Resistance to clinical supervision: A semi-structured interview study of non-participating mental health nursing staff members

Abstract

Introduction

Proponents of clinical supervision regard it as a supportive practice espousing personal growth in individual professionals and in organisational cultures. Clinical supervision can be defined as a formalised pedagogical process where a trained supervisor assists a clinician or a group of clinicians to reflect on their practices (1, 2). In mental health settings, group-based clinical supervision is commonly offered to develop professional competency and as a stress-reducing intervention, but the effects of supervision are not well-documented (3, 4) and nursing staff members can be anxious or feel ambivalent about participating in these practices (5-7).

Resistance to clinical supervision has most commonly been theorised within a psychodynamic perspective as motivated by anxiety and it has been identified in a variety of individual, group, and/or organisational actions. Liddle (8) viewed supervisee resistance as maladaptive coping with anxiety, which interferes with the supervisee’s learning processes. Liddle (8) listed five sources of anxiety in individual supervision: i) Evaluation anxiety (being evaluated by a supervisor), ii) Performance anxiety (difficulties living up to own standards), iii) Personal issues within the supervisee (supervisee’s unresolved conflicts and/or problems), iv) Deficits in the supervisory relationship (insufficient empathy, genuineness, and/or respect), and v) Anticipated consequences (the expected consequences of the supervisee’s actions lead to resistance). By describing resistance as maladaptive coping, Liddle (8) wanted to emphasise that resistance is not necessarily deliberately motivated by uncooperative supervisees, but can be seen as the result of coping gone astray.

Kadunshin and Harkness (9) approached resistance to supervision by depicting interactional games between supervisee and supervisor where they collude to produce hidden payoffs for both supervisee and supervisor. Kadunshin and Karkness described four sets of games with different elements and outcomes: i) Manipulating demand levels on the supervisee, ii) Reducing the level of demands on the supervisee by redefining the supervisory relationship), iii) Reducing power disparity, and iv) Controlling the situation. The paradoxical point forwarded by Kadunshin and Harkness was that the supervisee in fact looses by winning the games (9).

Addressing clinical supervision from a nursing perspective, Bond and Holland (10) argue that resistance to supervision practices should be understood as counter-productive defences against feeling anxiety in difficult situations. They divide the main sources of anxiety into: i) Fears about power and autonomy (issues related to structural and interpersonal power relationships), ii) The fear of developing professional relationships (issues related to interpersonal attachment), and iii) Anti-emotional climate in the nursing profession (issues related to the organisational suppression of emotions). A key point for Bond and Holland (10) was to view many organisational practices are unconscious defence mechanisms, which are as important to address as individual defences.

Resistance to clinical supervision is frequently mentioned in the literature, but most often without in-depth review or empirical analysis. A key problem of examining resistance to clinical supervision is a strong association between resistance to clinical supervision and resistance to
research. The vast majority of surveys of clinical supervision participation have low, or non-reported, response rates and have not examined non-respondents as a way of determining whether samples were biased (3). A noticeable exception was Buus and Gonge’s (11) sequential mixed methods study of participation and outcomes of group based clinical supervision, which combined organisational register data, survey data, observational data, and interview data. An examination of the survey sample (n = 236) indicated that the sample was not representative of the population (n = 239) and that participation in the survey was significantly linked to participation in supervision (12). The interview study sample (n = 22) was drawn from the survey sample and there were no statistical differences between these samples (13). However, the interview study sample was based on maximum variation and recruited both participating and non-participating informants. Unexpectedly, all informants spoke in favour of supervision, which again could indicate a substantial overlap between supervision non-participation and research non-participation. These observations seriously question the validity of the conclusions about outcomes of clinical supervision in many survey studies; they also emphasise the challenges of recruiting respondents for researching resistance to clinical supervision.

In a review and synthesis of the use of concept of resistance in sociology, Hollander and Einwohner (14) were curious about the range of actions that were identified as resistance. Unlike the psychodynamic conceptualisation of actions motivated by fear and/or anxiety avoidance, the sociological conceptualisations focused on resistance as oppositional action. Hollander and Einwohner (14) develop seven types of resistance by differentiating analytically between different types of resistance by examining recognition (who – actor, target, and observer – recognises an action as resistance?) and intent (are actors aware of their actions as resistance?). Hollander and Einwohner’s typology emphasises that analyses of resistance depends on perspective. The current “push towards clinical supervision” (10) in nursing can be regarded as part of a movement resisting the ways in which professionals are trained and the way in which they practice in current social and health care organisations. However, some organisations and individual nurses might perceive clinical supervision as an unacceptable intrusion rather than a positive relationship. Analysing the power dynamics of clinical supervision practices becomes a matter of perspective and interpretation of the complex, and sometimes ambiguous relationships between power and resistance. In this paper, we will use the social science perspective on resistance to further the existing discussions of resistance to supervision that have traditionally been dominated by the psychodynamic framework.

Aim:

The aim of this study was to examine resistance to clinical supervision by exploring perspectives on clinical supervision of mental health nursing staff who did not participate in group based clinical supervision.

Methods

Design:

Individual, semi-structured interviews.

Study context:
The study took place at five general mental health wards at two organisational sites of a Danish mental health hospital; three open wards and two locked wards. During the observation period, the wards were reorganised; two open wards and a locked ward was merged into a special observation ward and a locked ward; and an open and a locked ward was merged into a single special observation ward.

Group based clinical supervision was offered regularly to trained staff in all the wards. Sessions took place approximately 10 times/year and lasted for approximately 90 minutes. Most commonly, sessions took place in the mid-afternoon, at the end of the staff’s morning shift. The six supervisors were trained psychotherapists external to the organisation whose fields of practice included registered nurses (n=3), psychologists (n=2), and a psychiatrist. There were no general organisational directions about the precise supervision methods.

Participants:

As part of another inquiry into clinical supervision practices on the wards (15) 2014-2015, we surveyed a cohort of mental health nursing staff (n=115) and observed their supervision participation twice for 3 months (February-April 2014 and mid-September-mid-December 2014). In the first period, there were 14 sessions; in the last period, there were 16 sessions. The present interview study’s population included the staff members that had not participated in clinical supervision during the observation periods. A total of 37 staff were identified as potential participants in the study. However, at the time of recruitment, 10 of these staff members had resigned from their positions, were on maternity leave or long-term sick leave or had died. The remaining 27 staff were all invited to participate. Twenty-five staff initially to participate in the study, but one staff member was subsequently not able to find time for an interview and, thus, the final sample comprised 24 informants.

The sample included 22 women and 2 men. The average age was 46.7 years (SD = 10.4, range 25-65 years). 11 informants were educated to bachelor level (10 registered nurses and 1 occupational therapist), and 13 had an upper secondary education in health care (social and healthcare assistants). 11 informants worked primarily day shifts, 5 worked primarily evening shifts, 7 worked primarily night shifts, and 1 worked mixed shifts).

Recruitment:

We anticipated that the informants would be “reluctant” (16) towards being interviewed, because they might be uncomfortable talking openly about their non-participation in clinical supervision and, in general, might have very low internal motivations to voice their personal opinions. Therefore, the interviewer invited each potential informant in person. The invitation included a reassuring normalisation of non-participation in clinical supervision and an emphasis on confidentiality. The interviewer positioned himself as a non-intimate interviewer and the interview as a one-off, transitory event. Furthermore, the interview took place at a place and time that was convenient for the informant and the informants were compensated with time off in lieu, for the time spent on the interview. Finally, all informants participated in a draw where they could win two gift vouchers.

Interviews:
The first author is a trained and experienced interviewer and he conducted all the interviews during October and November 2015. Most interviews (n=23) took place in an undisturbed room at the hospital wards and one interview took place at an informant’s own home. Most interviews (n=16) took place in the daytime; the remaining interviews (n=8) took place in the late evening, which was convenient for many night staff. Most of the interviews (n=23) were audio-recorded and one was recorded by means of written notes because the informant felt uncomfortable being audio-recorded. On average, the interviews lasted 63 minutes, ranging from 43 minutes to 84 minutes. A research assistant transcribed the recordings into written language and the first author checked the accuracy of the transcriptions against the recordings. The interviews were made in Danish and the authors translated the English data extracts presented in this paper.

We developed an interview guide on the basis of a review of the literature on nurses’ resistance to supervision. The interview guide was designed to facilitate and support the interpersonal relationship between informant and interviewer and to focus the interview on particular issues (17). The interview had seven sections: 1. Introduction: The informant’s previous experiences with clinical supervision (if any). 2. The informant’s understanding of mental health nursing. 3. The informant’s views on threats to good mental health nursing. 4. The informant’s views on colleagues and collaboration. 5. The informant’s views on what facilitated or inhibited their participation in clinical supervision. 6. The informant’s understanding of the organisational support for clinical supervision (if any). 7. Close: Any suggestions that might help increase participation and outcome of clinical supervision.

Analysis:

Potter & Wetherell’s discourse analysis (18).

Ethics:

In full accordance with Danish legislation, we notified the regional research ethics committee and the Danish Data Protection Agency (J.nr. 2013-41-2658) about the interview study; neither institution had any reservations towards the study. All informants gave their informed consent to participate, based on written and oral information about the study. Interview responses were handled in full confidentiality and all details that could potentially be used to identify individual informants have been altered in the data extracts presented in the findings section below.

Findings:

The first part of the findings describes the most common discursive construction of reasons for non-participation. The second and the third parts describe the core themes drawn upon in the arguments for non-participation, emphasising the difficulties of participation and minimising the need and outcome of supervision.

Typical constructions of reasons for non-participation

There were two fundamentally distinct positions among the informants: One position, forced non-participation, was to state that they were in favour of participating in supervision, but that challenges outside their own immediate control made participation appear as something that would
presuppose an unreasonable amount of effort, e.g. supervision the day after a night shift, a long commute to work, or competing family obligations. Another position, deliberate rejection, was stating that non-participation was the informant’s active decision based on a their own perspective on supervision.

The informants’ reasoning was centred on two rhetorical strategies that would be forwarded with different emphases by the two positions. First, informants would accentuate objective difficulties related to participating in supervision. Second, the informants would minimise their experienced outcome of supervision and their personal need for supervision. These strategies added to making the informants’ non-participation appear reasonable and legitimate.

In the following Data Extract 1, informant 5 – a registered nurse who positioned herself at deliberately rejecting participating in supervision – constructs an array of legitimising reasons for non-participation. The data extract is taken right from the beginning of the interview.

**Data Extract 1:**

Interviewer: What are your experiences of attending supervision?

Informant 5: Not much. Actually I’ve been three times. A couple of times, twice since I’ve been employed here. I did night shifts and we had to come in during daytime. Sometimes it’s cancelled. But I was not interested in participating, because sometimes I’d been on a night shift and needed to sleep and then to come in on a day shift using a whole day on 1, 1½ hour [of supervision]. I thought it was silly to spend my day like that so I spoke to my manager and was excused. I was not to attend supervision anymore; I didn’t like it.

Interviewer: What do you mean by that? You didn’t like it?

Informant 5: It was not my cup of tea. I do not think it helps very much, you know. In my personal opinion, I don’t think I needed it.

Interviewer: You say that you don’t need it?

Informant 5: No, I don’t. But it is because night duty sometimes. If it was about patients or about some episode at work, you know, that I was not part of then I felt outside the discussion or the things that were said.

Informant 5 has very limited experiences of supervision and starts out by pointing briefly at problems of cancellations of sessions and later the problems of attending supervision the day after a night shift. She then explains how her manager excused her from attending, which lends legitimacy to her standpoint, and she repeats that she does not like nor needs supervision. She argues that she does not need supervision, because supervision was focused on issues that she was in effect excluded from because of her work at night. During the remaining interview, Informant 5 repeatedly argued that supervision was not valuable enough for her to prioritise participation. Unlike most other informants, she did not refer to personal feelings of unease during the sessions as a way of arguing for why she did not like it.
In the following two sections we will further explore the thematic content used in these two discursive strategies and contextualise them within the informants’ descriptions of their work.

**Difficulties related to participating in supervision**

All informants viewed participation in supervision as a question of prioritising. Shift work, timing, small turnouts, not knowing what would be discussed, cancellations, and the commute to work were the most frequently mentioned reasons for not prioritising turning up outside regular working hours. Descriptions of these difficulties made supervision sessions appear unreliable and somewhat irrational to prioritise and this added to a depiction of supervision as a caught up in a downward spiral of low continuity, poor attendance and cancellations.

Informant 22 was a [XX working XX] who positioned herself as **forced into non-participation** because of lack of time and competing obligations at home. She had participated in one supervision session in her 3 years with the team; this debriefing supervision-session was organised after a violent episode on ward. The session was described as a bad experience where she did not feel understood by neither supervisor nor colleagues and continues to describe the management of the violent situation as problematic and somewhat unresolved and that she should have acted differently. Leading up to the following data extract, she reflects on interactions with the supervisor and the other participants.

**Data Extract 2:**

Interviewer: In that situation, did you feel exposed in the group?

Informant 22: No, I didn’t feel exposed, just uncomfortable.

Interviewer: It was uncomfortable, but what created that feeling?

Informant 22: I was touched and felt sad and I found that a bit uncomfortable, because I thought that it wasn’t really a thing to sit and cry over. But I was very touched. It was very uncomfortable, most of all because I couldn’t focus. Perhaps, because I was in a place where I could not focus on what was said or the questions asked. So I think I missed the whole point.

Informant 22 describes how she felt very touched when the situation was discussed in the supervision group and that it was very uncomfortable for her to cry over a situation that she did not feel that she ought to cry over. She says that the most uncomfortable part of the situation was the unexpected loss of control and not being able to focus on what took place in the room. Towards the end of the interview, Informant 22 added that her bad experience was not the reason for her non-participation, but lack of time.

The informants described the process of getting ready for supervision as stressful, simply because of the work pressure. It was hard to finish work earlier than usual and to focus on supervision. The supervision room was described as uncomfortable and unsafe because of a fundamental lack of control. To most informants, it was uncomfortable to publicly display personal and intimate feelings and professional uncertainty. Further, the group dynamics meant that challenging questions and comments could trigger an unwanted disclosure of personal and professional uncertainty. Many
informants described searching questions as a central and important part of supervision, but as something they did not personally appreciate or wanted to part of.

Some informants did not like being at the centre of attention and some participants were concerned that the other supervisees would not interpret their contributions correctly. They were also concerned about who were present at the sessions, as they did not trust all of their colleagues and they were concerned that powerful and influential colleagues would “bulldoze” them, in particular if the supervisor was unable to control the session. Informant 21 was a XX and worked nights. She positioned herself as deliberately not participating in supervision, mostly because of the group format. Prior to the data extract below, she describes listening to the comments of “a reflective team” as horrible and disempowering because the rules of this approach meant she was not allowed to object even when she thought the other supervisees were misunderstanding and misinterpreting her. The key issue is about talking about personal issues in a group.

Data Extract 3:

Informant 21: I think it is uncomfortable and I think that if I have any issues then it works better for me to talk one-on-one about it. It is no problem if it is a general issue or something. I find it problematic if I’m somehow at the centre because I think you get stripped and vulnerable, because other things can emerge that you do not want to share with others.

Interviewer: What are you thinking of?

Informant 21: Well, we all have feelings and issues, also towards our consumers, towards patients, etc. Why exactly does it trigger in me when a patient does this or that? What exactly does it do to me? And why does it do so? You dig down into another layer and it is not because something is deliberately concealed or strange. I just don’t want to be navel-gazing like that and to be analysed. That’s just how it is.

Informant 21 starts out by saying that she has got no problem talking about personal issues in one-on-one conversations, but that she feels out of control, “striped and vulnerable”, talking about personal issues in group settings because the supervision inquiry can lead to the exposure of very normal, but personal issues. She describes it as uncomfortable objectifying navel-gazing.

The atmosphere at the beginning of a supervision session was often described as full of jittery anticipation because no one could think of anything relevant to address. Some informants described strategies for saying how they felt in a way that ensured that they would not be selected to be the centre supervisee; they tried to appear present and reflective, but not troubled. During the interview, an informant came to realise that nursing staff members unwittingly colluded to cancel supervision sessions. It happened when they all responded to supervisor’s general queries on arrival with an “I don’t have anything [to talk about]”; everybody would accept this statement, which legitimised suggestions about cancelling if the turnout was not very big. It was hard for the informants to prioritise supervision because of the practical and emotional investments needed, and they resisted participating.

Limited need for and benefits from supervision
All informants described alternative practices to formal clinical supervision that they found more relevant in their daily work. This included clinical review meetings, peer-supervision, and exchanging experiences. These practices were considered more relevant because of their flexibility, the focus on here-and-now, a strong focus on clinical problem solving, and — very importantly — a less challenging and safer communicative context. Supervision and supervisors were often criticised for not providing exactly these characteristics and depicted as monotonous, boring, and without wider clinical impact.

Informants regarded drawing on each other’s experiences as the most central way of keeping oneself professionally up to date. The idea of continual peer-supervision was very prominent among evening and night nurses, because they believed that work in the evenings and at night presupposed a strong sense of each other’s whereabouts and of the atmosphere on the ward. However, this sense of each other was must often tacit and they did not feel in need of talking much with the colleges they knew and trusted. Some informants argued that they had so many years of experience that they were able to critically reflect on their own practices without collegial intervention or formalised supervision.

Informant 6 is a XX working XX who positioned herself as deliberately non-participating in supervision. She has attended a single supervision session at the beginning of her 10-year long career in mental health. She described how the session was meant to address a conflict between staff members, but that it in effect was meant to silence her and her group’s part of the conflict. She lost faith in supervision and never participated again. She currently works nightshift and in the following Data Extract, she argues why she does not need supervision.

Data Extract 4:

Interviewer: Why do you think you don’t need it [supervision]?

Informant 6: Well, I could discuss with my colleagues if I had any problems with patients. It could also be [a problem] with a colleague or something. You could discuss, but I do not feel that I’ve tried that. The patients sleep at night; I only do nights. Really, we are good at starting nights by sitting and discussing what we could do better and so on.

Interviewer: So in many ways, you describe that the night nurses create some of the effects that one might imagine would come out of [formal] supervision?

Informant 6: Yes, where we deal with it here-and-now. But maybe I would profit from listening in [at supervision]?; I don’t know.

Interviewer: Listening in?

Informant 6: I would not know what to say because I don’t have anything concrete to talk about. But maybe you have when you get into it. I don’t know.

Informant 6 states that patients mostly sleep at night and that they do not cause problems that would need to be discussed. However, she argues that night nurses are good at discussing eventual problems as they unfold. She validates the interviewer’s interpretation and asks herself whether it
would be beneficial to listen in supervision sessions. She intuitively believes that it would be about listening to other participants’ discussions, because she cannot imagine what she would need to address and talk about.

Some informants working evenings and nights found supervision to be oriented towards day shifts, where most formalised decision-making took place. This implied an understanding of staff having different experiences of work depending on shift work and that organisational continuity primarily was organised in the day shifts on weekdays. Several informants described that this excluded them from grasping the continuity of care of patients and from participating in important decision-making processes. Supervision was described as part of this more formal day shift oriented work and therefore found less relevant.

Informant 19 was a XX working nights. She describes herself as deliberately choosing not to participate in supervision. She has participated in a single supervision session, which was organised to debrief staff after a violent situation during a night shift. She emphasises that she does not need additional supervision because she and her colleagues make good use of each other.

**Data Extract 5:**

Interviewer: It sounds as if you’re saying that you don’t need anything extra [than talking with your colleagues]?

Informant 19: No, I guess not. I’m not very talkative and outgoing and those kinds of things I keep to myself, I think. And then I can feel, I’m not sure how to say it, you know, that I should be more part of it [supervision], because I carry it inside myself if something has happened.

Interviewer: And how does that affect you?

Informant 19: That night [where something violent happened], even though we spoke in the morning, I was quite chocked when I got home and I couldn’t sleep. John [the ward manager] told us to come forward if anything felt wrong, but I didn’t. So I felt bad afterwards – but I just didn’t know – I just said, “Things are fine”.

(...) 

Interviewer: If you should summarise why you do not attend supervision, how would you do that?

Informant 19: Because I know deep inside that nobody will listen, yes, so I don’t want to waist my time on it.

Informant 19 describes herself as an introvert and that this makes it hard for her to imagine how she would be able to share her experiences and participate in supervision. She describes an extreme episode after the violent event where she feels bad, but chooses not to ask for help. At the end of the interview, Informant 19’s explanations shift and she summaries her decision not to participate in supervision as being about being excluded and bullied by colleagues that do not listen, not as a question about being introvert.
It was hard for the informants to explain who had the ownership of supervision. Management were described as only partially committed as they ensured the provision of monthly supervision, but did not create the resources for people to actually participate. Supervision was seen as very vulnerable for being down prioritised during organisational changes or when staff members were stressed.

**Discussion**

The findings indicated that the informants accounted for their non-participation in markedly different ways; positioning themselves as either legitimately forced into non-participation or as deliberately rejecting participation. The former position can be interpreted as a false negative; they would like to participate, but are unable.

The study’s findings did not resonate strongly with Liddle’s (8) five sources of anxiety in individual supervision because the group format extended the sources of tension and anxiety. The group-based supervision offered to informants in the present study created an extended space for group discussion that could generate or accentuate anxiety because of already existing conflicts and a fundamental lack of trust between members of the groups. Thus, it was characteristic that the informants identified relationships between staff members on the ward as a source of anxiety rather than individual conflicts and problems or problems related to the supervisor. Another important characteristic of the informants’ supervision practices was that they were not obliged to spend time with/being evaluated by an evaluating supervisor, and they could refuse participation without any formal or informal sanctions. In a similar vein, Kadushin and Harkness’ (9) descriptions of collusion in “games” between supervisee and supervisor was recognised by a few informants, but a potential larger “groups-based” game among the nursing staff members, managers, and supervisors undercutting supervision practices was never envisioned and articulated. Collusion (19) in mental health nursing practices has previously been identified as protective interactions necessary for reducing signs of uncertainty and ignorance (20); here it also subsumes signs of overt conflict. Irregular and dysfunctional clinical supervision was accepted as collateral damage in periods with high workloads, low job satisfaction, and organisational restructuring.

Hollander and Einwohner’s (14) distinction between seven types of resistance was based on an analysis of the actor’s intentions and on whether the oppositional action was recognised as resistance by the target of resistance and by an observer. This emphasis on opposition differs markedly from the psychodynamic focus on avoiding anxiety and begs the question: What or who was the target of the informants’ resistance? In general terms, the forced non-participants deliberately targeted their workload. Hollander and Einwohner would term this type of resistance “overt resistance”. The situation was more complicated with the deliberate rejecters whose actions in effect were targeting other colleagues on the wards who would most probably not recognise supervision non-participation as interpersonal opposition. Hollander and Einwohner would identify this a “covert resistance” to the group dynamics on the ward and simultaneously as “unwitting resistance” to supervision practices, because they would no longer be recognised as the target by the actor. Efforts to use Hollander and Einwohner’s typology ultimately question the role of the interpreter: Who defines an act as oppositional – and in relation to what? And transferred to the supervision context, the questions arising include: When people identify acts as resistance to supervision, how are these people positioned? And, What are the alternative interpretations of the actions’ directedness and intent?
Bond and Holland (10) drew on Menzies seminal study of social anxiety (21) to argue that nurses often are aware of the institutionalised social defences that create non-caring and non-compassionate institutions with increasingly burn-out nurses who long to be able to exercise their full range of skills. Bond and Holland argued that nurses suppress their emotions because of fear of retribution and fear of things getting out of control. In a similar vein, MacLaren et al. (6) suggested that benefits of supervision might be negated because it takes a massive effort to address emotions in an institutional environment where emotions are generally suppressed. In line with this, the informants in the present study prefer to develop their skills in small and safe parallel forums, which could be seen as flexible alternatives to supervision.

**Limitations**

The interview responses reflected the informants’ personal perspective on resistance to clinical supervision and the explanations were co-constructed with the interviewer and tailored the particular interview situation. Such interview findings must be interpreted within their conversational context (22). In order to situate the findings, data extracts were presented at length; further, they were contextualised and include basic interactions between informants and interviewer.

Supervision non-participation could be considered to be a sensitive topic to discuss in an interview, but the participation rate was unexpectedly high. Most interviews were conversational and appeared open; they included personal reflections on interpersonal relationships and organisational issues. Almost half of the informants positioned themselves in the socially less acceptable position of deliberately rejecting participation in supervision. It is possible that the development of a longer relationship between informants and interviewer could have created even deeper insight into the informants’ understanding of interpersonal relationships at the workplace and their relationships to supervision practices.

Finally, the participants’ personal perspectives on supervision resistance should not be viewed as the only explanations of supervision resistance; some reasons may be outside their immediate experience, for instance cultural or organisational factors. Finally, the findings from the discourse analysis could be combined with a more theory driven exegesis of the interview transcripts and/or with observational data.

**Conclusion**

In general, the informants in the present study described that they felt under pressure when they had to find time for supervision and that they did not like being scrutinized by neither supervisors nor the larger group of colleagues. Informants’ actions could, on one hand, be seen as successful coping with a work demand or with interpersonal conflict or, on another hand, be seen as maladaptive coping with supervision by avoiding participation. Choosing between different conceptions of resistance emphasises different outcomes of the informants’ non-participation in supervision.