusion regarding the purpose of supervision, what it should cover and how. This involves even the terminology that the participants used to describe their supervision. Throughout both focus groups the term 'clinical supervision' was used in relation to their group sessions with an outside facilitator, while 'caseload supervision' was used when talking about the supervision that they have with the psychologist in the team looking at patient issues. These two sessions were discussed by the participants as very separate entities.

I think that caseload supervision is more patient focused whereas I think the clinical supervision is more about how we feel, what's affecting us rather than patients somehow

When I go to (clinical) supervision… we sit there and we all think and oh I might mention that, or if you're fed up of something that's happening in the team, you're bringing it up, but when I go to caseloads I know what I'm going for and I need results, I need something to help me… develop my skills

As these quotes also begin to indicate the participants felt that there was a different purpose in each session, either to think about specific patient issues or to reflect on their own emotions or the dynamics of the team. This differing purpose appears to have been made more pronounced for the participants by the way each is approached and set up.

In clinical supervision we don't actually have a specific framework put around the problem… what we have is exploring what's going on in the dynamics…

The clinical supervision it's much more open, it's not structured as such

When I get to caseload supervision… I'm going there for a purpose; I'm bringing something that I cannot manage.

You've got that space to say your piece… you don't have to wait for a gap or anything, you just know your turn is coming.

This variation in purpose and approach of supervision also appeared to involve the participants feeling that they would share very different material in each setting. It appears that where the caseload supervision stays very factual, in their group clinical supervision session they are sharing quite personal information.

In-house clinical supervision that we get facilitated by an outsider I find beneficial because I feel quite comfortable to disclose what kind of knickers and bra I've got on. Opening myself up, becoming very raw

I think the current clinical supervision is good because… it makes you think about the psychological side of it all…

However some participants were able to say that they found the more open and unstructured clinical supervision more challenging because of the expectation of sharing quite personal information within a group.

It's much more challenging to be in that forum and thinking about wanting to bring something than it is talking about patients. I haven't got a problem with my difficulty with a patient situation because I just want to talk it through, but bringing something personal up, that's a whole other thing really.

If something's upset you or made you think you don't always want to share your inner feelings with… however well you know your colleagues you don't always want to share everything, and if it's people you don't know very well you certainly don't want to share everything…

Therefore currently it appears that some of the participants view supervision as two separate processes, covering separate issues with different boundaries and expectations. When considering whether these two sessions could be combined, the participants felt that something would be lost if they did not have both and that combining would be very difficult, perhaps because of the personal nature of some of the material and the need to trust another individual.

If you just had the caseload supervision I think there would be a whole lot, a big gap, wouldn't there, in how supported you felt probably.

You're just saying can we just let one person do all of that. I would question that because who we have… caseload supervision with is a person we work alongside with… so the other kind of supervision is more earthy, more homing in sometimes on how you are and what's going on with you personally. And sometimes you don't want the outside health professionals to know about that.

If… you've got a problem that you bring about your patient … that has to be done on like a caseload supervision type thing and the role management and the other aspects are very different…

However the participants then reflected that they did discuss some personal matters in relation to their work with patients within the caseload session. Therefore there was an element of cross over, further the work they did in the caseload might be more useful than that done in the group session.

In caseload supervision they do feed back…I've brought somebody I had a real problem with because they were very angry… I really felt I couldn't do it… and it was quite useful… having that conversation…well have you thought about where they're coming from and what you could achieve… would that happen in the clinical supervision in the same way, I wonder, which it does in the caseload?

It's about looking at the… supervision question that you take, about why you've taken that patient or that family, and then sometimes that's then turned around, well, how did you feel when that was happening?

Caseload supervision is a higher level… I had some things that I had to do with a patient, and I thought well, I wouldn't have done that if I hadn't had this caseload supervision. And I don't think that- no disrespect to the clinical supervision team- I don't think that higher level where it got me doing…

In summary this theme presents the current confusion that exists regarding the concept and uses of supervision. Is it about specific patient issues or sharing personal information? And is it possible to think about these processes together?

CHAPTER 4: DISCUSSION

4.1 Summary of Main Findings:

This study had several aims and areas of exploration. Initially a baseline description of the sample was sought, providing data on demographic features, current levels of stress, and provision of clinical supervision. Then to explore the participants' views of the concept of clinical supervision, its usefulness and relevance to their position as PCNSs and also how it may be best delivered to maximise its efficacy.

Several significant findings needing discussion arose. Quantitatively, results showed a certain level of stress and psychological morbidity within the teams participating and that the provision of clinical supervision is inconsistent across these teams despite being members of the same cancer network.

Qualitatively, results reflected participants' anxieties regarding their psychological role, the potential emotional impact this work can engender and the expectations that are placed upon them. Focusing on support and supervision, although there is overall recognition for the need of clinical supervision, there appears to be confusion regarding the concept and reluctance to embrace it fully based on fears regarding confidentiality and trust. Combined, these two issues possibly limit the efficacy and uptake of clinical supervision for this professional group.

4.2 Stress and Distress within the Sample:

In the CBI, the rates of participants experiencing significant stress varied between subscales. Although the mean sample score for each element did not exceed the cut off indicating that overall rates across the sample fell within the normal range, the difference was minimal in the 'personal burnout' scale. The scores on the 'work burnout' and 'patient burnout' subscales demonstrated a greater discrepancy between the numbers of participants experiencing and not experiencing significant levels of stress. This may suggest that more participants were experiencing stress in relation to personal issues than with work and patients.

The GHQ data identified that approximately half of the sample were experiencing significant psychological distress. However as the majority of the participants had also indicated they were having some personal difficulties within their home lives, it was hard to distinguish whether the high scores on the GHQ were a product of work or home related issues. This confounding variable may also account for the higher results on the 'personal burnout' subscale of the CBI. If this was the case, then it may suggest that it is possibly the personal rather than the more work related issues that were causing the measured distress. Regardless of the source of the participant's distress, the GHQ data suggests that a good proportion of this sample is experiencing clinically significant levels of distress. This raises the question of how they manage this on a daily basis within their work. Feeling so low and stressed may well have a significant impact on their ability to cope effectively, particularly as their role involves such intense emotionality.

The results from both the CBI and GHQ are consistent with the literature as there has been shown to be high stress rates both in general nursing and palliative care specifically (Keidel, 2002, Taylor et al, 1999). In terms of the psychological morbidity, it has been stated that palliative care is one of the most challenging nursing roles because of the possible emotional consequences (Kendall, 2007). Therefore, although the GHQ data may be as a result of more personal based issues, the stress and distress experienced by PCNSs has been shown before to be related to the work they do on a daily basis.

4.3 Provision of and Need for Clinical Supervision:

4.3.1 Inconsistent Provision of Clinical Supervision:

Results demonstrated a mixed picture in the provision of clinical supervision for PCNSs, even within the same cancer network and indeed the same team. There was variation in the amount of supervision available, some receiving both caseload specific and team sessions on a monthly basis while others had just caseload supervision. There were also differences within mode of delivery (group or individual) and in the qualifications and/ or profession of the supervisor.

There were still some PCNSs who had no access to any supervision at the beginning of this study. Interestingly, it was the PCNSs working in acute hospital settings who

were without clinical supervision, in contrast to their colleagues employed by a local hospice. This possibly reflects a difference in organisational perception of the importance of emotional support.

The inconsistency of clinical supervision provision appears to be representative of the situation within the wider nursing culture. Despite the Department of Health recognising the benefits of clinical supervision (DOH, 1999, cited in Edwards et al, 2006), there seems to have been a delay in its widespread implementation (Cole, 2002, cited in Davey et al, 2006). Davey et al (2006) discussed possible reasons for this seeming reluctance to adopt clinical supervision. Firstly they cite Mc Sherry et al, (2002, cited in Davey et al, 2006) who argue that the implementation of clinical supervision has been more difficult because of a lack of higher organisational support. Nurses may have found it hard to justify time off the ward seeking support, particularly when working within the acute sector (Bishop, 1998, cited in Cutliffe, Butterworth and Procter, 2001).

Secondly Davey et al (2006) allude to resistance to clinical supervision from both management and practitioners. Cleary and Freeman (2006, page 988) openly demonstrate resistance describing clinical supervision as, "…despite it being a rather nebulous and poorly understood term in practice, it is often touted as a panacea to correct the ills of the health care system. Far-reaching benefits are often ascribed to clinical supervision including its ability to solve nursing's discontent, despite a lack of published empirical studies to support this assertion."

Possible reasons behind resistance include fears regarding managerial control and confusion around the purpose and delivery of clinical supervision (Davey et al, 2006). These ideas are expanded below.

4.3.2 Recognition of the Need for Clinical Supervision:
Despite resistance to and delay in uptake of clinical supervision, all participants interviewed, either individually or within a focus group, believed that they needed clinical supervision. This is in contrast to literature which suggests that nurses are satisfied with support already offered to them (Cheater and Hale, 2001, cited in Davey

et al, 2006) and that problems only occur when nurses are seen not to access this support (Cleary and Freeman, 2006).

There was recognition that clinical supervision could both develop their skills and protect their own emotional health. As in the Introduction (Mc Caughan and Parahoo, 2000, Botti et al, 2006), participants freely discussed anxieties surrounding their complex psychologically based work. Despite enjoying and valuing this aspect of their work, some participants felt this was difficult as it was an area in which they had little formal training. Instead they learnt this through experience of the role; indeed sometimes their psychological role was not stated within their job description. As mentioned, the communication skills and ability of PCNSs to create and maintain a therapeutic relationship are discussed without mention of training and development in the literature (Canning et al, 2007, Wallace, 2001).

Participants also discussed the personal emotional impact that their role can have. The need to build such intense relationships means the PCNS almost inevitably appears drawn into the emotional world of the patient. However when that individual dies there is an awareness that they should not be feeling grief. Instead they seem to deny this emotion from their experience. This can have consequences for their own emotional health by overloading them with unresolved bereavements (Rich, 2005). This may be evidenced in this sample by the results in the GHQ, although of course difficult to separate out from the impact of other life events.

The participants spoke of the value of clinical supervision in relation to both of these aspects of their role. They reflected on the difficulty of having to cope with the psychological role and emotional consequences on their own.

4.4. Expectations and Barriers Related to the Implementation of Clinical Supervision:

Despite participants' recognition that clinical supervision is a valuable concept and resource, when exploring possibilities further, barriers appear which seem to impact on their enthusiasm for it.

4.4.1 Expectation:

In palliative care, due to the PCNSs Band and level of experience, there is an expectation from management that they will be autonomous in their practice (Kelly et al, 2001). However this expectation of autonomy appears to have extended to how they cope with the complexity and emotionality of this particular field.

Participants reflected that they are left in difficult situations without support, sometimes to the detriment of their own needs. Their role appears to demand they 'give everything' of themselves in order to ease the patient's suffering. However, they are then expected to move on without thought or reflection. One participant described this as the need to be "super human" and therefore not rely on supervision.

There appears to be an increasing focus on the PCNS providing their own support or self care. One participant stated she was able to reflect on difficult situations in her own head, meaning that she was then able to cope with them better. The focus group participants reflected on the need to maintain a separate life outside work to look after themselves.

The volume of self care literature has increased in both general and palliative care nursing (Baumrucker, 2002, Keidel, 2002, Canning et al, 2007). Self care is an important aspect of how anyone, including nurses, can think about their quality of life. However, in this context it appears to exacerbate the perception that nurses should not reveal emotions regarding their work and that they should remain autonomous (Rich, 2005, Vachon, 1998). The danger is that a focus on self care and not clinical supervision may lead to a position where needing clinical supervision is seen as a failure by the nurse to do their job properly. Because of the need to be "super human" admitting to a fault may be very difficult.

4.4.2 Suspicion and Agenda:

Suspicion regarding the 'real' reason for clinical supervision appears to be another major barrier to its implementation (Butterworth, 1998, Hawkins and Shohet, 2006, Ladany et al, 1996 cited in Scaife, 2001).

The participants reflected that there are still assumptions made regarding clinical supervision having more in common with managerial control than personal support. This appears to be more common with less experienced nurses. Several participants stated they had once thought clinical supervision was about a manager checking on their work. One participant recounted an incident when they had tried to set up clinical supervision with less experienced nurses only to find that they felt unable to open up because they were concerned about the managerial 'agenda'.

It appears Davey et al (2006, page 239) are correct in their assessment that, "if clinical supervision is not disentangled from managerial control, nurses can perceive it as an invasive management tool used for performance monitoring, assessing 'coping abilities' and managerial discipline". The participants, despite experience, still appeared wary about the purpose of clinical supervision and possible 'agenda' setting.

Therefore the introduction of clinical supervision challenges their sense of power and autonomy (Bond and Holland, 1998). Not only does this mean they are less likely to welcome the concept of supervision, it also limits the possibilities of clinical supervision. In this situation a successful supervisory relationship is difficult to achieve. The nurse may feel unable to discuss issues openly, as were the nurses within the example provided by the participant. Without the trust that you can share anything but still feel 'safe' means that there is no relationship and therefore no basis for effective supervision (Butterworth et al, 1998).

4.5 Confusions within the Concept of Clinical Supervision:
Findings presented to this point create a background, against which confusion regarding the purpose of clinical supervision is understandable. However this confusion appears to have led to inconsistency between what is provided and accepted and the theoretical understanding of clinical supervision.

4.5.1 Clinical Supervision as Separate Discrete Tasks:
Many participants demonstrated confusion regarding both the concept of clinical supervision and how it should be delivered. Instead of viewing it as one model or framework, they tended to separate it into discrete tasks when discussing it. Their caseload management, facilitated by the psychologist was seen as a very different

process to the supervision with an outside facilitator focusing on personal issues. Cleary this distinction was emphasised as the two were covered within different sessions, but the participants' perception was that the two were disassociated from each other. One participant stated that, although she could see her emotions were implicated within her work with one patient, she would not raise this in her caseload session as personal issues were not discussed. Other participants demonstrated the same viewpoint; there was a definite barrier between what should and should not be discussed in each session. Either supervision was about the discussion of specific patient issues where you were given direct advice or it was based around the personal reflections of the nurses.

This separation of the functions of supervision is mirrored within the literature. Gilmore (2001, page 129) identified, "two principle and polarised types of supervision" being used with nurses. As in this study she stated that these focused either on caseload management or were an "in- depth exploration" of the nurse and their practice. In caseload management, attention is given to the decisions making of the nurse regarding treatment pathways for their patient. As the title given suggests it is close to a management supervision style and leaves no room for any further reflection or discussion (Gilmore, 2001). Whereas the more personal supervision is structured very differently with nurses being able to raise issues such as team dynamics, interactions with patients and their families and the therapeutic relationship (Gilmore, 2001). Here the supervisor concentrates on the process of the nurses' practice and focuses on more personal information.

The most obvious example of the separation of the concept of clinical supervision is seen in how it is applied with the two nursing groups currently seen to have access to clinical supervision regularly. For midwives supervision is primarily a management exercise looking at staff appraisal and disciplinary procedure (Bond and Holland, 1998).

In comparison, mental health nurses, perhaps because of their close links with therapy and counselling, experience a more personal form of clinical supervision. Difficulties noted by mental health nurses are the opposite of those discussed for midwives. Here

there is a reported tendency to over- 'therapise', pathologise and use non- responsive listening or interpretations by way of support (Bond and Holland, 1998).

Not only is it apparent that in nursing, clinical supervision has been divided into different processes but these processes have become polarised and allow for no overlap in the way they have been developed. Gilmore (2001) reflects that as both processes are such different interpretations, can they both still be termed clinical supervision and can the same outcomes be expected?

4.5.2 Inconsistency with Theoretical Understanding:

Three different models each describing the important factors that make up clinical supervision were presented in the Introduction (Inskipp and Proctor, 1993, 1995, Hawkins and Shohet, 2006, Holloway, 1995). Despite their differences in focus and attention each model followed similar principles and refer to the same processes and functions. At the heart of effective clinical supervision it appears that there needs to be a framework in which each of the functions and purposes are conceptualised (Scaife, 2001). The framework assists both the supervisor and supervisee to organise their experience and as a base from which to explore different issues and emotions. Clinical supervision is a complex process, whichever framework is utilised and involves the concurrent exploration of multiple factors. However as Hawkins and Shohet (2006, page 57) state, "combining the multiple functions is at the heart of good practice".

The main functions of clinical supervision present or underpinning each of the described models are learning and development, interpersonal reflection and awareness and monitoring or evaluation.

Learning and development is acknowledged to be one of the central components of clinical supervision (Scaife, 2001). Case conceptualisation in said to be fundamental as it is through this process that the supervisee begins to make theory practice links based on the client's presentation and their formulation of it (Holloway, 1995). Using learning theory, the supervisee's active involvement in putting knowledge and practice together, shifts 'declarative' knowledge into 'procedural'. This means that their understanding becomes tacit and automatic rather than the supervisee simply

being able to reproduce material verbally (Scaife, 2001). Scaife (2001, page 15) states, "learners cannot acquire the skilled performance without their own active involvement".

In clinical supervision it is recognised that, within their understanding of a client, the supervisee also needs to be aware of their own reactions and judgements. This is particularly important when working with people in distress as with the palliative care nurses within this sample (Scaife, 2001, Holloway, 1995). The cost of not being able to reflect on this in relation to their work is thought to be high. Hawkins and Shohet (2006 page 58) reflect, "not attending to these emotions soon leads to less than effective workers, who become over-identified with their clients or defended against being further affected by them".

One of the key reasons for the initial implementation of clinical supervision was the protection of the client or patient. Therefore a crucial element is the responsibility of the supervisor to maintain the standards expected by the organisation (Hawkins and Shohet, 2006). Outside of their association to the organisation the supervisor also has to consider a moral and ethical stance in relation to the supervisee's work (Scaife, 2001).

In essence clinical supervision is a multi factorial framework that supports each of these functions using the vehicle of the supervisory relationship to promote change and development. Although each element of the framework may be emphasised to a greater or lesser extent dependent on the profession and setting (Proctor, 2001), it could be said to be a symbiotic relationship. The overlap between different functions, for example the need to be aware of interpersonal interpretations while formulating a case conceptualisation, means that each function needs to be present for clinical supervision to be effective (Hawkins and Shohet, 2006). Indeed as Hawkins and Shohet (2006, page 60) state, "a good deal of supervision takes place where developmental (learning), resourcing (personal) and qualitative (evaluative) considerations all intermingle".

4.5.3 Is the Current Clinical Supervision Meeting Their Needs?

The majority of the participants in this study acknowledged a need for clinical supervision. From their primary concerns as palliative care nurses, this need was to have clinical supervision that both helped their confidence, particularly in regards to their psychosocial work with patients, as well as allowing them to discuss the impact that these patients had on themselves. In theory using a framework of supervision would have enabled them to consider both of these aspects, developing their skills in linking their knowledge to the situation while being aware of their own emotional processes. Because of the different structure of their role and the expectation that they provide emotional care this may have been even more beneficial.

However in practice, the inconsistent provision of clinical supervision meant some of the sample received solely caseload management, with no facility for reflection, while others had both caseload management and personally focussed group sessions. There is evidence to show that each separate process fulfils different needs of the practitioner. However by removing some of the picture there is also the possibility that other equally important needs are unmet (Gilmore, 2001).

4.5.3.1 Caseload Management:

As discussed above, in conceptualising cases it is important to be aware both of the patient and your own emotional reactions and interactions (Holloway, 1995). In taking the personal element out of caseload supervision it is harder for the PCNS to learn and to fully understand the process that is occurring between them and the patient. However the participants were clear that this was not something that regularly happened in their caseload management. They stated that personal reactions were taken to their reflective sessions. Although one of the focus groups did acknowledge the overlap and that they had begun to discuss such processes as part of case conceptualisation. If case discussion is kept at a patient level the consequence is that it will not allow the nurse to develop fully in their practice, meaning that their supervision has not met this need.

4.5.3.2 Group Reflection:

Some of the participants had reflective supervision with an outside facilitator. Reflection is defined by Johns (2004 page 3) as, "being mindful of self, either within

or after experience, as if a window through which the practitioner can view and focus self within the context of a particular situation, in order to confront, understand and move towards resolving contradiction between one's vision and actual practice". He considers the importance of the practitioner gaining insight and understanding of themselves within their interactions. The vehicle used to achieve this is 'reflection in the moment'. Here the practitioner can pay attention to the self within a situation and be able to reflect on this in the moment (Johns, 2004).

Using reflection as clinical supervision is seen as giving the practitioner space within their busy schedule to consider their actions. Johns (2004) quotes Senge (1990) regarding the goals of clinical supervision from a reflective standpoint. These include development of personal mastery, to clarify personal and collective visions of practice, to scrutinise one's mental models and shift towards effective practice, to review and revise systems, to develop dialogue expertise and to generate creative tension.

Reflective practice appears to be similar to that of Jones (2000, 2003, 2006). Again it is focussed very much on the internal experience of the nurse rather than considering factors such as the patient and the impact that their emotionality will have on the situation (Skilbeck and Payne, 2003). The PCNS is learning to focus within herself rather than to reflect on other psychological factors that come from the direction of the patient and their family.

Obviously reflective practice within a clinical supervision framework is a valuable tool. It allows the supervisee to think about their personal reaction to the patient and to evaluate why they acted in a certain way and how they may have done it differently. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC 1996 cited in Fowler and Chevannes, 1998) identified that reflective practice is a key process between the supervisor and practitioner. Further Fisher (1996 cited in Fowler and Chevannes, 1998) stated that reflection is the enabler between the three factors of clinical supervision.

However Fowler and Chevannes (1998) posited that reflective practice, which in some places is now regarded as the key element in clinical supervision, is not actually

the "sole happening within the process". Instead of seeing reflective practice as the only factor utilised within clinical supervision they suggest that while interesting and useful, it is not sufficient. It is unrealistic to expect that practitioners will naturally be able to effectively reflect on their own practice. One of the strengths of clinical supervision is its flexibility and the ability to structure it to fit the needs of particular groups. Due to these limitations of the reflective model it appears to be inappropriate to offer this as the primary form of supervision to all.

The participants in this study clearly demonstrated the concerns expressed by Fowler and Chevannes (1998). Some found their reflective sessions very useful and benefited from the opportunity to reflect so openly on their practice. For these individuals this model appeared to fit and they felt comfortable enough, as one participant stated, to 'display their bra and knickers', metaphorically speaking. Although they acknowledged that taking time out of their schedules was frustrating, particularly after certain sessions they could see the benefits.

However for a significant number, reflective sessions were a 'horrendous' experience as one participant reported. These individuals felt almost threatened by the openness of the format and found it very difficult to share any information. As a result they stated that they did not value these sessions and, in some cases, dreaded them. Due to their anxiety regarding having to discuss their practice in this forum some participants admitted to having fabricated events to take to the session to avoid feeling challenged about real happenings. For these individuals reflective practice in this group format was not meeting their needs. Indeed it may also have a detrimental effect on their stress levels (Fowler and Chevannes, 1998). However due to the structure employed the thoughts of these nurses may not be clear as this would not be generally voiced.

One issue is that this format of reflective practice seems to require a great deal of trust in both the other participants and the facilitator. Firstly this is difficult due to the general suspicion regarding supervision existing within the nursing culture. Secondly, for some individuals this level of trust is personally challenging in itself. Some of the participants discussed their difficulty in feeling comfortable in sharing personal information with people that they knew very little. Without this ability to trust the situation, despite being present, these individuals would get no benefit from their

supervision sessions. Trust is a central factor in the art of clinical supervision and no trust means that it can have little efficacy (Cutliffe et al, 2001, Hawkins and Shohet, 2006).

Because of the personal nature of the content of reflective sessions, without very careful handling by the facilitator, it can become very close to therapy. Going back to the participant who felt able to reveal her bra and knickers, is this an appropriate level for a supervision session? Within the models of clinical supervision two guidelines for practice were presented. Clinical Supervision should always remain relevant to the work context and should not become personal therapy (Scaife, 2001, Hawkins and Shohet, 2006). However in discussing their reflective sessions some of the participants stated that they brought situations that were more personal to the group setting. Johns (2004) also states that some of the benefit of reflective practice does occur outside of work.

In each case it appears there are instances when the needs of the nurse as a supervisee are not being adequately met. Interestingly some of the participants, who had access to both caseload management and reflective practice, albeit in different sessions, did not appear to be any more satisfied. Instead of being able to fuse the concepts together, they demonstrated more frustration and confusion regarding their supervision.

4.6 Future Practice:

As stated in the Introduction NICE guidelines (2004) recommend that the task of clinical supervision for nurses in palliative care is provided by the Level 4 practitioners. The findings from this study reveal that, while the potential of clinical supervision is recognised by PCNSs, confusion and suspicion has developed which impacts on its efficacy in practice.

It appears that, for clinical supervision to be accessible and useful for all PCNSs the inconsistencies between the theory and practice need to be bridged. For example education regarding the models of supervision may reduce the suspicion and careful discussion and contracting may help tailor a clinical supervision package that is flexible enough to suit the majority.

In 2007 the British Psychological Society (BPS) published guidelines regarding the role of psychology in end of life care. However there are some discrepancies between their recommendations in this area and the findings of this report. Although they refer to clinical supervision as a particular form of support useful in this context, they appear to advocate the education of nurses in a variety of self care skills as the main task of this role.

As mentioned previously in this report, due to the societal climate regarding individualisation, and the expectations of the nursing culture, self care may not be the most appropriate way to protect palliative care nurses. Instead of empowering them, it can feed into the concept that nurses should take care of themselves and not seek support from others. Due to their anxieties regarding the psychological role that they provide, it also appears vital that they have access to supervision in order to learn and develop in this area. Again a focus on self care would not provide them with this facility. Palliative care nurses already have to be "super human", having full responsibility in maintaining their stress levels, may be detrimental rather than helpful.

4.6.1 Recommendations for Changing Supervision Practice:

Following this study it is clear that a number of changes have to be accomplished in order to promote understanding of and better access to clinical supervision for PCNSs. These changes need to be targeted at different levels to maximise the impact of the issues involved and lead to generalised change across the organisation over time rather than local changes in one team. As Level 4 practitioners and the intended supervisors, clinical psychologists should take a lead role in the promotion and implementation of these changes, both within their teams and in the wider community.

Firstly, as mentioned throughout this study, changes are beginning to occur at a policy level, both from the NHS and the BPS. While encouraging, it is important that these organisations continue to promote the usefulness of clinical supervision. Involvement at this level could lead to more widespread implementation as well as continued research into the benefits of clinical supervision for this staff group.

At a management level there needs to be a presence from clinical psychology providing education regarding the aims and functions of clinical supervision and how this should be structured. Currently, as seen within this study, there appears to be confusion around the focus of supervision and the separation of it from other managerial monitoring practices. This leads to supervision being an object of anxiety for nurses, particularly when management figures are directly involved. From a management perspective it is beneficial for nurses to be able to freely discuss cases and their own issues leading to less stress. Therefore a need for greater confidentiality and distance from management practices should be raised. For example management should not attend sessions where nurses are expected to discuss sensitive issues. There also needs to be more consistency in the provision of clinical supervision and team strategy needs to be changed to account for this. This means having 'central' supervision, rather than different functions being fulfilled in different meetings.

Finally there needs to be changes implemented with the nurses themselves in order to enable them to feel more confident in using clinical supervision effectively. This can be pursued by the clinical psychologist through education and within the practice of supervision itself leading to greater trust.

4.7 Limitations of this Study:

There are several limitations to this study which became apparent during the process of investigation and are presented here.

4.7.1 Recruitment Issues:

In order to gain access to the palliative care nurses who made up this sample, it was necessary to first approach the Lead Nurse. This did have its advantages, for example the Lead Nurse was able to arrange for the researcher to present the study at the area multidisciplinary team meeting. However as the study progressed it was recognised that this scenario also had costs. Firstly it did precipitate a situation in which the Lead Nurse may have become clearer regarding the identity of the participants. Secondly, in one of the teams it meant that the research was discussed at a multidisciplinary team meeting without the researcher's prior knowledge. Although no confidentiality was breached in this situation the potential for this occurrence was there.

Having to use the Lead Nurse as an intermediary may also have meant that the research became associated with the management for the nurses. Due to suspicion and anxiety regarding the purpose of supervision and the possible 'agenda' of the management this may have meant that the participants felt more restricted in what they could say.

4.7.2 Limits of Confidentiality:

At times during this study it was difficult to ensure that confidentiality was maintained. This was particularly the case as the participants were interviewed at their place of work. Initially this was arranged due to the time pressures involved in them having to travel. However it meant that some of the other nurses present could have become aware of who was being interviewed. The researcher attempted to contain this within limits.

Due to some of the concerns regarding confidentiality there have been aspects of the results that have been under reported. In some cases the possibility of the nurse in question being identifiable was raised and therefore some quotes and examples were removed.

4.7.3 Association with the Psychologists Attached to the Teams:

The connection of the researcher to the psychologists within the teams was recognised as a possible limitation. Particularly in one of the teams the researcher was known to the nurses as being part of the psychology team. This association may have impacted on the participants feeling that they could talk openly regarding the caseload management as this was provided by the psychologists. Had the researcher been more independent then their feedback on this aspect may have been different.

4.7.4 Focus Groups:

It is recognised that the make up of the focus groups was not truly representative of the sample. In the first focus group all of the PCNSs present were working within a community setting and in the second they all worked in the acute hospital sector. This meant that it is difficult to compare the data as their roles were actually different.

Therefore the results from the focus groups in particular have problems in terms of generalisation of findings.

From a wider perspective on this study there are also limitations in terms of the data from the interviews. Due to the stratified random design only one nurse from each setting was interviewed. Again this means that this individual's view may not be representative of their colleagues and therefore these views cannot be assumed to be shared by all.

Wider still, this study only approached two teams within a cancer network. To achieve more representative data each team would have to have been included. In order to create more generalisable findings the next stage would be to design a study which involves the whole network.

4.7.5 Coping Strategies:

One aspect that was not fully explored in this study was the PCNSs personal coping styles. This may have introduced more variables in interpreting how they cope with their role and what form of clinical supervision would have been useful.

4.8 Future Directions for Research:

In the course of doing this study several questions for future research were raised and some are presented here:

4.8.1 Clinical Supervision with Less Qualified Nurses:

The participants of this study were all Band 6 and above meaning that they were highly skilled and specialist in their role. Although still not consistent, clinical supervision for these nurses is something that has been an issue for some time because of their stature and the complexity of their role. It was noted that nurses below Band 6 do not have the same access to supervision. These nurses, such as those on the ward and district nurses are seen not to need clinical supervision to the same extent as their role is more physical. However, this distinction is not clear and the patients and families do still ask these nurses for support at very intense times. The nurses also tend to spend a lot of time with families, meaning that the emotional consequences are

possibly even greater for them. It was the participants themselves who raised the issue, stating that these nurses were the ones in greater need of support.

As a future study it would be interesting to look at the value of initiating clinical supervision with these nurses.

4.8.2 Personal Burnout:

The main finding from the questionnaires was that the nurses were experiencing a great deal of personal burnout during this study. The majority commented that they were having difficulties outside of work. This raised a question whether this was comparable to the amount of personal difficulties seen in a sample of workers with a less stressful job and whether the same impact on the personal burnout scale was observable. It was hypothesised that the stress of the job may be having significant consequences for the nurses outside of work, then making their work life more difficult. It would be interesting to investigate this further.

4.9 Conclusions:

This study examined the stress levels of nurses and then explored the usefulness and delivery of clinical supervision for palliative care nurses within two teams. The results showed that, despite enthusiasm for the concept, a range of barriers and confusions meant that an inconsistent pattern of clinical supervision which did not meet all the needs of the nurses had developed. In order to rectify this and provide better support for these nurses a framework of supervision consistent with theory was suggested.

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APPENDIX 1: QUESTIONNAIRE PACK

University of Hertfordshire **UH**

CONSENT FORM

Title of Project: **Supervision and Palliative Care Nurses: An Exploration in Providing Interdisciplinary Support for the Psychosocial Aspects of Their Role**.

Researchers: Elizabeth Dixon, Trainee Clinical Psychologist
Dr Anne Lee, Macmillan Consultant Clinical Psychologist

Please initial box

1) I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information and if needed ask questions that were satisfactorily answered.

2) I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my professional position being affected.

3) I agree to take part in the above study

4) I agree that information given in the questionnaires will be used anonymously in the study but that confidentiality will be maintained at all times.

5) If participating in the interview or focus group I agree that it will be audiotaped

……………………………….. ……………….. …………………………………
Name of participant   Date   Signature

……………………………….. ……………….. …………………………………
Name of person taking   Date   Signature
consent (if different from
researcher)

……………………………….. ……………….. …………………………………
Name of researcher   Date   Signature

Study Title: Supervision and Palliative Care Nurses: An Exploration in Providing Interdisciplinary Support for the Psychosocial Aspects of Their Role.

Researchers: Elizabeth Dixon, Trainee Clinical Psychologist
Anne Lee, Macmillan Consultant Clinical Psychologist

You are being invited to take part in a research study. Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives or colleagues if you wish. Please feel free to ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the Purpose of the Study?
In this research project the aim is to explore the level of work related stress in a team of palliative care nurses and to explore a model of supervision that would adequately meet their psychological needs. Research has shown that this is an important area because of the amount of emotional stress that nurses are under on a daily basis (Jones 2006).

Supervision would provide a space for nurses to be able to reflect on and discuss their work in a supportive environment. Obviously some supervision is currently available but in some teams this can be infrequent and difficult for the Nurses to access, both practically and emotionally. The ultimate aim of the study is for me, as a trainee Clinical Psychologist, to work collaboratively with Nurses to reflect on a model of supervision that is both managerially practical and adequate to meet their psychological needs.

Supervision means different things to different people. In this study, when we use the term supervision we mean having time to think about and discuss cases with a peer as well as being able to consider our own psychological reaction to patients. We are aware that in the nursing profession, supervision may take different forms, such as a Reflective Group with your colleagues. One of our aims here is to differentiate the different types of supervision offered to nurses, and to think about the strengths and weaknesses of different supervision practices.

Why Have I Been Chosen?
We have approached palliative care nurses working within the Bedfordshire and Hertfordshire teams and part of the Mount Vernon Cancer Network. Nurses employed from Grade 6 and above, working either in a hospital, hospice or community setting will be asked to participate.

Do I Have To Take Part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect your professional position within the Trust.

What Will Happen To Me If I Take Part?
If you decide to take part you will be asked to complete some questionnaires looking at your stress levels and your general level of health. I will also be taking some demographic information about yourself (e.g. your age, ethnicity) and your level of experience within the profession. It is anticipated that it would take no more than half an hour to complete these forms and you will have a period of a week in which to do this.

We may then approach you and ask if you would be willing to be interviewed on an individual basis. This interview will be with the researcher and will cover information regarding your daily job and discussion about the supervision that you currently have. This will last approximately one hour and will be conducted at your place of work. The interview will be taped and then transcribed by the researcher and the data drawn from it will be completely anonymised. The information collected from these interviews will be used to develop a model of supervision.

Following the interview you will be invited to attend a focus group. The purpose of this group will be to give you information about the supervision model that has been developed through the interviews, and to ask for your feedback on it. It will not involve you discussing any personal information. The focus group will probably last for approximately one hour and will take place in Luton.

Dealing with stress:
If, in the course of this research, it becomes apparent that you are suffering with significant levels of stress, we will encourage you to seek support for this through your GP or Occupational Health service. If we were to become concerned that your level of work-related stress was impacting on your performance at work, we would discuss with you whether this needed to be shared with your line manager. In extreme circumstances, it may be necessary for us to seek advice from a senior colleague if we were significantly worried about your mental health. We do not anticipate that this will be the case for any of the nurses involved in this study, but have an ethical obligation to inform you of this as a possibility.

What Are The Possible Benefits Of Taking Part?
Following the completion of the study you will receive both group and individual feedback regarding the outcomes. This may give you added support in dealing with the emotional strain of your job. You will also have contributed to building a greater understanding of the stress related with working in this area and the role for supervision in addressing this. This information will hopefully then be used to guide future service development.

Will My Taking Part Be Kept Confidential?
All information that is collected about you during the course of this research will be anonymised and kept strictly confidential. Any information about you, which leaves

the hospital, will have your name and address removed from it so that you are not identifiable. If on a computer the information will also be password protected.

Information will be kept in a secured place within the Psychology Department based at the Disability Resource Centre, Dunstable, only to be accessed by the researchers. Transcripts and audiotapes from the interviews and focus groups will all be numbered to protect the identity of the participants. Tapes will be wiped following the completion of the study.

Who Has Reviewed The Study?
The Bedfordshire Research and Ethics Committee has reviewed this study and found it ethically sound.

Thank you for reading this information and for taking part in this study. You will be given a copy of this sheet and the signed consent form to keep.

Contact Information:
Researcher: Elizabeth Dixon, Trainee Clinical Psychologist
E-mail: E.Dixon@herts.ac.uk
Telephone Number: 01707 286322
Postal Address: Doctor of Clinical Psychology Training Course, University of Hertfordshire, Hatfield, Herts., AL10 9AB

Researcher: Dr. Anne Lee, Macmillan Consultant Clinical Psychologist,
E-mail: Anne.Lee@blpt.nhs.uk

DEMOGRAPHIC INFORMATION

Section 1: Personal Information:

Name:

Age: under 25   25-35   35-45   45-55   55+

Gender: F   M

Section 2: Professional Information:

Place of Work:

Setting of work e.g. ward based, community:

Job Title:

Working Hours (per week):

Number of Years Qualified: 5 and under   5-10   10-20   20+

Qualifications to date:

Number of Years Practising: 5 and under   5-10   10-20   20+

Section 3: Previous experience of supervision:

Do you currently have supervision (Please circle)?

          Yes   No   Available but I don't participate

If yes:

How regular is the supervision?

Weekly   Fortnightly   Monthly   Other

Please explain if Other:

Who is your supervisor (e.g. your manager, clinical psychologist…)?

Is your supervision individual or group based and, if in a group, who else is present and how many?

If no:

What other support structures do you have in place?

Have you had supervision in the past?

Yes   No

If Yes please explain:

If you have chosen not to participate in supervision can you please briefly explain why?

Are there currently any stressful events at home that may be impacting on your stress levels at work? (Please circle)

  Yes   No

1. *Please tick box that is closest to your experience:*

	Always	Often	Sometimes	Seldom	Never/ Almost Never
How often do you feel tired?					
How often are you physically exhausted?					
How often are you emotionally exhausted?					
How often do you think 'I can't take it anymore'?					
How often do you feel worn out?					
How often do you feel weak and susceptible to illness?					

2. Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks*. Please answer ALL the questions simply by marking the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions.

Thank you very much for your co-operation

HAVE YOU RECENTLY…

Been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual

Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
Felt constantly under strain	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
Been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

3. *Please tick box that is closest to your experience*

	To a very high degree	To a high degree	Somewhat	To a low degree	To a very low degree
Is your work emotionally exhausting?					
Do you feel burnt out because of your work?					
Does your work frustrate you?					

	Always	Often	Sometimes	Seldom	Never/ almost never
Do you feel worn out at the end of the working day?					
Are you exhausted in the morning at the thought of another day at work?					
Do you feel that every working hour is tiring for you?					
Do you have enough energy for family and friends during leisure time					

4. *Please tick box that is closest to your experience*

	To a very high degree	To a high degree	Somewhat	To a low degree	To a very low degree
Do you find it hard to work with patients?					
Do you find it frustrating to work with patients?					
Does it drain your energy to work with patients?					
Do you feel that you give more than you get back when you work with patients?					

	Always	Often	Sometimes	Seldom	Never/ almost never
Are you tired of working with patients?					
Do you sometimes wonder how long you will be able to continue working with your patients?					

Thank you for filling in this questionnaire.

If any of the questions in these questionnaires have raised issues for you personally, please contact the researcher using the following.

Researchers: Elizabeth Dixon, Trainee Clinical Psychologist, University of Hertfordshire and Anne Lee Macmillan Consultant Clinical Psychologist. E-mail: E.Dixon@herts.ac.uk or Anne. Lee@blpt.nhs.uk

APPENDIX 2: INTERVIEW SCHEDULE

QUESTIONS FOR RESEARCH INTERVIEWS

Section 1:

What is your job description?
What does that mean in terms of your day to day experience?
- What do you do in a day?
- How many families do you hold at any one time?
- Do you work independently or with a colleague?
- Do you work on- call?

Thinking about the different aspects of their role:
Medical:
- What is involved?
- What is the aim?
Psychosocial:
- How do you feel about this aspect of your job?
- What are the challenges?
- How do you manage personally, in the moment and afterwards?
- How do you find building therapeutic relationships?

What the difficulties and rewards of your job?
What support structures do you have in place?

Section 2:

What is your experience of supervision?
- Do you currently have supervision?
- Have you had supervision in the past and in what format?
What are your views around supervision?
What are your beliefs around supervision?
- What do you understand about supervision?
- What is it for?
- What's useful about it?
What might present you from going to supervision?
What support/ supervision do you feel nurses in their role need?
- medical
- psychosocial
Is the supervision you get meeting your needs?
Are there any specific gaps?
What would be your ideal supervision package?

APPENDIX 3: FOCUS GROUP PROMPTS

1. When reading through the literature I noticed that there are a lot of expectations placed on palliative care nurses. How do you feel about this and what do you think the expectations are from the management, patients and society.

2. In your role how do you feel about building relationships with patients and families?

3. What do you feel would be your ideal supervision package which would meet all your need in your role?

4. How does the issue of trust arise in supervision?

APPENDIX 4: ETHICAL APPROVAL LETTER

Bedfordshire Research Ethics Committee

Ambulance Training Centre
Via Location Code Q7
QE11 Hospital
Howlands
Welwyn Garden City
Hertfordshire
AL7 4HQ

Telephone: 01707 362585
Facsimile: 01707 394475

02 October 2007

Miss Elizabeth Dixon
Trainee Clinical Psychologist
Cambridgeshire and Peterborough NHS Trust
Doctorate of Clinical Psychology Training
University of Hertfordshire, College Lane,
Hatfield

Dear Miss Dixon

Full title of study: **Supervision and McMillan Nurses: Meeting the Psychological Needs of Palliative Care Nurses**
REC reference number: **07/H0309/49**

Thank you for your email of 25 September responding to the Committee's request for further information on the above research and submitting revised documentation.

The Chair has considered the further information on behalf of the Committee

Confirmation of ethical opinion

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

Ethical review of research sites

 The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

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

Document	Version	Date
Application		24 August 2007
Investigator CV		
Protocol	2	24 August 2007
Covering Letter		24 August 2007
Questionnaire: Demographic	V3	25 September 2007
Questionnaire: General Health		
Questionnaire: The PsychNurse Methods of Coping		
Participant Information Sheet	V3	25 September 2007
Participant Consent Form	2	24 August 2007
Response to Request for Further Information		
Maslach Burnout Inventory (MBI)		
Supervisor's CV		
Letter of Unfavourable Opinion		13 August 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

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

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

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

Yours Sincerely

**Mrs Jocelyn Ang
Chair**

Email: jenny.austin@nhs.net

Enclosures: Standard approval condition, SL-AC2

Copy to: Dr Nicholas Wood
                     University of Hertfordshire Q217
                     College Lane
                     Hatfield
                     Herts
                     AL10 9AB

                     Dr Alex Harbourne
                     Clinical Tutor, Dept of Psychology
                     University of Hertfordshire, Q217
                     College Lane
                     Hatfield
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                     AL10 9AB

                     Sue Hall, Administrator for RM&G
                     HertNet
                     University of Hertfordshire, Q217
                     College Lane
                     Hatfield
                     Herts
                     AL10 9AB

APPENDIX 5: LETTER TO PARTICIPANTS

<div align="right">
Department of Clinical Psychology
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB
</div>

Dear

Thank you for taking part in my recent research project, your participation was very valuable. I will be presenting the results to the team soon.

As was discussed at the meeting when I first presented the research and mentioned in the information sheet I asked for your names on the questionnaires. This was so that I could identify if anyone was currently experiencing high stress levels and then inform you of this.

When you completed the questionnaires, there was an indication that you are feeling stressed at the moment. You may be experiencing some of the symptoms of stress or feeling quite low or anxious. This may happen either at home or at work. Sometimes people can be very aware of themselves feeling stressed and recognise the triggers, but sometimes this can be harder to identify, particularly in such a hectic environment.

There are various places you can go if you wish to discuss your stress. Your GP will be able to offer advice and maybe make some suggestions. Also Occupational Health may be able to offer some support. Otherwise you could discuss it, if you wish to, with your manager, supervisor or a trusted colleague.

As I am not fully connected with the team I would not be able to offer you direct support. However feel free to email me if you have any questions regarding this letter.

Once again thanks for your participation

Yours sincerely

Elizabeth Dixon
Trainee Clinical Psychologist

EXAMINING CLINICAL SUPERVISION WITH PALLIATIVE CARE NURSES

JOURNAL READY COPY

July 2008

ABSTRACT:

This study addresses the provision of clinical supervision for palliative care nurses. It employs a staff survey, including a demographic questionnaire, the Copenhagen Burnout Inventory and the General Health Questionnaire, followed by individual interviews and focus groups, analysed using thematic content analysis. Participants were recruited from two teams within one Cancer Network. Although recognised as beneficial, there was confusion regarding the concept of clinical supervision and suspicion about the 'real' agenda. Its application in context was inconsistent with the theoretical basis. It concluded that a more structured and consistent picture of clinical supervision was needed.

INTRODUCTION:

Service Context:

Cancer services and palliative care are one of the most complex areas of the NHS. National Institute of Clinical Excellence (NICE, 2004) guidelines place increased focus on provision of specialist psychological care for cancer and palliative patients as research suggests this is a core component of good quality care (DOH, 2000 cited in Payne and Haines, 2002).

Aside from providing specialist care for the patient, the two main roles for the clinical psychologist in palliative care refer to support and supervision.

Providing Case Related Supervision:

Within cancer and palliative care services professionals from both health and social care backgrounds provide psychological support (NICE, 2004). However NICE (2004) suggest some professionals may feel overwhelmed by this role and lack confidence. Therefore NICE (2004) developed the Model of Professional Psychological Assessment and Support.

In this model there are four levels of intervention based on training. The aim is that professionals at lower levels receive support and supervision from those at higher levels, for example clinical psychologists, thereby boosting confidence and effectiveness.

Providing Personal Support for Palliative Clinical Nurse Specialists (PCNS):

The clinical psychologist is also seen to have a role in the provision of emotional support for the nurses. Being a PCNS is described as one of the most challenging and potentially stressful roles within the nursing profession due to emotional impact (Barnard, Street and Love, 2006).

The Stress of a Palliative Care Nurse:

Clinical Role:

Despite an increased focus on the importance of emotional support within their role, PCNSs feel inadequate in providing this (McCaughan and Parahoo, 2000). However,

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a belief exists that they will develop an intimate understanding of the individual's response to their illness in a "highly skilled, sensitive, timely and person- centred way" (page 227 Barnard, Hollingum and Hartfiel, 2006, Canning et al, 2007). There is no explanation offered beyond experience of how the nurse gains these skills. Wallace (2001 page 87) states that there is "no mystery" involved in the maintenance of a therapeutic relationship. This fails to recognise that both nurse and patient contribute equally to any interaction (Skilbeck and Payne, 2003).

Emotional Consequences for the PCNS:

Continual exposure to dying patients and the requirement to develop close relationships can result in "death anxiety" (Rich, 2005). The PCNS is constantly reminded of their own mortality and that of their loved ones.

PCNSs also have to cope with feelings of intense personal pain and an acute sense of loss. Rich (2005, Kendall, 2007) discussed the difficulties of not having space to grieve for patients.

The Use of Clinical Supervision to Reduce Stress and Enhance Practice:

Literature focuses on self care strategies to avoid stress (Baumrucker, 2002, Keidel, 2002, Canning et al, 2007). This fits with evidence regarding the current stress discourse and focus on individualised self care (Donnelly and Long, 2003, Harkness, 2005). However is it a realistic expectation that nurses manage their own stress (Baumracker, 2002, Keidel, 2002)?

The British Association for Counselling and Psychotherapy (BACP) definition for clinical supervision (CS) is, "the task is to work together to ensure and develop the efficacy of the counsellor/ client relationship. The agenda will be the counselling work and feelings about that work, together with the supervisor's reactions, comments and confrontations" (BACP cited in Fleming and Steen, 2004 page 2).

Three models contributing to the understanding of clinical supervision have been devised by Inskipp and Proctor (1993, 1995), Hawkins and Shohet (2006) and Holloway (1995). Each focus on a different aspect, providing insight into the purpose of CS (Inskipp and Proctor, 1993, 1995), the interaction between function, task and

relationship (Holloway, 1995) and the centrality of the supervisory relationship (Hawkins and Shohet, 2006).

Although clinical supervision is shown to be a multi-faceted concept, core ideas in each model include the need to protect the client (Scaife, 2001), to enhance the skill of the practitioner (Hawkins and Shohet, 2006, Holloway, 1995) and exploration of the emotional impact of psychosocial work on the practitioner (Hawkins and Shohet, 2006).

Issues that may impact on the efficacy of CS are the danger of crossing the line between supervision and therapy (Scaife, 2001), the importance of trust (Hawkins and Shohet, 2006) and the necessity to only discuss personal issues in relation to the work (Scaife, 2001, Hawkins and Shohet, 2006).

Clinical Supervision in Nursing:

In nursing CS is thought to be a valuable preventative measure against stress (Hawkins and Shohet, 2000) and a tool that can improve nursing practice (Jones, 2000). However there is concern over perceived methodological weaknesses within early literature (Teasdale et al, 2001) due to concentration on individual research and subjective opinion (Hyrkas, Appelqvist- Schmidlechner and Haataja, 2006).

This confusion is intensified as there appears to be no clear definition of CS in the nursing culture (Davey, Desousa, Robinson and Murrells, 2006). Therefore a 'patchy' pattern of CS has appeared, possibly using inappropriate models for different care contexts. It also means that CS has become a non-mandatory requirement (Cleary and Freeman, 2007).

This reluctance appears to be creating a situation in which CS may be difficult to achieve. Nurses may feel that they are being evaluated meaning trust is unlikely (Davey et al, 2006).

Clinical Supervision for Palliative Care Nurses:

Jones (2000, 2003 2006) provided group supervision for PCNSs. Based on his theory that palliative patients unconsciously project negative emotions onto the PCNS; the

purpose of CS would be to help the nurses not feel overwhelmed by these feelings (Jones, 2003).

Although nurses described supervision as providing new and experiential ways of looking at their jobs (Jones, 2006), it was also reported that nurses found CS stressful due to having to share very personal information (Jones, 2006).

These negative findings may reflect issues of trust and the importance to remain work focussed. This model concentrates very much on the lived experience and internal processing of the PCNS.

In relation to the models of supervision presented, it does not acknowledge contextual factors, complexity of the patient's emotional state, the impact of this on the nurse and the discussion within the supervisory relationship (Scaife, 2001). The PCNS is learning to focus on themself rather than reflect on other psychological factors coming from interaction with the patient.

Aims of the Current Study:

This study seeks to explore further the use of clinical supervision with palliative care nurses, including how it is currently structured and how it is received and perceived by the nurses themselves.

There appear to be barriers preventing CS from being effectively provided for this staff group. However there is clear need for these professionals to have clinical supervision to aid their management of patients and their own emotional reactions.

This study proposes to ask the following questions:

- What are current stress levels present within each team and the impact on their psychological well being?
- What supervision are they currently receiving?
- How effective do they find this supervision, strengths and weaknesses, what are their needs are in this area, what would mean they would not attend and what else would be useful?

- What would the most useful supervision package for them look like?

The aim is to consider what is currently happening concerning provision of CS for this group and how this can be taken forward in the future by clinical psychologists in this role.

METHOD:

Design:

This study employed a mixed research design using both quantitative and qualitative methods, presented in three stages. Full ethical approval was granted by the relevant Ethics Committee.

Stage 1: Quantitative:

Participants completed a range of questionnaires (some standardised and one designed by the researcher). These elicited the participants' stress levels, psychiatric morbidity, their experience of supervision and demographic information.

Stage 2: One to One Interviews:

Eight participants were invited to attend a face to face interview. Interviews were semi- structured; allowing information to be gathered without restricting what each participant could bring to the discussion.

Stage 3: Focus Groups:

Two focus groups took place after the interviews. The aim was, firstly to open up discussion around some issues raised by the literature and secondly to address the supervision needs of the participants and how these may best be delivered.

Participants and Selection:

The participants came from the same Cancer Network but represented two cancer teams in different counties (Areas A and B). The two teams differed in the amount and type of supervision the participants currently had access to.

Within each team participants were further split as they worked in different contexts (community, hospice and hospital). The researcher used a stratified random sample to ensure each was adequately represented. All the PCNSs approached were Band 6 or above on the Agenda for Change pay scale.

In Area A, 13 out of 20 (65%) nurses responded to the questionnaires. In Area B, 14 out of 20 (70%) responded. Four nurses from each area were invited for interview and all (100%) agreed.

For the focus groups an open invitation to attend was extended to all of the nurses in each area. In Area A four participants attended while in Area B, three attended. Only one participant who attended interview also participated in the focus groups.

All participants were asked to give their consent to the procedure. They retained freedom to withdraw at any point during the process. All records and quotes are used with full confidentiality.

Analysis:

Quantitative:

The results from the questionnaires were analysed using SPSS. Descriptive statistics gave a baseline indication of the amount of stress and psychological distress present in the participants.

 Qualitative:

Data from the interviews and focus groups were analysed using thematic content analysis. In this study the themes presented reflect the content of the entire data set in order to create a rich overall description of the participant's thoughts. To maintain this richness, the themes were identified in an inductive way. Finally the themes were identified at a semantic level, reflecting the explicit meaning, rather than exploring below the surface.

Measures:

Demographic Questionnaire:

The Demographic Questionnaire consists of a series of open and closed questions, starting with details regarding the participant and then exploring their access to supervision.

The General Health Questionnaire 12 Item (GHQ- 12)

The General Health Questionnaire 12 Item (Goldberg and Williams 1988) was chosen due to the speed of completion. In this study the GHQ was scored using both the GHQ method (to identify participants achieving "caseness").

The Copenhagen Burnout Inventory (CBI)

The CBI was developed in 2001 by Borritz and Kristensen, based on the results of their project on Burnout, Motivation and Job Satisfaction (PUMA). It explores burnout in the context of personal, work and patient related factors. It has been shown to have good reliability data with Cronbach alpha scores of 0.87 (Personal Burnout), 0.87 (Work Burnout) and 0.85 (Client Burnout). It also has high inter-item and item-scale correlations.

CHAPTER 3: RESULTS

Questionnaire Data:

Current Supervision:

66.7% of the participants reported currently having supervision. The most common facilitators of supervision for this sample were the team psychologist (29.6%) and outside professionals (25.9%).

Copenhagen Burnout Inventory (CBI):

	N	Minimum	Maximum	Mean	Std. Deviation
Personal burnout	27	21.00	73.00	45.6667	14.76222
Work burnout	27	18.00	61.00	40.1111	13.54006
Patient burnout	27	.00	58.00	20.4444	16.53977
Valid N (listwise)	27				

Table 1: A Description of the Spread of Scores Across the Sample on the CBI

Participants scored higher on both the personal and work elements of the questionnaire than they did on the scale examining patient related burnout (Table 1). In each case more participants fell below the threshold of 50, however this was very close on the Personal Burnout Scale (Table2, 3 and 4 below).

	Frequency	Percent
Significant	13	48.1
not significant	14	51.9
Total	27	100.0

Table 2: Significance on the Personal Burnout Scale of the CBI

		Frequency	Percent
Valid	significant	9	33.3
	not significant	18	66.7
	Total	27	100.0

Table 3: Significance on the Work Burnout Scale of the CBI

		Frequency	Percent
Valid	significant	2	7.4
	not significant	25	92.6
	Total	27	100.0

Table 4: Significance on the Patient Burnout Scale of the CBI

General Health Questionnaire (GHQ 12 Item)

The GHQ was originally designed to define whether an individual had reached 'caseness' in terms of their current level of distress.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	significant	14	51.9	51.9	51.9
	not significant	13	48.1	48.1	100.0
	Total	27	100.0	100.0	

Table 5: Discrepancy Between Significance and Non- Significance on the GHQ

At least half of the participants were experiencing significant distress at the time of answering this questionnaire (Table 5). However most participants indicated that they were also having difficulties outside work making it hard to differentiate the cause of distress.

One to One Interviews:

Theme 1: The Psychological Role of the Palliative Care Nurse:

This theme reflects thoughts of participants on the psychological role they play in the care of their patients and how competent they feel to fulfil it. The majority felt that the psychological element of their role was their primary task.

I see a bigger part of my role as being the supportiveness of the role to the family and to the patient, listening to them really, seeing what their concerns are and then trying to unpick them… (P 4)

However participants spoke of the difficulties of having to make quick judgments and the need to try and establish relationships quickly. There was also a feeling that they were very alone with the psychological work.

You are jumping in and having to make relationships very quickly…you might be jumped into talking about very scary things with people because they become real at the point of meeting them…you've got to make huge judgment calls…you haven't had the chance to build up a relationship… (P 2)

You carry that yourself and you have to unpick it yourself and worry about it … (P 4)

The majority of participants reflected on their doubts regarding their ability to support such distressed people.

Sometimes I'm valuable from an emotional support angle … but I don't know, I suppose I come away thinking have I really done anything… (P 6)

Participants felt that they did not have the training to enable them to cope with some of the situations they were left with.

I suppose because we've never had any formal training in how to deal with psychological issues you know, it's all just done as an add-on (P 6)

Its personal experience really (P 4)

Theme 2: Emotional Impact:
The second theme reflects participants' thoughts on the emotional impact of their role. The majority spoke of the difficulties involved in working in such close proximity to death.

I often describe it to friends and family, it's like watching sometimes a weepy movie that makes you cry but actually that's your life, you're in that (P 2)

The relationship that participants have to build with the patient appears to be the main source of the emotional impact as it becomes very difficult for the PCNS when the patient dies.

You've completed your part of their journey almost… we do so much with like, we've got to look after this patient, we've got to care for this family and you do get so involved sometimes and when they're gone its just like, oh they're gone now and whilst you're busy doing something else you do still think… (P 3)

Some of the participants reflected that the intensity of their emotional reaction is just too difficult to cope with and therefore they may avoid having these conversations.

There are times I know that I don't go there for whatever reason, just because either I'm a but too busy or too you know- I think that's only human…sometimes you feel that if they're not forthcoming then I won't… (P 6)

Theme 3: Concept of and Need for Supervision:

In the interviews all participants spoke of their need for supervision and recognized its usefulness as a concept and as a way of coping with stress and perhaps preventing burnout.

I think supervision is so important, um, I think if you have people working with very raw emotions and do not have in place something that, um, prevents burnout, um, then its naïve (P 2)

Concept of Supervision:

However, participants had different ideas regarding what they thought clinical supervision should provide.

Because I think of my own health…and to prevent, help you not get over- involved with people, to be able to leave it somewhere else…and it helps you to have more boundaries somehow I feel (P 5)

Development of your practice…by helping you to examine what you do and unpick it and see where you need to learn and helping you to reflect on what you do and develop your skills (P 7)

Some participants referred to the aims of CS as separate and discrete tasks, dealt with in different contexts with little cross over.

Again I mean I do find the meetings with…very helpful but I would take a patient very specifically to her and seek her advice… but I potentially wouldn't say … perhaps I'm

really struggling emotionally with this family and I don't know whether I would take that to that meeting (P 1)

Sometimes I do really get a little bit confused with them because I'm never quite sure what to bring to what really sometimes. (P 4)

The participants' confusion may arise from the fact that some of them do currently have different supervision sessions which have separate aims and approaches.

We obviously meet with (the psychologist) which I find very useful to take specific issues... how do I get through this? (P 1)

I think its called- support it's called- basically what it is we have a lady who comes to the meeting...but I would say that is more about the politics of work, what is going on in the team and how we are all feeling... but it's not about specific patients... (P 5)

However some participants found the sessions with a focus of team dynamics anxiety provoking and not meeting their CS needs.

You'd almost be thinking something up to take to supervision which completely defeated the object of the whole process and then you'd sit there thinking you know you'd done something wrong or you know somebody else would challenge you... it was horrendous (P 1)

Complicating Factors:
Some of the participants spoke of the suspicion that still exists regarding the 'motives' or 'agenda' behind supervision.

The need to trust both the supervisor and their colleagues was something that could impact on their ability to feel comfortable to use supervision effectively.

I don't know how helpful group supervision is...you know if I'm going to be completely honest about something and how it's affecting me and what I need to do I

think that's something that I would rather deal with one to one. You need to feel comfortable in a group (P 8)

Participants reflected on their anxiety about what it meant to admit that they needed to share and discuss things.

I think it (autonomy) gets in the way of them saying actually its good to talk about things because if you need to talk about things is there a question that you're not managing your case load. It might become, do you need to talk to me because you need advice? (P 2)

Focus Groups:

Theme: How Should Supervision be Structured?

The main theme identified from the focus group data concerned the structuring of supervision. Participants appeared to be confused regarding the main purpose of supervision and how it is structured. The term 'clinical supervision' was used in relation to their group sessions with an outside facilitator, while 'caseload supervision' was used when talking about the supervision that they have with the psychologist in the team looking at specific patient issues.

I think that caseload supervision is more patient focused whereas I think the clinical supervision is more about how we feel, what's affecting us rather than patients somehow

When I go to (clinical) supervision… we sit there and we all think and oh I might mention that, or if you're fed up of something that's happening in the team, you're bringing it up, but when I go to caseloads I know what I'm going for and I need results, I need something to help me… develop my skills

The variation in purpose and approach of supervision meant the participants felt that they would share very different material in each setting.

In-house clinical supervision that we get facilitated by an outsider I find beneficial because I feel quite comfortable to disclose what kind of knickers and bra I've got on. Opening myself up, becoming very raw

I think the current clinical supervision is good because... it makes you think about the psychological side of it all...

However some participants found the more open and unstructured CS more challenging because of the expectation of sharing quite personal information.

It's much more challenging to be in that forum and thinking about wanting to bring something than it is talking about patients. I haven't got a problem with my difficulty with a patient situation... but bringing something personal up, that's a whole other thing really.

When considering whether these two sessions could be combined, the participants felt that something would be lost if they did not have both and that combining would be very difficult.

You're just saying can we just let one person do all of that. I would question that because who we have... caseload supervision with is a person we work alongside with... so the other kind of supervision is more earthy, more homing in sometimes on how you are and what's going on with you personally. And sometimes you don't want the outside health professionals to know about that.

If... you've got a problem that you bring about your patient ... that has to be done on like a caseload supervision type thing and the role management and the other aspects are very different...

However the participants then reflected that they did discuss some personal matters in relation to their work with patients within the caseload session. Therefore there was an element of cross over, further the work they did in the caseload might be more useful than that done in the group session.

Caseload supervision is a higher level… I had some things that I had to do with a patient, and I thought well, I wouldn't have done that if I hadn't had this caseload supervision. And I don't think that- no disrespect to the clinical supervision team- I don't think that higher level where it got me doing…

In summary this theme presents the current confusion that exists regarding the concept and uses of supervision. Is it about specific patient issues or sharing personal information? And is it possible to think about these processes together?

DISCUSSION

Several findings needing discussion arose in this study. Quantitatively, results showed evidence of stress, psychiatric morbidity and inconsistent provision of clinical supervision.

Qualitatively, results reflected anxiety regarding the psychological role and evidence of emotional impact. Although there is recognition of the need for supervision, there is confusion and suspicion regarding its implementation and delivery.

Evidence of Stress:

GHQ data identified approximately half the sample as experiencing significant psychological distress. However, both this and results from the CBI suggested significant stress was personal rather than work/patient related. Conversely, results from both were consistent with literature identifying high stress rates and psychiatric morbidity in palliative care (Kendall, 2007). Whatever the source, what impact can stress have on their ability to cope with the emotionality of their work?

Provision of Clinical Supervision:

Results demonstrated a mixed picture in provision of CS for PCNSs. It varied in amount, type, mode of delivery, and facilitator background. This inconsistency mirrors previous research and may derive from organizational reluctance (Davey et al, 2006) or practitioner resistance (Cleary and Freeman, 2006).

Despite this all interviewees recognized that CS could both develop their skills undertaking complex psychologically based work for which they had little formal training while protecting their own emotional health.

Barriers to Acceptance:

There were barriers to participants' enthusiasm for CS. PCNSs are expected to be autonomous in their practice (Kelly et al, 2001), emotionally available for each patient, and to rely on their own self care (Baumrucker, 2002, Keidal, 2002, Canning et al, 2007). In this context taking up CS may be seen as a failure.

Secondly there is suspicion regarding the "real" reason for CS in nursing culture (Butterworth, 1998). It appears Davey et al (2006, p239) are correct that "if clinical supervision is not disentangled from managerial control, nurses can perceive it as an invasive management tool". Participants, although experienced, still appeared wary about the purpose of CS.

Conceptual Confusion:

Against this confused background, how consistent is CS in this context with the theoretical understanding of it?

Separation of Function:

Many participants, instead of viewing CS as one model, separated it into two discrete tasks, caseload management and personal issues. This separation is mirrored in the literature. Gilmore (2001) suggests separate processes have become polarized. Therefore as both are such different interpretations, can they still be termed CS and can the same outcomes be expected?

Inconsistency with Theory:

For effective CS there needs to be a framework in which functions and purposes are conceptualized (Scaife, 2001). As Hawkins and Shohet state (2006 p 57) "combining the multiple functions is at the heart of good practice"

Although different models exist (Inskipp and Proctor, 1995, Holloway, 1995, Hawkins and Shohet, 2006) certain functions are key. Learning and development, case conceptualization and ethical monitoring are fundamental processes.

The supervisee also needs to be aware of their own reactions and judgements, particularly when working with people in distress. Hawkins and Shohet (2006 p 58) reflect "not attending to these emotions soon leads to less than effective workers who become over-identified with their clients or defended against being further affected by them"

For CS to reach maximum efficacy each of these elements needs to be present as the work exists between these points. (Hawkins and Shohet, 2006)

Are PCNS Needs Being Met?

In practice, some of this sample received solely caseload management while others had separate caseload management and personally reflective group sessions.

Caseload Management:

Taking the personal element out of caseload supervision makes it harder for the PCNS to fully understand the process occurring between them and the patient (Holloway, 1995). However, the participants reported that this regularly happened.

Group Reflection:

Some participants had reflective supervision with an outside facilitator. Johns (2004 pg 3) defines reflection as an almost entirely internal process – without reference to patient interaction. Reflective practice thus appears similar to Jones (2000, 2003, 2006), focused on the internal experience of the nurse rather than considering the patient and the impact of their emotionality (Skilbeck and Payne, 2003).

Obviously reflective practice is a valuable tool. However, Fowler and Chevannes (1998) posited that reflective practice, now regarded by some as the key element in CS, is not actually the "sole happening within the process". It is in fact unrealistic to expect practitioners to naturally access this medium. One strength of CS is its flexibility. Limitations of reflective practice make it inappropriate as a primary form of supervision to all.

Participants in this study clearly demonstrated the concerns of Fowler and Chevannes (1998). Some found reflective sessions very useful. For others sessions were described as "horrendous" with some participants feeling threatened. This group reflective format was not meeting their needs and may actually increase stress (Fowler and Chevannes 1998)

Such reflective sessions can also become very close to personal therapy, contrary to best practice (Scaife 2001, Hawkins and Shohet 2006).

Future Practice:

The inconsistencies between theory and practice need to be bridged. Education regarding the models of supervision may reduce suspicion and careful discussion may tailor a package flexible enough to suit the majority.

Self care (as seems to be advocated by the 2007 British Psychological Society guidelines for end of life care) may not be appropriate for PCNSs. Instead of empowering them, it contributes to the expectation that they should not seek support.

Limitations:

Recruitment:

The researcher had to access participants through the Lead Nurse. Whilst convenient, there was risk of compromising confidentiality, and it may have given the study a management "aura"

Confidentiality Limits:

For their convenience, participants were interviewed at their place of work. That meant that other nurses present could have become aware of who was being interviewed. Therefore some results may have been underreported and some quotes and examples were removed to avoid identification.

Knowledge of Psychologist:

That participants knew the researcher was a possible limitation. It may have impacted on their willingness to talk openly about case management provided by the psychologists.

Future Research:

CS with Less Experienced Nurses:

CS for PCNSs, even while inconsistent, is being implemented. This is not the case for less experienced nurses, perceived not to require such measures. However, they possibly have the greater need as they spend considerably more time with the family, leading to more stress. This was suggested as an area for future research by participants.

Personal Burnout:

Results from questionnaires suggested the main source of stress was personal. This raised a question for the researcher whether this group would have higher rates of personal burnout than the normal population. Possibly the real emotional impact of their role happens within their home life rather than at work.

Conclusions:

This study examined stress levels and explored the usefulness of CS within a sample of PCNSs. Results showed despite evident stress, provision of CS is inconsistent. PCNSs acknowledge the need for CS, but demonstrated confusion and suspicion. In order to provide better support a framework of CS more consistent with theory was suggested.

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