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Oncology clinicians' feelings towards patients presented in supervision: A pre-post assessment using the feeling word checklist

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Abstract

Objective: Clinical supervision of oncology clinicians by psycho-oncologists is an important means of psychosocial competence transfer and support. Research on this essential liaison activity remains scarce. The aim of this study was to assess the impact of supervision on oncology clinicians' feelings towards patients presented in supervision.

Methods: Oncology clinicians' (n = 23) feelings towards patients presented in supervision were assessed with the Feeling Word Checklist (FWC). The FWC was filled in by supervisees prior and after their supervision sessions (n = 91), which were conducted by experienced supervisors (n = 6). Pre- post-modification of feelings was evaluated based on a selection of FWC items, which were beforehand considered as likely to change in a beneficial supervision. Items were evaluated on session level using t-tests for dependent groups. Composite scores were calculated for feelings expected to raise and feelings expected to decrease and analysed on the level of supervisees.

Results: Feelings related to threats, loss of orientation or hostility such as "anxious", "overwhelmed", "impotent", "confused", "angry", "depreciated" and "guilty" decreased significantly after supervision, while feelings related to the resume of the relationship ("attentive", "happy"), a better understanding of the patient ("empathic"), a regain of control ("confident") and being "useful" significantly increased. Feeling "interested" and "calm" remained unchanged. Significant increase or decrease in the composite scores for supervisees confirmed these results.

Conclusions: This study demonstrates modification of feelings towards patients presented in supervision. This modification corresponds to the normative, formative, and especially restorative function (support of the clinician) of supervision.

KEYWORDS
countertransference, emotions, feeling word checklist, oncology, supervision

1 | BACKGROUND

The history of clinical supervision dates back to the early psychoanalytic movement.[1] Since then, different supervisory models and techniques have been developed.[2] While different formats of supervision exist, core elements or "ingredients" can be identified: a supervisor – who usually is a senior, professionally approved mental health specialist – provides education and support, on psychosocial and relational issues, to junior colleagues on their ongoing clinical work.[1,3–5] Three different functions of supervision can be identified: a normative function focussing on quality of care such as considering ethical aspects or adherence to accepted standards, a formative function focussing on educational aspects such as knowledge and skills, a restorative function focussing on the support of the supervisee.[3] The primary aim of supervision is to develop and enhance the supervisees' conceptual and clinical abilities regarding the psychosocial dimensions of care. Following Michael Balint's views on his groups and supervision,[1,6,7] we also believe that one of the major issues of these reflexive processes is to enhance clinicians' ability to empathize with the patient, in other words to help them change the way they look at their patients. This can be achieved by comprehending and addressing the clinician's own emotional reactions, known as 'countertransference'.

Countertransference feelings and reactions towards patients are well-known to interfere with psychotherapeutic work, but also with the clinical care of the medically ill, especially in the oncology setting,[8] where clinicians face difficult emotional[4] and existential[9] challenges, which may resonate with clinicians' own past or present experiences.[10]

While clinical supervision is an essential liaison activity of psycho-oncologists working with oncology clinicians,[11] research on supervision in this setting is scarce and focus on (i) clinicians' satisfaction and attitudes and (ii) content of the supervisions. For example, cancer nurses working with adult patients reported benefits from supervision regarding their understanding of patients' needs.[12] In a similar study, Sekeres et al.[13] assessed the impact of a Balint-like awareness group on supervisees' self-reported attitudes: positive effects, were found on hematology-oncology fellows' perception of their comfort when dealing with emotional patient/clinical situations. More recently, Salander and Sandström[14] qualitatively analysed sixty-three cases presented by oncology residents in Balint-inspired groups and found that they faced three main challenges regarding (i) the patient-physician relationship, (ii) organizational matters and (iii) the encounter with close relatives of patients.

A narrative review (published in 2020) on clinical supervision in oncology[3] found only fifteen studies, most of them exploratory and qualitative, demonstrating positive impacts on staff, professional care and development, and competences in exploring patients' existential issues. Specifically, the review identified no study measuring the possible impact of supervisions on clinicians' countertransference emotional reactions, a very important target as aforementioned. The authors recommended that future research should not only rely on supervisees' self-perceived benefits and use validated measures to evaluate effectiveness of supervision, pre/post or randomized controlled trials, larger participant numbers and experienced and/or trained supervisors to ensure consistency of quality. We designed our study with these recommendations in mind.

The aim of this study was to assess the impact of supervision on oncology clinicians' feelings towards the patient they presented to psycho-oncologists.

2 | METHODS

2.1 | Design

The design of the study was based on a pre-post supervision assessment of oncology clinicians' feelings towards the patient presented in supervision.

2.2 | Participants and procedure

Supervisees ($n = 23$) were oncology or hematology residents ($n = 19$), who participated in the Swiss communication training (CT),[4] which is mandatory since 2005 for medical oncologists[15] and more recently for hematologists, and nurses ($n = 4$), who participated in a Certificate of Advanced Studies (CAS) in psycho-oncology of Lausanne University,[16] which is conducted under the scientific responsibility of the first author. The professional experience of the participants was similar, there were no senior staff members among the supervisees, and none of them had prior training in communication or an experience with supervision. The number of individual supervision sessions, which are part of these trainings, differed in CT (usually $n = 4$-6 supervisions per participant) and in the CAS (usually $n = 8$ sessions per participant). Supervisions ($n = 91$) were provided to oncology nurses ($n = 32$ sessions) and to physicians ($n = 59$ sessions).

2.3 | Supervisors and supervision

Supervisors ($n = 6$) were senior liaison psychiatrists and psychologists working in the same service (Psychiatric Liaison Service of Lausanne University Hospital) with a supervisory activity of at least 10 years, and who are familiar with the clinics of oncology. Five supervisors were trained in psychodnamyic psychotherapy and one in cognitive-behavioral therapy, as this is part of the specilization to become a psychiatrist or clinical psychologist in Switzerland. Since supervision seems to be effective across models and theoretical backgrounds,[2] the sample of supervisors can be considered as homogeneous, especially regarding the long-standing supervisory experience.

2.4 | Assessment

Multiple ways exist to assess efficacy[17] or impact[3] of clinical supervision. Modification of clinicians' emotional reactions towards

patients is one of the main aims of supervision, which corresponds to its restorative, formative and normative functions.[3]

The Feeling Word Checklist (FWC) is a self-report questionnaire including words designed to assess therapists' feelings when meeting patients. It was first developed with 30 words (FCW-30) to investigate countertransference in psychiatric nurses.[18] Holqvist et al. further adapted and validated the instrument, and used it in different settings and versions[19–22]; while countertransference is understood as partially unconscious reactions, associated feelings as their conscious manifestations are measured as a proxy. Clinicians are invited to indicate if and to which extent the feelings described through the words are experienced regarding a given patient. We used a translated version of the FWC (backward and forward translation with a native English-speaking physician and a native French-speaking social scientist), based on the FCW-58, which is an extended version of the original FCW-30 and consists of a 5 point rating scale for feelings (0 = not at all, 1 = little, 2 = average, 3 = much, 4 = very much).[23] Supervisees were asked to fill in the questionnaire immediately prior to the supervision and immediately after the supervision. Instead of running statistical tests for all feelings listed on the FWC, which has been developed for the psychiatric setting, we considered that it might be more adequate to select those feelings, which seem most salient in the oncology context and – based on our experiences – frequently encountered emotional difficulties of oncology supervisees.[8] We therefore proceeded in the following way: in a first step, two of the authors (LM and FS) chose among the feelings of the FWC those considered as likely to raise ($n = 6$) or decrease ($n = 6$) in intensity after effective supervision. The feelings expected to raise were "interested", "happy", "useful", "confident", "empathic" and "calm"; those expected to decrease were "anxious", "overwhelmed", "depreciated", "inadequate", "frustrated" and "confused". Three colleagues with at least 10 years of experience with supervision, were then asked to indicate feelings of supervisees likely to raise ($n = 6$) and decrease ($n = 6$), without providing them the list already developed. Based on their feedback, minor modifications of the first list were made by using again the FWC: "inadequate" was replaced by "impotent", and "frustrated" by "angry"; and "attentive" (to raise) and "guilty" (to decrease) were added to the list. The final set of variables to be analysed thus included fourteen feelings expected to raise ($n = 7$) and expected to decrease ($n = 7$).

Selection of feelings were based on our experience that supervisees often present patient situations of concern, which represent a threat for their clinical task ("anxious") and/or provoke a loss of orientation ("overwhelmed", "confused"), helplessness ("impotent") or hostility ("angry", "depreciated"), often experienced with self-criticism ("guilty"). Supervision, on the other hand, often allows supervisees to reconnect with patients ("interested", "attentive"), better understand their psychological functioning ("empathic"), and to regain a sense of control ("confident", "calm") and the lost feeling of being "useful" for the patient; finally, supervision often reminds supervisees, that they are motivated and engaged clinicians, restoring feelings of satisfaction regarding their care of the patient ("happy").

2.5 | Statistical methods

Mean values and standard deviations of the reported feelings were calculated for pre-supervison and post-supervision assessments. Differences between pre- and post-assessments were analysed using *t*-tests for dependent groups. For the 14 *t*-tests we applied Bonferroni correction leading to an adjusted significance level of $\alpha = 0.0036$. Composite scores were calculated by adding up (i) the seven items expected to raise ("positive score") and (ii) the seven items expected to decrease ("negative score"). Composite scores were analysed on the level of supervisees and the level of supervisors. For each of the $n = 23$ supervisees, mean positive and negative composite scores were calculated and pre-post changes in composite scores were tested using *t*-tests for dependent groups. In addition, for each supervisor, mean positive and negative composite scores were calculated for all supervision sessions and pre-post differences were graphically inspected. Because of the uneven distribution of supervisions across supervisors, we cannot interpret this plot with statistical inferences. We can just see, that the effect is not contradicted by some supervisors or based only on the supervisor. Subgroups analyses were run to compare changes in positive and negative composite scores between physicians and nurses, as well as between the CBT-trained and the psychodynmic-trained supervisors.

3 | RESULTS

Mean values of the pre-post FWC assessments are shown in Table 1. All selected feelings did indeed raise or decrease significantly in the direction we hypothesized prior to the analysis, except for "calm" and "interested" (see Table 1).

Data analysis on the level of supervisees also revealed that the positive component score had significantly increased ($t_{23} = 4.3$, $p = 0.0003$) and the negative component score significantly decreased ($t_{23} = -4.91$, $p < 0.0001$) after supervision. There were no differences between physicians and nurses regarding change of positive ($t_{87} = -1.19$, $p = 0.24$) or negative ($t_{87} = 0.10$, $p = 0.92$) feelings. On the level of supervisors, the effects for both composite scores were visible for all supervisors. A test of the CBT based sessions against the psychodynamic based sessions revealed no differences in changes in positive ($t_{87} = 1.53$, $p = 0.13$) or negative ($t_{87} = -0.54$, $p = 59$) component scores between the two groups.

4 | DISCUSSION

Our study attempted to overcome some of the limitations of prior research evaluating supervision in the oncology setting by focussing on modification of feelings towards the patient presented in supervision. Clinicans' feelings may impact patients, clincian-patient communication and interaction, the clinicians themselves and medical care[8] and are thus an important target of supervision. Selected feelings of the FWC, based on our clinical experience, were indeed

TABLE 1 Pre-post FWC assessment: mean values were calculated over all assessed sessions; *t*-values were derived from *t*-tests for dependent groups.

Feeling	Mean value (SD) (pre-supervision)	Mean value (SD) (post-supervision)	Mean difference (SD)	*t*-value	df	*p*-value
Useful	1.77 (1.03)	2.37 (0.97)	0.57 (1.27)	4.26	88	<0.0001
Interested	2.30 (1.04)	2.43 (1.02)	0.13 (0.98)	1.30	88	0.1973
Confident	1.54 (0.97)	2.04 (0.86)	0.52 (1.00)	4.87	88	<0.0001
Attentive	2.42 (1.00)	2.74 (0.91)	0.33 (0.96)	3.19	88	0.0020
Happy	1.31 (1.02)	1.85 (1.03)	0.51 (1.16)	4.12	87	<0.0001
Empathic	2.38 (0.99)	2.65 (0.85)	0.30 (1.00)	2.78	86	0.0066
Calm	2.06 (1.13)	2.36 (1.00)	0.31 (1.10)	2.62	87	0.0103
Angry	0.97 (1.13)	0.53 (0.93)	−0.44 (0.98)	−4.23	88	<0.0001
Overwhelmed	1.40 (1.22)	0.95 (1.05)	−0.48 (1.02)	−4.40	87	<0.0001
Impotent	1.76 (1.34)	1.10 (1.12)	−0.63 (1.37)	−4.32	86	<0.0001
Depreciated	0.86 (1.20)	0.58 (0.91)	−0.25 (0.78)	−3.02	86	0.0033
Anxious	1.30 (1.19)	0.74 (0.95)	−0.58 (1.10)	−5.03	88	<0.0001
Confused	0.91 (1.05)	0.39 (0.78)	−0.52 (0.91)	−5.50	88	<0.0001
Guilty	0.96 (1.26)	0.54 (0.88)	−0.42 (1.14)	−3.45	88	0.0009

Note: Adjusted significance level according to Bonferroni is 0.0036.

modified by the supervisory process. More specifically, feelings related to clinicians' concern decreased and feelings reflecting a renewed desire regarding the patient increased. These modifications in feelings reflect an impact of all three functions of supervision.[3] The formative function: modification of own feelings may enhance psychosocial competence. The normative function: negative feelings can interfer with patient care. Finally, the restorative function: alleviation of negative feelings and the regain of positive feelings can contribute to diminish work-related stress and distress and improve clinicians' well-being.

The results confirmed thus our hypothesis, except for the feeling of being "interested" and "calm". The word "interested" can carry different meanings: the interest for a patient may be the expression of a pro-social motivation towards a patient for whom one experiences rather positive feelings, but it might also be an adjective to describe that one is intrigued by a patient towards whom one has rather negative feelings. Our clinical experience supports this last idea. Indeed, clinicians present patients they are interested in, despite or even because they represent challenges regarding their own emotions or interpersonal aspects of care. In other words: patients who do not leave them indifferent. We observe that oncology clinicians are interested to know more about difficult interactions with patients and most of them are motivated to address and acknowledge their own difficulties and contributions to the situation. This observation was confirmed in a recent qualitative study evaluating oncology clinicians' interest in and satisfaction with a supervision centred on clinicians' countertransferential experiences and their connection with their own psychological functioning and biographical background.[24] The word "interested" might therefore not be suited for the evaluation of the impact of supervision on clinicians' feelings. Regarding the feeling "calm", one can make the hypothesis, that it might be difficult to feel calm regarding a patient with whom one had a difficult encounter, even after supervision. We come back to this issue, when we will discuss the limits of our study.

We consider that the FWC has limitations, assessing solely the conscious manifestations of feelings and being possibly subjected to social-desirability biases regarding negative feelings. However, conscious manifestations of countertransferential emotions is the material supervisees bring into supervision, and it is the material with which supervisors work and with what supervisees leave the supervision. The changing intensity of feelings observed during supervision indicates that a process has taken place. This process of setting the psychic apparatus into motion is, from our point of view, one of the most essential and powerful ingredients of supervision. Rigidified attitudes of clinicians often have their sources in their developmentally constructed inner world and lead to repetitive interactions with patients.[8] Mobilization of rigid psychological states, on the other hand, allows positive evolutions, as can be observed in systemic therapies.[2]

4.1 | Strenghts and limitations of the study

The strenght of the study relies in its fullfillment of many of the recommendations made in the before mentioned narrative review on supervision in the oncology setting. The study used validated measurements, and was based on a hypothesis established prior to the analysis and a pre/post design. Moreover, all supervisors were very

experienced and knew the clinical and institutional reality of the oncology setting. Limitations are the small number of supervisees participating in this study, which did not allow to analyse subgroups (e.g., regarding experience). A possible source of bias is social desirability of supervisees, who wish to provide a positive feedback regarding the supervision; however, it is quite hard to remember how one has scored all the items of the FWC and then score differently after supervison. One can argue that this checklist has not been specifically developed for the evaluation of supervison, but we consider that regarding the evaluation of the conscious manifestations of emotional reactions towards patients, the instrument fulfils its aim. As with other instruments, it is impossible to avoid that on an individual level words are interpreted and experienced in different ways. The fact that all feelings were modified by supervision, except feeling "interested" and "calm", raises questions: are these feelings not relevant for supervisees or didn't they change because supervision had no impact on them? One might consider in future studies to first assess if these words evoke different understandings among participants or if there exists a certain homogeneity in their appreciation. Finally, the FWC has not been validated in French, but we do not have any indications that the (positive and negative) valences of feelings differ between linguistic regions.

4.2 | Clinical implications and future research

Our results underscore the importance of the supervision process in addressing countertransference reactions clinicians develop towards oncology patients. By alleviating negative feelings and bolstering positive ones, supervision can strengthen the therapeutic alliance and enhance the overall care of cancer patients. This makes a compelling case for implementing more broadly supervision in oncology settings. The study goes beyond assessment of supervisees' satisfaction with supervision, evaluating a specific and relevant impact of supervision. Our ambition regarding future research is to demonstrate the benefits we witness in our supervisory work and to improve the supervisory activity and teaching of future supervisors. We must therefore also investigate (i) the impact on the patient and patient care, identify the ingredients and benefits of different types of supervison[8] and measure the long-term effects on clincians distress and well-being.

5 | CONCLUSIONS

Supervision of oncology clinicians by experienced psycho-oncologists is a powerful tool to address difficulties they encounter in the interaction with patients. Our study goes beyond self-reported satisfaction of supervisees and demonstrates modifications of feelings towards patients presented in supervisions, thus confirming the benefits of supervision. Since feelings towards patients have an impact on the patient, the clinician-patient interactions, the carers themselves and the quality of medical care, this study encourages to continue to research to know more about supervisees, supervisors and the supervisory process, and to gain insight into how to best handle and teach this important psycho-oncological activity.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

The Ethics Committee of Canton Vaud exempted the study from approval because it does not fall within the scope of the Human Research Act, HRA. However, participants signed an informed consent form.

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