Supervision in the Psychological Therapies

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Table of Contents

PART C: PROFESSIONAL PRACTICE

A Case Study: Context Driven Supervision

PART D: CRITICAL LITERATURE REVIEW

Review of Supervisor Training in the Psychological Therapies in the UK: Issues and Challenges

List of Tables and Figures

List of Tables

List of Figures

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Declaration

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PART A: PREFACE

Introduction

Supervision in the psychological therapies, and more specifically, the 'talking therapies' is the theme that connects the elements of the thesis portfolio. Supervision has become a 'cornerstone' (Division of Counselling Psychology, 2007, p.3) of the practice of counselling, psychotherapy and clinical and counselling psychology and yet the evidence base for its efficacy remains limited (Lombardo, Milne & Proctor, 2009; Watkins, 1997). This is an interesting anomaly, especially in an era of increasing emphasis on competence and evidence-based practice (Thomason, 2010) and where supervision itself is perceived to have an essential role in the delivery of competent and evidence-based practice (e.g. Bond, 2013; Division of Counselling Psychology, 2005; Falender & Shafranske, 2007; Watkins, 2011).

It is an activity at the heart of a therapist's practice from the first days of training, where many trainees will receive their first supervision before seeing their first client. In the UK, where lifelong supervision is a mandatory requirement for maintaining a range of professional accreditations (e.g. British Association for Behavioural and Cognitive Psychotherapies, 2010; British Association for Counselling and Psychotherapy, 2011; Division of Counselling Psychology, 2007), it remains a core activity in the therapist's professional life. As psychological therapists, we turn to supervision for support, for teaching and learning, for maintaining standards of practice and for sharing the vicissitudes and rewards of clinical practice, and yet we appear not to question its empirical base. In effect, a range of benefits are attributed to supervision, such as being the 'signature pedagogy' of professional psychology (Goodyear, 2007), restoring the supervisee and preventing burnout in an emotionally exhausting profession (Knudsen, Ducharme, & Roman, 2008) and being the safeguard of standards of practice (Holloway, 1995). Perhaps because most therapists can offer many examples of the benefits of supervision we have tended to take it for granted (Hess, 1987).

One of the areas of least research is the effect of supervision on client outcome (Inman & Ladany, 2008), which is the specific focus of the research project in this thesis. My interest in the role of supervisor training grew from the research study and became the focus of the Critical Literature Review. The Professional Practice element is a case study drawn from my supervision practice and focuses on a particularly challenging experience where I was holding a dual role in relation to my work with a group of three supervisees.

PART B: Research

The impetus for the research topic, and consequently the thesis portfolio, emerged from a workshop I attended in 2009, which challenged my assumptions about the nature and purpose of supervision. It became the genesis of the idea for the 'problem area', which was how supervision attends to and influences therapeutic outcomes. Qualitative inquiry was the chosen methodology because I was interested in supervisors' formulation and experience of the relationship between supervision and therapeutic outcomes; grounded theory was the chosen method for data collection and analysis because I was looking to construct an explanatory model of their formulation and experience of the relationship. This problem area developed into the research question: What are supervisors' perceptions of the relationship between supervision and therapeutic outcomes?

As the research project developed, I became increasingly interested in the role of supervisor training and took the opportunity of using the Critical Literature Review to focus on this in greater depth. Participants in the research study worked in a variety of contexts, performing multiple and diverse supervisory roles, which mirrored my own experience in the case study and is a thematic link with the Professional Practice element of the thesis portfolio.

PART C: Professional Practice

This was the first part of the portfolio to be completed and it was written in the late spring of 2011 when data collection and analysis of the research project was at an early stage. It is a case study of group supervision in a university setting and is an account of my experience of managing a dual role in the context of a complicated organisational matrix. This was the first piece written and completed, and the last piece revisited for revising, reference updating, editing and proof reading. This was a useful and beneficial turn of events. Revisiting my own work after a two year gap and, more importantly, a two year gap in which I had been immersed in exploring supervisory processes in painstaking detail, was an insightful experience. Reciprocal connections between the case study and the research findings were plain. My own implicit and unexamined assumptions about supervisory practice before undertaking the research were demonstrated in the case study, reflecting some of the central issues emerging from the findings, and a brief retrospective reflection is included at the end of the case study.

PART D: Critical Literature Review

As I have indicated, interest in the topic of supervisor training grew from the research study. Since the purpose of a grounded theory study is to develop an explanatory theory of the

studied phenomenon, the empirical and discursive literature is not reviewed until the analysis is nearing completion. This prevents the researcher from being biased by the existing literature and accordingly, the critical literature review was completed towards the end of the analysis process. The aim of the review was to identify current issues and challenges in the field of supervisor training in the UK in the psychological therapies. Writing it towards the end of the research process has given this element of the thesis portfolio the benefit being a current review of the field as it reviews literature published as recently as 2013.

Conclusion

A theme that has been present throughout the researching and writing of each of element of the thesis portfolio has been a tendency for the psychological therapies to take supervision for granted (Hess, 1987) and this leads me to conclude that there is a need to be more challenging of professional rhetoric. My hope is that this thesis portfolio will contribute to a dialogue within the professions, in which we open ourselves up to scrutiny and challenge, being prepared to look beneath and beyond professional discourse. To this end, recommendations are proposed for supervision practice and I believe these recommendations will make a meaningful and tangible contribution to the practice of supervision in psychological therapies, including counselling psychology.

As I reach the end of more than three years devoted to studying supervision in the psychological therapies, I find my interest in it undiminished and remain intrigued by the richness of the data that has emerged. Completing this thesis has been an extraordinary experience and one that has changed my assumptions, honed my capacity for critical reflection and enabled me to engage meaningfully with the research base of supervision practice.

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PART B: RESEARCH

Supervisors' Perceptions of the Relationship between Supervision and Therapeutic Outcomes

ABSTRACT

The purpose of this study was to investigate supervisors' perceptions of the relationship between supervision and therapeutic outcomes in the psychological therapies. Research investigating the contribution of supervision to therapeutic outcomes is limited and often methodologically weak (e.g. Freitas, 2002; Inman & Ladany, 2008; Watkins, 2011b; Wheeler & Richards, 2007a, 2007b). Watkins (2011b) identified only three methodologically robust research studies in this area in a period spanning thirty years, from 1981 to 2011 and only one of the three was situated within the psychological therapies (Bambling, King, Raue, Schweitzer, & Lambert, 2006). This qualitative study used a constructivist version of Grounded Theory to analyse the data collected from individual semi-structured interviews with ten participants, and a focus group with three participants. All participants were experienced supervisors and qualified psychological therapists based in the South West of the UK. Findings suggest that supervisors perceive the relationship between supervision and therapeutic outcomes to be indirect and that enabling the supervisee to become a better therapist is how supervision is perceived to indirectly contribute to improved outcomes for the supervisee's clients. A number of issues emerged from the findings including difficulties in finding a common language for the term 'therapeutic outcome' and difficulty in ascertaining supervisory responsibility for therapeutic outcome, particularly where the supervisor did not have the 'full picture' of the supervisee's caseload. These findings are captured in the core connecting category, which is conceptualised as 'making sense of paradox and inconsistency in an indirect relationship between supervision and therapeutic outcomes'. An explanatory theory of the relationship between supervision and therapeutic outcomes, together with a diagrammatic theoretical model, is presented and recommendations for supervision practice and supervisor training in the psychological therapies are proposed. The study concludes that future research investigating the efficacy of supervision and its influence on client outcomes should first take account of supervisors' frame of reference in relation to client outcomes and its application in supervision practice.

Keywords: supervision; psychological therapies; therapeutic outcomes; grounded theory; recommendations for practice.

INTRODUCTION

Background

Supervision plays a central role in the delivery of the psychological therapies across a wide range of therapeutic orientations, and numerous theories and models of supervision have emerged over the last five decades (e.g. Carroll, 1996; Hawkins & Shohet, 2012; Holloway, 1995; Milne, 2009; Page & Wosket, 2001; Proctor, 1988; Stoltenberg & Delworth, 1987). However, empirical research remains limited (e.g. Milne, 2009; Milne & James, 2002; Watkins, 1997; Wheeler & Richards, 2007a, 2007b). In particular, the evidence base supporting its contribution to therapeutic outcomes is sparse and inconclusive (e.g. Vallance, 2004; Watkins, 2011b; Wheeler & Richards, 2007a, 2007b) and often methodologically weak (Ellis & Ladany, 1997; Freitas, 2002; Inman & Ladany, 2008; Watkins, 2011b; Wheeler & Richards, 2007a, 2007b). Watkins (2011b) was able to identify only three methodologically robust research studies in a period spanning thirty years, from 1981 to 2011, and only one of the three was situated within psychotherapy research (Bambling, King, Raue, Schweitzer, & Lambert, 2006).

The psychological therapies operate in an increasingly pressurised economic environment of budget cuts and time constraints. Recent reorganisations within the National Health Service (NHS) in the UK have led to the implementation of 'payment by results' methods of delivering therapy, resulting in increasing pressure on available resources (Centre for Mental Health et al., 2012). One of the key resources for the psychological therapies is supervision, perceived to be a critical factor in the delivery of ethical and competent psychological therapy (e.g. Bond, 2013; Division of Counselling Psychology, 2005; Falender & Shafranske, 2007; Watkins, 2011b). It is a paradox that in an environment that has an increasing emphasis on competent and evidence-based practice (e.g. Thomason, 2010), that supervision – itself playing a central role its delivery - continues to operate with a relatively flimsy evidence base.

Personal Relationship to the Research

In keeping with a constructivist qualitative research philosophy (e.g. Morrow, 2005; Morrow, 2007; Ponterotto, 2005) this report is presented in the first person and begins with a brief summary of my personal and professional background. I hope that by being transparent about my relationship with the research, the reader will be able to determine how it influences my interpretation of the data and how it limits the transferability of the findings. My cultural context is as a white British female and despite a commitment to cultural

competency in practice (e.g. Berkel, Costantine, & Olson, 2007; Gray & Smith, 2009; Ryde, 2009), it will profoundly shape my perspective. I have a vested interest in the research since for over fifteen years a portion of my income has derived from my supervision practice with psychological therapists and allied mental health professionals, and from training psychological therapists and supervisors. I have a strong professional identity as a practitioner and my clinical practice has been maintained alongside other activities. As an academic in a university, I have been programme director for a Professional Doctorate in Counselling Psychology and have been involved in developing and leading a High Intensity Cognitive Behavioural Therapy (CBT) training programme as part of the Improving Access to Psychological Therapies (IAPT) initiative (IAPT, 2013). The experience of being a counselling psychologist working within an IAPT context, contributed to the genesis of this research study. My personal relationship with the research question is very much connected with the development of the research question, which is continued in the next section.

Development of the Research Question

After a decade and a half of supervisory practice, my sense was that I provided 'good enough' supervision (Hawkins & Shohet, 2012, p.4), believing I was reasonably competent, professionally aware and had an acceptable level of ethical maturity. However, attending a workshop in 2009, made me question everything about how I practised supervision. The workshop was organised by IAPT and introduced a computerised case management type of supervision for supervising a group of workers known as Psychological Wellbeing Practitioners (PWPs) (Bower, Gilbody, Richards, Fletcher, & Sutton, 2006; Richards, Chellingsworth, Hope, Turpin, & Whyte, 2010).

Although this supervision had a strong administrative function and was conceptually very different from 'traditional' supervision (Turpin & Wheeler, 2011), it nevertheless challenged my existing assumptions about supervision practice. Specifically, it dawned on me, in a very uncomfortable way, that I had little knowledge of my supervisees' clients' therapeutic outcomes, in any kind of consistent or routine way, nor had it ever occurred to me to explicitly seek the knowledge. Identifying this as a 'problem area' (Glaser, 1978), I was curious about the degree to which my own perspectives and experience of supervision were shared more widely by other supervisors of psychological therapists.

Rationale for the Research

Several studies have attempted to investigate how supervision influences client outcomes, but my own experience indicated that there were aspects of the supervisory process that remained unknown. Key questions were:

- Do supervisors have a frame of reference for thinking about how supervision attends to and/or influences therapeutic outcomes?
- How is this frame of reference applied in supervision practice?
- Do supervisors believe that supervision has any responsibility to account for therapeutic outcomes?
- If so, how is it evaluated?
- If there is no frame of reference for thinking about how supervision attends to and/or influences therapeutic outcomes, what is the supervisor's formulation of supervision?
- How is this formulation applied in practice?
- How is it evaluated?
- How does this formulation inform supervisors' perceptions of the relationship between supervision and therapeutic outcomes

In short, do supervisors perceive a relationship between supervision and therapeutic outcomes and if so, how is it envisioned and implemented?

This study postulates, therefore, that these questions focus on a critical missing step in the research literature, and drawing on data from supervisors, attempts to explain 'what is actually happening in real life rather than describing what should be going on' (McCallin, 2004, p.27). In summary, the rationale for this study is to investigate how supervisors understand and explain the relationship between what they do in supervision and their supervisees' clients' therapeutic outcomes.

Research Question and Aims of the Research

The research question developed into 'Psychotherapy Supervisors' Perceptions of the Relationship between Supervision and Therapeutic Outcomes'.

The aim of the study is to find answers to the above questions that will lead to developing an explanatory model of the relationship between supervision and therapeutic outcomes as perceived by psychotherapy supervisors.

Contribution to Counselling Psychology

One of the primary reasons for conducting research is to make a positive contribution to one's discipline or field of study. This study contributes to an area that is paradoxically under-researched and yet has central prominence in the psychological therapies, including counselling psychology. Given this central role, there is an ethical imperative (Lichtenberg,

2007), within the profession, for research where we willingly open ourselves to scrutiny and account for elements of supervisory practice.

The study contributes to the profession in several ways. In terms of application to practice, there is the potential for direct value for the immediate stakeholders, the supervisor-supervisee-client triad, in relation to the learning deriving from the emergent explanatory model and its potential for challenging existing assumptions. Looking to wider stakeholders, there are potential benefits for service providers in relation to raising awareness of supervisory focus on client outcomes and for supervisor training programmes. The intention is that proposed recommendations for supervision practice and training will be transferable beyond the parameters of the study and be of value to the profession (see Discussion section below).

The study contributes theoretically to the evidence base regarding the relationship between supervision and client outcomes, as well as providing a foundational understanding of the supervisor's frame of reference with regard to therapeutic outcomes, which will inform future research studies. As one of the applied psychologies, the practice of counselling psychology is firmly rooted in psychological theory and counselling psychologists prioritise the integration of psychological theory with therapeutic practice (British Psychological Society, 2014). As such, this is one of the primary factors differentiating counselling psychology from counselling and psychotherapy within the cluster of the psychological therapies (Strawbridge & Woolfe, 2003).

How to balance the 'science' of psychological theory with therapeutic practice remains a central debate within the discipline of counselling psychology, embedded in explorations of the application of the scientist-practitioner model (e.g. Blair, 2010; Fassinger, 2005; Strawbridge & Woolfe, 2003). Bury and Strauss (2006) note that this model has been embraced by counselling psychologists in the US and the UK, but they point out that the current emphasis on evidence-based practice has led to a re-examination of 'the meaning of the scientist-practitioner model within counselling psychology' (Bury & Strauss, 2006, p.120). Woolfe and Strawbridge (2003) suggest applying the alternative notion of the 'practitioner-scientist' within counselling psychology, and this reformulated notion is an appropriate one in this study. It captures the concept of practice-based research and emphasises a model where 'science' develops from practice. By using Grounded Theory to generate theory grounded in real-life practice, this study draws upon this alternative conceptualisation of the scientist-practitioner model, where evidence emerges from practice.

In addition, it is particularly apt that this supervision-focused research study sits within the discipline of counselling psychology since the Division of Counselling Psychology was the first division within the British Psychological Society to mandate supervision for its members (Woolfe & Tholstrup, 2010).

Defining Terms used in the Study

Therapeutic Outcomes

There is no shared language defining the outcome of therapy for the client, across therapeutic orientations. Lambert and Hawkins (2001, p.132) suggest the following definition 'Regardless of the theories governing different psychotherapies, typically, the desired outcome across orientations is lasting and meaningful change in a patient's life ... changes in the patient's distress level, interpersonal relationships, and the performance of societal and communal roles'.

Defining 'therapeutic outcome' is complex and dependent on diverse variables, including therapeutic orientation. For this reason and for the purposes of this study, a tentative description of a positive therapeutic outcome has been developed as:

> 'the client reports receiving benefit from therapy that can be evidenced by a perceived improvement in quality of life.'

The terms 'client outcome, psychotherapeutic outcome, clinical outcome, therapeutic outcome' have been used interchangeably in this study although the term 'Therapeutic Outcome' has been more generally used, and is abbreviated to 'TO' throughout the report.

Psychological Therapist

The term 'therapist' is used throughout the report and refers to psychotherapist, counsellor, clinical psychologist or counselling psychologist.

Supervision

There are fundamental difficulties in defining psychotherapy supervision, largely because there is a diverse range of models identifying different variables (Milne, 2009) and having different goals (Morgan & Sprenkle, 2007), leading to a spectrum of definitions (Milne, 2009) drawing on a variety of therapeutic and theoretical approaches (Morgan & Sprenkle, 2007; Rich, 1993; Watkins, 2011a). Despite the difficulties, there has been a sustained attempt to define the activity of clinical supervision within the psychological therapies,

highlighting both the complexity of supervision and the general lack of clarity surrounding its theory and implementation.

Watkins (2011a) suggests that over the last century a definition has emerged that is a blend of teaching, therapy and consultation though not exclusively any of them. An investigation of over a dozen definitions, reveals either a lack of any substantial reference to enhancing client outcome, or none at all, as an element of supervision (e.g. Bernard & Goodyear, 2009, p.7; British Association for Counselling & Psychotherapy, 2011, p.1; Butterworth, 2001, p.319; Carroll, 2007, p.36; Department of Health, 2000, p.1; Division of Counselling Psychology, 2007, p.4; Falender & Shafranske, 2004, p.3; Hawkins & Shohet, 2012, p.5; Holloway, 1992, p.177; Inskipp & Proctor, 1988, p.4, 1993, p.1; Lambert, 1980, p.425; Loganbill, Hardy & Delworth, 1982, p.4; Milne, 2009, pp.15-16).

This simultaneously presents a problem in settling on a definition of supervision for this study, whilst highlighting the absence of focus on client outcome in the literature. The following two definitions emphasise client welfare more than others:

> 'Supervision is a joint endeavour in which a practitioner with the help of a supervisor, attends to their clients, themselves as part of their client practitioner relationships and the wider systemic context, and by so doing improves the quality of their work, transforms their client relationships, continuously develops themselves, their practice and the wider profession' (Hawkins & Shohet, 2012, p.5).

> 'A working alliance between the supervisor and counsellor in which the counsellor can offer an account or recording of her work; reflect on it; receive feedback and where appropriate, guidance. The object of this alliance is to enable the counsellor to gain in ethical competence, confidence, compassion and creativity in order to give her best possible service to her clients' (Inskipp & Proctor, 1993, p.1).

Whilst both definitions reflect valid aspects of supervision, I suggest that it is necessary to go further in integrating the client into supervisory purpose and, on the basis of the findings, offer a reconceptualised definition of supervision in the Discussion section below.

The next section presents a review the literature relevant to the research study.

LITERATURE REVIEW

The Role of the Literature Review in Grounded Theory

A central characteristic of the grounded theory approach is that the researcher holds back from researching the literature until theoretical integration has been reached. The degree to which this is desirable or practical continues to be debated (e.g. Charmaz, 2006; Fassinger, 2005; Glaser, 1978; Glaser & Strauss, 1967). Glaser's view is that the literature should be accessed only when the emergent theory is sufficiently developed so that the risk of bias is reduced (Glaser, 1978; Hernandez & Andrews, 2012; Holten, 2007). Strauss and Corbin (1998) take a more pragmatic view, suggesting that the literature may be accessed at an earlier stage in the process. It is unrealistic to suppose that the researcher sets out on a research study with no prior knowledge of the subject area (e.g. Bryant & Charmaz, 2007; Gray, 2004; Pidgeon, 1996) and Lempert (2007) suggests that some familiarity with the literature is essential to ensure that the researcher's knowledge of the subject area is current. Fassinger (2005) suggests that the consensus leans towards a minimal familiarity with the literature and encourages finding a balance between enough knowledge yet not so much that the research is limited by preconceptions.

At what point to conduct a thorough literature review is therefore a critical decision in a grounded theory study. I brought a good working knowledge of the field from my professional life but refrained from further literature searches until most of the analysis was complete and theoretical integration in its final stage. Since supervision is the overall topic for the thesis portfolio, the timing of the writing of PART D: Critical Literature Review was also a factor, and this was written towards the end of data collection, and when the analysis was well developed.

Introduction

The primary focus of this review is the relationship between supervision and TOs, together with related issues relevant to the study. The review begins with a overview of the current status of supervision, followed by a discussion of essential issues relating to the study, and ending with a more detailed examination of the supervisor-client outcome literature.

Background

There is widespread acceptance across the psychological therapies that clinical supervision is an essential component of the implementation of effective and ethical psychotherapeutic practice (e.g. Milne, 2009; Wheeler & Richards, 2007a, 2007b). Professional organisations

(e.g. British Psychological Society [BPS], Division of Counselling Psychology [DCoP]; British Association for Counselling and Psychotherapy [BACP], British Association for Behavioural and Cognitive Psychotherapies [BABCP]) make professional accreditation conditional upon receiving regular supervision. DCoP states that 'supervision is a cornerstone of Counselling Psychology training and practice and a requirement of every practitioner, however senior, throughout their working life' (Division of Counselling Psychology, 2007, p.3).

It is clear, therefore, that supervision is rooted firmly at the centre of professional standards and yet it continues to be under researched (e.g. Lombardo, Milne & Proctor, 2009; Milne & James, 2002; Watkins, 1997; Wheeler & Richards, 2007a, 2007b). The need for more research is increasingly recognised (e.g. Ellis, 1991; Ellis, Ladany, Krengel & Schult, 1996; Milne, 2009). BACP published an Action Plan, in which they stated 'the activity and function of supervision within counselling, psychotherapy and the wider helping field, requires research in order to critically comprehend and appropriately challenge its identity**,** validity**,** role**,** responsibility and scope' (British Association for Counselling and Psychotherapy, 2008). Lombardo et al. (2009) point out that supervision continues to be little understood, which impairs research and practice. Roth and Pilling (2008) draw attention to the lack of literature linking supervision with therapeutic outcomes, despite supervision being considered an essential element of clinical training and practice.

Parameters of the Search

The search was limited to work in the English language, and studies situated within the psychological therapies but more specifically, the 'talking' psychological therapies, hence studies focusing on psychiatrists, mental health nurses, social workers and other health professionals are excluded. While there is a considerable amount of research in the systemic literature, this is excluded on the grounds that there are wide differences in supervision methods. Systemic supervision routinely uses 'live' supervision through observation, one way mirrors and the 'bug in the ear', whilst non-systemic approaches use more conventional methods of case presentation, such as supervisee self report and audio or video recordings. This review has drawn on both the discursive literature and empirical studies.

The search used electronic databases PsycINFO, PsycArticles and Psychology and Behavioral Sciences Collection from 1980 to 2013 and references were subjected to further hand searching. Key terms for the main search were supervisor/supervisee/supervision; client/patient; therapy/psychological therapy/ counselling/psychotherapy/clinical

psychology/counselling psychology; therapeutic/clinical/client/patient outcome and all results were followed up.

Overview of the Development of Supervision

Supervision began with Freud and the practice of psychoanalysis (e.g. Bernard & Goodyear, 2009; Leddick & Bernard, 1980; Milne, 2009) emerging in its current form within the psychological therapies in the 1950s (Carroll, 2007). A crucial change occurred in the US in the 1990s when the American Psychological Association named supervision as an area of training for psychologists and one of their top five professional activities (American Psychological Association, 1996, 2000). Supervision became a separate and distinct area of study and led to a significant increase in the literature (Inman & Ladany, 2008). A similar change occurred in the UK in 1983, when BACP (then the British Association for Counselling - BAC) made supervision a mandatory requirement for professional counsellors wishing to apply for and maintain accreditation with them (British Association for Counselling & Psychotherapy, 2011). Currently, monthly supervision is a requirement for counselling psychologists who wish to remain chartered members of DCoP (Division of Counselling Psychology, 2007) and CBT therapists wishing to seek and maintain accreditation with BABCP (British Association for Behavioural and Cognitive Psychotherapies, 2010). These organisations are examples, and there are numerous psychotherapy and professional psychology bodies in the UK who have their own accreditation criteria. Nevertheless, mandatory supervision for accreditation purposes has led to a widening recognition of the central role of supervision in the psychological therapies (Carroll, 2007).

By the mid 2000s, supervision was established as a distinct professional activity in its own right (e.g. Bernard, 2005) and established as a core competency in professional psychology (Falender & Shafranske, 2007; Kaslow et al., 2004). Bernard (2005, p.7) declares that the supervision field 'simply exploded' between 1992 and 2004 bringing a proliferation of research and discursive literature. More recently, Watkins (2011a) praised the increasingly sophisticated methodological pluralism of supervision research and the broadening base of themes within the literature, commending a century of productive work. At the same time, he lamented the fact that research into the supervisor role has been slow, 'the developmental process, trajectory, and experiences of the supervisor have remained more mystery than manifest for far too long' (Watkins, 2012a, p.79).

According to Watkins (2011a), supervision plays a key role in the teaching and learning of psychotherapy. Shulman (2005) coined the term 'signature pedagogy' to define a

discipline's central learning strategy, and supervision is now recognised as the 'signature pedagogy' for professional psychology (e.g. Goodyear, 2007; Watkins, 2011a). Although supervision is accepted as a key learning tool for psychotherapy trainees, in both the US and the UK (e.g. Bernard & Goodyear, 2009; Callahan, Almstrom, Swift, Borja, & Heath, 2009; Holloway, 1992; Milne, 2009; Scaife, 2009), there is a critical distinction in how supervision is practised in the US and the UK. This has implications for how we read the literature and is especially important since the majority of the supervision literature still emanates from America (Carroll, 2007).

In the UK, the culture of supervision (West, 2003) is one in which supervision is a mandatory requirement throughout the professional life of many practitioners who wish to maintain accredited status (e.g. BABCP, 2010; BACP, 2011; DCoP, 2007). This is very different from the US, where licensed professionals are normally permitted to work 'without formal supervision' (Bernard & Goodyear, 2009, p.13). As such, American literature has a heavy emphasis on the educative function of supervision, demonstrated in the following remark, 'throughout the history of supervision, the enduring issue of concern has been and remains: How can we as supervisors best prepare and train our supervisees to be competent, committed, and effective psychotherapy practitioners?' (Watkins, 2012b, p.280).

On the other hand, different functions of supervision, such as providing a reflective space, maintaining ethical practice, providing resourcing (e.g. Gilbert & Evans, 2000; Hawkins & Shohet, 2012; Page & Wosket, 2001; Scaife, 2010; Wheeler & King, 2001) are more pressing requirements for qualified and experienced practitioners. Wheeler and Richards (2007a, p.3) highlight the need 'to examine the impact of supervision on qualified and experienced practitioners', a more relevant issue in a culture of lifelong supervision. Page and Wosket (2001, pp.1-2) suggest using different terms such as 'trainee supervision' and 'practitioner supervision', Carroll (2007) notes the emphasis on the reflective-practitioner model in counselling psychology and Hawkins and Shohet (2012) emphasise the need for different contracting for different types of supervision.

These different emphases must inevitably lead to some blurring of definition as to how supervision is conceptualised and implemented and yet, this is scarcely addressed in the literature, although Wheeler and Richards (2007a) assert the need to develop a supervision research strategy in the UK. It has a bearing on this study insofar as the increased focus on training the supervisee for practice as opposed to the welfare of the client, or the client's outcome, is understandable in a training context, but less desirable over a practitioner's professional lifetime or as a longer term strategy.

Models of supervision

Supervision began by being approach specific within psychoanalysis, and largely developed within therapeutic orientations as new therapeutic perspectives emerged (Watkins, 2011a). Supervisors relied on their own therapeutic approaches to provide a theoretical base for supervisory practice (e.g. Baranchok & Kunkel, 1990; Falender & Shafranske, 2004; Hess, 1987; Leddick & Berrnard, 1980) tending to draw upon experiences of being supervised (Watkins, 1997) or therapeutic approach to inform supervision practice (Milne, 2006). Psychotherapy-based models have become more sophisticated over time across a range of psychotherapy approaches (Bernard & Goodyear, 2009; Leddick, 1994) and a major benefit of these approaches is enabling supervisees to implement their own model of therapy, perceived to be a key factor in delivering effective therapy (Holloway & Neufeldt, 1995).

However, there are drawbacks for supervisors in relying on psychotherapy-based models for supervision practice insofar as therapy and supervision are different activities requiring different skills (Ladany, Friedlander & Nelson, 2005) and there is the risk of its leading to a narrow allegiance to one therapeutic perspective (Holloway, 1995). Furthermore, Falender and Shafranske (2010) suggest that the broader competences frameworks, developed over the last decade, now need be integrated into psychotherapy-based models.

The educative focus of supervision led to the development of developmental models of supervision (Watkins, 2011a), based on Hogan's (1964) hypothesis of four levels of counsellor development. Models emerged in the 1980s (e.g. Stoltenberg, 1981; Stoltenberg & Delworth, 1987), which were effective across therapeutic approaches (Stoltenberg, 2005). Holloway (1987) identified eighteen different developmental models and suggested that the underlying assumptions needed further exploration. There has been wider criticism because of their limited empirical support (Bernard, 2005; Stoltenberg, McNeill & Crether, 1994; Watkins, 1995).

Despite the fact that these models have been widely accepted in supervision practice, seeming to be 'intuitive' (Bernard, 2005, p.16), both Summerall et al. (1998) and Fisher (1989) found that supervisors appeared not to alter their supervision according to the developmental stage of the supervisee. It should be noted that these were American studies using a trainee sample, and results may have been different with developmental stages beyond the training stage. On the other hand, Worthington (1987, p.206) found the opposite, declaring that supervisors do 'pay attention to the counselor's aging and aid his or her development'. Since the 1980s, there has been limited advancement in these models,

consisting only of general refinement and some model testing (Bernard, 2005) and the need for further research remains.

Alongside the developmental models, a wide range of integrated models of supervision has emerged. They are not tied to a therapeutic approach but are designed to offer a framework for delivering supervision across approaches (e.g. Bernard, 1979; Hawkins & Shohet, 2012; Holloway, 1995; Milne, 2009; Page & Wosket, 2001). A full evaluation of the diverse range of integrated models of supervision is beyond the scope of this review, which will focus on the functional model. This was one of the earliest supervision models, originally formulated by Kadushin (1976) for social work supervision and subsequently adapted by Proctor (1988) for counselling and psychotherapy supervision. She proposed three basic functions of supervision: normative, formative and restorative, and this model has continued to inform the practice of psychotherapy supervision (e.g. Hawkins & Shohet, 2012; Milne, 2009; O'Donovan, Halford & Walters, 2011).

The normative function refers to the quality control element of supervision (Hawkins & Shohet, 2012), where the supervisor takes responsibility for monitoring and evaluating the supervisee's clinical work and ensuring that the supervisee works within the 'norms' of the profession. This role entails a consistent monitoring of the supervisee's competence in professional practice and his/her capacity to practise within ethical boundaries, and in effect, adopting the role of gatekeeper of the supervisee's professional practice (Holloway, 1995). This function serves the client's welfare, aiming to ensure delivery of good therapeutic practice in an ethical and boundaried manner. It is the most challenging function of supervision for both supervisors and supervisees (O'Donovan et al., 2011) since it incorporates the difficult tasks of evaluation and providing feedback (Inman & Ladany, 2008).

Giving feedback about sensitive issues such as supervisee incompetency or breaches in ethical practice can be daunting and supervisors are apt to avoid doing so (Hoffman, Hill, Holmes & Freitas, 2005), leading to there being a leniency bias (Karpenko & Gidycz, 2012). Gonsalvez and Freestone (2007, p.23) suggest there is 'the very real possibility that supervisors' assessments are not as reliable or valid as professional psychology assumes'. They point out that this is could inflate the supervisee's sense of their own competence, hindering the supervisee's professional development and having damaging consequences for client welfare. There is some evidence that supervisors make judgements on the basis of their liking for the supervisee (e.g. Steward, Breland & Neill, 2001; Turban, Jones & Rozelle, 1990) and that supervisors respond to the supervisee's liking for them (Dodenhoff, 1981).

An additional difficulty for supervisors when making evaluations of supervisees' practice is that supervisors tend to rely on supervisees' self report about clinical practice when making their evaluations (Inman & Ladany, 2008; Scott, Pachana & Sofronoff, 2011). Research shows that therapists are not necessarily accurate when evaluating client progress or outcomes (Hatfield, McCullough, Frantz & Krieger, 2010; Lambert, 2010), and usually overestimate improvement and underestimate deterioration when compared with client self reports (Grove, Zald, Lebow, Snitz, & Nelson, 2000; Worthen & Lambert, 2007). Since therapists tend to trust their own instincts over statistical data (Garb, 2005), Worthen and Lambert (2007) suggest that supervisors should include regular client outcome monitoring into routine supervisory practice. Lambert, Hanson and Finch (2001) conducted a study in which they trialled giving client feedback data to therapists. They found the deterioration rate for clients whose therapists received feedback on progress was 6% whereas the deterioration rate in the control group of therapists, not receiving feedback data, was 23%. They used an automated system and recommend the wider use of such systems to enhance client outcomes.

Using a system of outcome measures, Hawkins, Lambert, Vermeersch, Slade & Tuttle (2004) conducted a study with three conditions: where both therapist and patient received patient feedback (from the outcome measures) of patient progress during treatment; where only the therapist received patient feedback of patient progress during treatment; and, thirdly, where neither therapist nor patient received patient feedback of patient progress during treatment. Patients in both feedback conditions (where patient and therapist received patient feedback of progress during treatment, and where only the therapist received patient feedback of patient progress during treatment), demonstrated significantly greater improvement at the end of therapy than the treatment-as-usual condition (i.e. where neither therapist nor patient received patient feedback during treatment). This appears to provide evidence that if the therapist receives information regarding patient progress during treatment there is likely to be a greater improvement in patient outcome.

Relying on supervisees' self report of clinical work, raises the question of non-disclosure in supervision. In a study with a sample of 108 supervisees, participants reported an average of 8.06 non-disclosures, with negative reaction to the supervisor being the most frequent type, attributing supervisor style to the reasons for non-disclosure. Supervisees were less satisfied with supervision in these circumstances and non-disclosure was found to negatively impact the process of supervision (Ladany, Hill, Corbett & Nutt, 1996). Yourman and Farber (1996) claimed that their study revealed that supervisees withhold 90% of the time. A later study revealed that trainee supervisees withheld 84.3% of information with an average of 2.68 non-disclosures occurring per session (Mehr, Ladany & Caskie, 2010). Yourman (2003)

found that non-disclosure typically occurs when a supervisee feels shame, and Webb and Wheeler (1998) found that non-disclosure was more likely to occur in group supervision than in individual supervision.

Radcliffe and Milne (2010) conducted a study to investigate how supervisees defined satisfactory supervision. It emerged that satisfactory supervision was 'supervisee-centred, excluded therapy tapes, ignored client outcomes and made little reference to training' (2010, p.19). They concluded that 'high satisfaction findings may actually be suggestive of poor supervision' (2010, p.19) and this raises challenging questions about supervisee-centred supervision and how supervisors respond to supervisee satisfaction reviews.

There is an inherent tension between the normative function and the restorative function of supervision (Bogo, Regehr, Power & Regehr, 2007; O'Donovan et al., 2011). Where the normative function is evaluative, the restorative function requires the supervisor to help protect the supervisee from the stresses of the work, and to provide a caring environment where the supervisee can be personally supported, 'essential if workers are not to become over-full with emotions' (Hawkins & Shohet, 2012, p.63). Demonstrating the protective effects of the restorative aspects of supervision, Knusden, Ducharme and Roman (2008) conducted a study in which they found that perceived quality of supervision was strongly associated with perceptions of job autonomy, and justice in the workplace. They surmised that supervision would help protect staff from emotional exhaustion and reduce turnover.

Where the normative function raises dilemmas for the supervisor, the restorative function mirrors the supervisor's therapeutic training and he/she is able to draw on a pool of therapeutic and relationship skills ((Bernard & Goodyear, 2009; Hoffman et al., 2005). Given the tension, O'Donovan et al. (2011, p.110) suggest that supervision 'might often compromise its normative function of protecting clients and determining supervisee competence to practise, to achieve its restorative and formative functions of supporting and educating supervisees'. Their solution is that the role of giving summative feedback should be placed elsewhere, leaving the supervisor to provide formative feedback in a supportive environment (O'Donovan et al., 2011).

The formative or educative function supports the supervisee in developing as a practitioner, in terms of knowledge and skills. James, Milne, Blackburn and Armstrong (2006) suggest that learning theory should be formally applied within supervision, such as Vygotsky's Zone of Proximal Development (Vygotsky, 1978). They propose structuring the supervisee's learning within a framework of assessment, establishing a baseline developmental level, applying the correct techniques and evaluating outcome.

Providing an opportunity for reflection is particularly important in order to enable the trainee supervisee to make connections between theory and practice (Bootzin & Ruggill, 1988; Shaw, 1984). It is also an important function for qualified and experienced practitioners who are less likely to be grappling with learning new skills and more likely to be deepening their understanding and application of therapeutic concepts.

Supervisory Relationship

Bernard (2005) emphasises the importance of the centrality of the supervisory relationship, suggesting that supervisors are 'in our element' with the supervisory relationship and 'drawn back to the relationship womb' (p.15). It has been at the centre of supervision research for many decades (e.g. Bordin, 1979, 1983; Inman & Ladany, 2008; Nelson &Friedlander 2001). Watkins (2011a) equates 'good' or 'bad' supervision with the quality of the supervisory relationship and Carey, Williams and Wells (1988) conducted a study demonstrating that the supervisee's level of trust in the supervisor was significantly related to trainee performance and was a more important factor in relationship terms, than expertness or attractiveness. Patton and Kivlighan (1997) found that the trainee supervisee's perception of the supervisory alliance was significantly related to the client's perception of the counselling alliance and, in addition, it was significantly related to the supervisee's treatment adherence (i.e. the supervisee's level of adherence in correctly implementing the chosen therapeutic approach).

Clearly, there is a need for supervisors to make efforts to build a sound supervisory relationship and working alliance. This nests within the restorative function of supervision, whilst contributing to ease of implementation of both normative and formative functions. However, there is the potential for supervision to be harmful to the supervisee where the supervisory relationship is damaging (e.g. Gray, Ladany, Walker & Ancis, 2001; Nelson & Friedlander, 2001; Ramos-Sanchz et al., 2002; Veach, 2001) or just ineffective (Ellis, 2001). There is also risk of supervisor-supervisee collusion (Milne, Leck & Choudhri, 2009) along with the risk of the supervisor sliding into the role of therapist (Feltham & Dryden, 1994). The quality of the supervisory bond is therefore a central factor in the delivery of effective supervision. However, the triadic nature of the supervisory relationship is key and some attention has been paid to the potential conflict inherent in the triadic relationship of supervisor-supervisee-client (e.g. Hawkins & Shohet, 2012; Page & Wosket, 2001) with Watkins (2011a) suggesting that supervision has now achieved 'maturation' in fully embracing the psychology of all three persons within the supervisory frame. The closeness of the supervisor-supervisee bond and its central place in the literature may be at the expense of attending to the client's outcome, leading Inman and Ladany (2008, p.506) to suggest that

'given that client outcome is at least one step removed from the supervision work, it is possible that supervision may have limited influence on it'.

Supervisor Accountability

Supervisor accountability and evaluation are becoming more prominent issues (e.g. Thomason, 2010; Watkins 2011b) but a major difficulty is the lack of availability of psychometrically sound instruments with which to evaluate supervision practice (Milne, 2009; Watkins, 2011a). According to Inman and Ladany (2008) supervisee development has been a major area for supervision research from 1980 to 2007 while there have been far fewer studies focusing on supervisor development (Watkins, 2012a). Following a review of a range of qualitative and quantitative instruments designed for evaluating supervision, Ellis, D'Iuso and Ladany (2008) concluded that there was a lack of measures that were psychometrically valid and reliable. (See PART D: Critical Literature Review for a more detailed overview of supervisor competences and evaluation).

Borders (2005) suggested that Hess's inclusion of a section on legal issues for supervisors in the 1980 edition of *Psychotherapy Supervision: Theory, Research and Practice* was a defining moment for supervision, given that no ethical codes for the practice of supervision existed at that point. Since that edition, supervision practice is now supported with more accreditation frameworks and ethical guidelines in America (Borders, 2005) but in the UK there are still few guidelines and little monitoring or regula tion of supervisors (Roth & Pilling, 2008) and, as yet, no system for accrediting supervisor training programmes. Inman and Ladany (2008) point out that little empirical work has been carried out on ethical standards for supervisors. One study focusing on ethical practice in supervision revealed that 51% of the trainee sample reported that their supervisor did not adhere to at least one of the ethical guidelines (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999). In a further study, more than 50% of trainee supervisees were still reporting at least one unethical behaviour by their supervisor (Ladany, 2002). The implication is that further research is needed in the area of negative role modelling in supervision.

Legal implications for the practice of supervision continue to be unclear although the Tarasoff case (Tarasoff v Regents of the University of California, 1976) was a significant landmark in terms of legal implications in the US. The ruling was that a psychologist is obliged to break confidentiality and has a duty to warn a third party if she/he has reason to believe her/his client poses a threat (Ewing, 2005; Walcott, Cerundolo & Beck, 2001).

Therapeutic Outcomes

Although a review of the literature on psychotherapy outcomes is beyond the scope of this report, the way in which they are perceived does have a bearing on the current study. Research identified above indicates that it is not routine clinical practice to measure or monitor client outcomes using psychometric measures, nor to present such information in supervision, although there appears to be a growing interest in this area. For example, a recent qualitative study investigated therapists' and clients' perceptions of the use of providing computerised CORE (Clinical Outcomes in Routine Evaluation– one of the most commonly used client outcome measures in counselling practice) information in therapy sessions (Unsworth, Cowie & Green, 2012). They found that therapists were originally resistant though saw benefits over time, recognising that it alerted them to incongruence between clients' verbal report and scores, and gave earlier warnings of risk issues. In contrast, clients were more immediately positive and liked to see a visual representation of their mental state. McNaughton, Boyd and McBride (2006) had earlier suggested that introducing CORE into the supervision process would have positive benefits.

Lambert and Hawkins (2001) proposed a framework model for using client outcome data in supervision and Reese et al. (2009) investigated the effects of using client feedback data in supervision with trainee therapists. The study consisted of two conditions, where one set of supervisors received client progress data and the other provided supervision as usual, receiving no client data, over a period of one year. Although both groups of trainees demonstrated better outcomes by the end of the year, trainees' outcomes in the feedback condition were more improved. In addition, there was no significant difference in rating the supervisory alliance or satisfaction with supervision.

With an increasing emphasis on evidence based practice (e.g. Roth & Pilling, 2008; Thomason, 2010; Watkins, 2011b), this is where supervision could take a lead, given the encouraging evidence (i.e. Lambert et al., 2001; Hawkins et al., 2004; Reese et al., 2009). Additionally, it may be that such innovative methods would lessen the distance of the supervisor-client relationship and bring client welfare and outcome more to the fore in supervision. Amerikaner and Rose (2012, p.61) found that 'supervisee-initiated case presentation' was that most frequent method used in supervision and warned that this may increase supervisors' ethical vulnerability.

Supervision and Therapeutic Outcomes

Ellis and Ladany refer to the client's outcome as the 'acid test' for supervision (1997, p.485) and yet the relationship between supervision and client outcomes has been a long neglected

area of research (e.g. Freitas, 2002; Holloway & Neufeldt, 1995; Watkins, 2011b). Furthermore, Inman and Ladany (2008, p.507) are pessimistic about developing a robust empirical base in this area, declaring 'given the complexities inherent in the supervisor-supervisee-client triadic experience, the influence of supervision on client outcome may present significant challenges for researchers wishing to demonstrate the efficacy of supervision'. This view is shared by others (e.g. Callahan et al., 2009; Wampold & Holloway, 1997) and indicates why the area has been consistently criticised for weak methodology (e.g. Ellis & Ladany, 1997; Freitas, 2002; Watkins, 2011; Wheeler & Richards, 2007a, 2007b).

An issue that contributes to the gap in the supervision research literature is indecision as to whom or what supervision is there to serve. Inman and Ladany (2008, p.506) point out that although one aim of supervision is to further supervisee development, the 'ultimate effect of supervision is intended to influence client outcome'. Omand (2010) notes that the twin aims of protecting the client and promoting the learning of the supervisee may sometimes seem to be in conflict. The preponderance of the literature has been on how supervision benefits supervisees in multiple ways (e.g. Britt & Gleaves, 2011; Carroll & Gilbert, 2010; Goodyear & Guzzardo, 2000; Holloway & Neufeldt, 1996; Inman & Ladany, 2008; Watkins, 2011b; Wheeler & Richards, 2007a, 2007b). Holloway and Carroll (1996, p.54) make a stark comment on this preponderance by suggesting that it is akin to 'viewing parenthood solely for the enrichment of parents'. Page and Wosket (2001, p.10) caution that 'any supervisor who is not endeavouring to balance these two fundamental elements of the role is avoiding one of the central aspects of effective supervision'.

Several literature reviews on this topic have been conducted over the last twenty five years (Ellis & Ladany, 1997; Freitas, 2002; Watkins, 2011b; Wheeler & Richards, 2007a, 2007b). (See Appendix 1. Table 1. Outcome Studies for a summary of the studies reviewed here). Ellis and Ladany (1997) compiled the first list of supervision studies focusing on client outcome, finding nine studies between 1981 and 1993. Several of these studies do not fit the parameters of this review and are excluded: two studies, one relating to social work and one relating to a youth residential care setting, respectively, are excluded (Harkness & Hensley, 1991; Triantafillou, 1997); and two studies (Iberg, 1991; Mallinckrodt & Nelson, 1991) have been excluded since the foci are psychotherapy skills training and the impact of the level of counsellor training on client outcome, respectively.

Freitas (2002) reviewed six of the studies identified by Ellis and Ladany (1997), excluding the Mallinckrodt and Nelson (1991) on the grounds identified above, and excluding two more studies on the grounds of their 'limited external validity' (Freitas, 2002, p.354).

Freitas included a study from 1981 (Dodenhoff, 1981), missed by Ellis and Ladany (1997) and extended his review to include two more by Harkness (1995, 1997), which are excluded from this review on the grounds that they relate to social work not psychological therapy.

Wheeler and Richards (2007a, 2007b) conducted a large scale systematic review of the impact of supervision on therapists, their practice and their clients, therefore having a wider remit than the current review. They concluded that evidence for any beneficial effects of supervision on client outcome was limited to one study, Bambling et al., 2006 (Wheeler & Richards, 2007a).

In the most recent review, Watkins (2011b) set out to integrate earlier research findings with more recent studies, and in a period spanning thirty years from 1981 to 2011, he counted a total of eighteen studies. He is sceptical about the relevance of many of the earlier studies and dismisses (p.247) seven as being 'not really patient-supervisor outcome studies at all' (Alpher, 1991; Friedlander, Siegel & Brenock, 1989; Iberg, 1991; Kivlighan, Angelone & Swafford, 1991; Milne, Pilkington, Gracie & James, 2003; Sandell, 1985). He is critical of others, dismissing a further two as being 'purely survey or opinion based' (Steinhelber, Patterson, Cliffe & LeGoullon, 1984; Vallance, 2004), one for being a pilot study (Triantafillou, 1997), two others for duplicating the data (Harkness, 1995, 1997) and one for failing to address client outcome (Dodenhoff, 1981). Of the remaining five, two more are criticised for having methodological errors (Couchon & Bernard, 1984; Harkness & Hensley, 1991), leaving (p. 249) 'only three such studies upon which we can now draw' (Bambling et al., 2006; Bradshaw, Butterworth & Mairs, 2007; White & Winstanley, 2010).

Whilst Watkins has treated the studies to swathing criticism, on the whole, it is warranted as there are misidentifications and weak methodology across many of the studies. Of the three studies Watkins deemed methodologically sound, only Bambling et al. (2006) is included here as the other two are situated outside the psychological therapies. Those meeting the inclusion criteria for this study are reviewed below.

In the earliest study, Doderoff (1981) uses a quasi-experimental design to investigate supervision as a social process. She proposed that supervisee attraction to the supervisor would increase the supervisor's influence over the supervisee, leading to improved client outcomes, and that supervisor relational style (direct or indirect teaching behaviours) would be a further determining influence on supervisee effectiveness. Results supported the hypothesis that counsellors who are more attracted to their supervisors will be more effective at the end of the practicum and that a direct supervisory behavioural style was positively correlated with supervisors' rating of client outcome. The central limitation of this study is that there was only one measure of client outcome taken around the fifth session, after which

the supervisors rated client outcome, thereby invalidating the study's relevance to client-supervisor outcome studies. Psychometric data on the measures used was omitted, as was data on how supervisors were rated for supervisory behaviours. Freitas (2002) points out that supervisors may have rated supervisees who found them attractive more positively, and this was supported in a later study, which found that supervisors' evaluations of trainees were influenced by how much they liked them (Carey et al., 1988).

Several years later, Steinhelber et al. (1984) noted that they could find no empirical studies directly investigating the relationship between supervision and patient outcome and conducted a study to examine the effects of the amount of supervision and the effects of congruence of supervisee-supervisor-therapeutic approach on client outcome. Client outcome was measured using the Global Assessment Scale (GAS) at two points, the beginning of therapy and at the time of the study. This was the study's greatest limitation as it did not assess client outcome but progress at an arbitrary midway point, which the authors note. They found no statistical difference between GAS scores and amount of supervision but found congruence of therapeutic approach related positively but only in the lowest amount of supervision condition. This may be accounted for by the fact that less severe client presentations are more likely to improve and need less supervision time. There were other methodological flaws, such as wide variation of client diagnosis, wide variation of trainee level of training and lack of information about the supervision and, therefore, the relationship between supervision and patient outcome.

In the same year, Couchon and Bernard (1984) investigated whether the proximity of supervision to therapy would have an effect on supervisor and counsellor performance in supervision, counsellor performance in counselling, client and counsellor satisfaction with counselling and counsellor satisfaction with supervision. Their experiment had three conditions: supervision four hours prior to the counselling session (T1); the day before the counselling (T2); two days before the counselling session (T3). They hypothesised that the greater the proximity of supervision to counselling sessions, the greater the influence of supervision on the supervisee and therefore the counselling. Results indicated that counsellors implemented more supervision generated strategies in the T1 condition, as hypothesised, but this could have been down to simple recency effects. There was no evidence that the timing of supervision had any effect on client or counsellor satisfaction with the counselling session or on counsellor satisfaction with the supervision session. There were major methodological difficulties with this study, including little description of the measures used. The Counselor Evaluation Inventory had been modified for the study and there was weak psychometric testing of the others (Supervision Session Reaction Scale and Counseling Session Reaction Scale). There were other complications such as

differences in therapy conditions and some supervisors occasionally using live observation of sessions instead of audio recordings. Finally, they did not control for Type I error (i.e. controlling for the incorrect rejection of the null hypothesis), casting further doubt on the reliability of their findings.

In 1985, Sandell investigated the effects of the relationship between several variables: client ego level, counsellor competence level and supervision on client outcome. This study had major methodological difficulties, primarily with information omitted. Ellis and Ladany (1997, p.485) suggest that the study had 'such extensive conceptual and methodological problems as to obviate inferences from the data', while Freitas (2002, p.357) says the presentation of the study was 'vague and convoluted to the point of rendering the methods and results almost incomprehensible'. Sandell (1985, p.103) says of the findings, that supervision appeared to have 'if anything, a negative influence'.

Two studies (Alpher, 1991; Friedlander et al., 1989) investigated the phenomenon of parallel process using single case study design but neither demonstrated the relationship between supervision and client outcome. In a much later study, published after Watkins' review, Tracey, Bludworth and Glidden-Tracey (2012) designed a study to investigate for the occurrence of parallel process and whether parallel process was related to client outcome, with a sample of 17 supervisor-trainee counsellor-client triads. Data for the relationship of parallel process to client outcomes was examined using hierarchical Bayesian modelling (e.g. Gelman, Carlin, Stem, & Rubin, 1995). The authors found a significant relationship between lower residual score for the client (indicating better outcome) with lower dissimilarity score (i.e. greater similarity) in supervisor-therapist behaviours. They report 'over time, the more the therapist acted like the supervisor did in the previous session ... the better the therapy outcome' (2012, p.337). Limitations of the study include the small sample (3 supervisors, 7 therapists and 17 clients), limiting generalisability and all therapists were trainees so may have been more likely to absorb supervisor behaviours and be less experienced in managing transferential processes. There was some duality of role with one of the supervisors supervising the other two supervisors, who were themselves trainee supervisors. Although the Outcome Questionnaire had good psychometric data, the Interpersonal Communication Scale was adapted for the study.

Another study identified as a supervisor-client outcome study (Kivlighan et al., 1991) is in fact a study investigating methods of supervision in that they compare the effects of live supervision with the use of videotapes on supervisee learning. However, the study did show that live supervision impacted positively on therapists' performance and led to clients in this condition indicating a stronger working alliance and rating their therapy as 'rougher' (which

I construe as more challenging though this is not explained). Although the primary intention was not to investigate supervision effects on client outcome, nevertheless the study provides useful information about supervision methods.

Milne et al. (2003) assessed the effectiveness of CBT supervision in terms of its observed impact on a supervisee and her patient. They employed an *N*=1 design, utilising qualitative and quantitative content analysis methodology. They coded ten video-recorded supervision sessions and linked them to the subsequent ten therapy sessions. Fourteen supervisory themes were identified and demonstrated thematic transference from supervision to therapy.

In the only qualitative study in this group, Vallance (2004) explored counsellors' perceptions of the impact of counselling supervision on their clients. This was a small scale study with data collected from thirteen questionnaires and six semi structured interviews and analysed using a phenomenological approach. Her findings were indeterminate as she concludes that counsellors find supervision at times both helpful and unhelpful, impacting on clients in both direct and indirect ways.

Bambling et al. (2006) conducted a well designed and methodologically robust study (Watkins, 2011b; Wheeler & Richards, 2007b) to evaluate the effects of supervision on therapeutic working alliance and client symptom reduction. This was a quantitative study using a nested design with multiple intervals of measurement with a sample of 127 therapists, 127 clients and 40 supervisors. Supervisors were recruited for the study and received a short two day training in problem solving therapy supervision, the approach used in the study. Clients received eight sessions of treatment with either a supervised or unsupervised therapist and were randomly assigned to one of the conditions: process-focus condition, skill-focus condition and no supervision condition. The results showed a significant effect for both supervision conditions on working alliance, symptom reduction, treatment retention and evaluation but no effect differences between supervision conditions.

The small numbers of studies culled from thirty years research, together with the methodological weakness, is discouraging, but the lack of attention paid to this topic in the supervision literature is further emphasised by some significant omissions. Numerous reviews of the supervision literature fail to identify the relationship between supervision and client outcome as important or omit it completely (e.g. Borders, 2005; Bernard, 2005; Hess, 2008; Ladany, Mori & Mehr, 2013). The emphasis on supervisee development is clear in Bernard's closing statement in her review of 2005 (p.17), 'supervision was, is and will be defined by the realization of our supervisees that they understand themselves and the therapeutic process at least a tad better than when they entered supervision, and our own realization that we have been players in the professional of development of another. It is as

simple and as profound as this'. This statement reflects something of the dominant focus on the supervisee, highlighted earlier in this review.

Inman and Ladany (2008) devote just one paragraph to client outcome research in their chapter on the state of supervision research. In a study investigating the elements of effective and ineffective supervision, Ladany et al.'s (2013) participants do not identify impact on client outcomes as an indicator of effective supervision, nor do the authors make any reference to its omission. Similarly, in a phenomenological investigation of 'good' supervision events, Worthen and McNeill's (1996) participants did not identify the influence of supervision on client outcomes as an example of a 'good' supervision event.

A quick search of the contents and indexes of a range of key supervision books, failed to identify any substantial treatment of the effects of supervision on client outcomes, with the exception of Scaife (2009) who included an extra section on 'Outcome Studies in Supervision' in her second edition. I acknowledge, however, that there will be other books or content that I have missed.

Summary

This review has revealed a worrying gap in what we know about how the efficacy of supervision on client outcomes and Watkins (2011b) correctly concludes that the last thirty years of research has not significantly contributed to our knowledge and understanding. The inability to identify an empirical base to support the contribution of supervision to client outcome, means that the case for the efficacy of supervision remains weak (e.g. Lambert & Hawkins, 2001; Wheeler & Richards, 2007a) and the ethical imperative to justify the effectiveness of supervision remains urgent (Lichtenberg, 2007). Although the effects of supervision on therapeutic outcomes is difficult to measure (Inman & Ladany, 2008), there is a critical need to address it. Basing our faith in supervision on the assumption that it has a beneficial effect on client welfare and psychotherapeutic outcomes is not enough (Worthen & Lambert, 2007). Green (2004, p.95) sums up the argument 'the acid test of effective supervision would be demonstrable proof that a particular form of supervisory intervention could be traced through to a positive clinical outcome for the client receiving help from the supervisee', and this remains elusive.

The next section describes the methodological stance of this study with a procedural account of the method of data collection and analysis.

METHODOLOGY

The right choice of methodology is the one that enables the researcher to answer the research question in a way that is rigorous, documented and challenges the initial thinking and assumptions (e.g. Holloway & Todres, 2003; Mintz, 2010). This section summarises the process of choosing the 'right' methodology and its implementation in this study. I begin with an outline of the research design and offer a rationale for the choice of methodology and method. Key features of the chosen method (Grounded Theory) are presented and the section concludes with a procedural account of data collection and analysis.

Research Design

This is a qualitative study using data collected from semi structured interviews with ten participants and a focus group with three participants. Data were analysed using a constructivist version of Grounded Theory (GT).

Research Paradigm

The research paradigm represents the researcher's belief system in terms of the nature of reality (ontology), the nature, scope and acquisition of knowledge (epistemology), values (axiology), linguistic representation and presentation of findings (rhetoric) and, finally, the best way of discovering the nature and meaning of the given phenomenon (methodology) (e.g. Guba & Lincoln, 1994; Ponterotto, 2005). Positioning the research study paradigmatically, is therefore critical for the integrity of the research project (Birks & Mills, 2011; Fassinger, 2005) since it 'informs and guides the inquiry' (Guba &Lincoln, 1994, p.105). This study is positioned within a constructivism-interpretivism paradigm and this is explained in the sections below.

Rationale for Methodology

Qualitative inquiry emerged within a post modern cultural landscape that is characterised by pluralistic perspectives and contextualised within social constructs that shape personal realities (Lovlie, 1992), where meaning is grounded in subjectivity and intersubjectivity (e.g. Gillespie & Cornish, 2010; Stolorow & Atwood, 1989; Wachtal, 2008). Qualitative methodology embeds this core philosophy. The focus is on understanding participants' subjective realities, presented in their own language, as the researcher co-constructs meaning 'at the intersection of the two subjectivities' (Stolorow & Atwood, 1989, p.364) from a reflexive interpretivist stance (Howitt, 2010; Mintz, 2010; Morrow, 2007; Morrow & Smith, 2000).

These values are important for understanding the purpose of this study. Although there is little research in the area of supervision and client outcomes, what exists is largely quantitative. It may be that the absence of the participant voice accounts, in part, for the widespread methodological difficulties in this area since what is omitted is an understanding of supervisors' frame of reference for supervision practice. Meaning making is at the heart of the psychological therapies and, hence, at the heart of supervision. It is fitting, therefore, to put meaning making at the heart of this study. By giving a voice to participant supervisors, the aim is to explore the complexity of supervisor experience and thereby arrive at a better understanding of the relationship between supervision and TOs. An acknowledged interpretivist stance is equally important. As a supervisor and therapist myself, I bring my own lived experience to the study and the emergent meanings will be a product of the interplay between my reality and the realities of my participants.

Counselling psychology has been at the forefront of developing qualitative methods (Fassinger, 2005; Morrow, 2007; Morrow & Smith, 2000; Ponterotto, 2005) as they are uniquely suited to exploring the complexity of human experience, a central issue for counselling psychology (Morrow, 2007; Polkinghorne, 1984). Qualitative research has been widely used in the psychological therapies (McLeod, 2001; Mintz, 2010) with a significant increase in its application since the 1980s (Fassinger, 2005; Madill & Gough, 2008; Ponterotto, 2005) and plays a key role in bridging the gap between research and practice (Williams & Hill, 2001). This is particularly important for this study since the study strives for a pragmatic validity in attempting to establish a theoretical understanding of a central function of clinical practice.

Like qualitative inquiry in general, GT in particular, is indicated where the focus of the study is in an under-researched area (Birks & Mills, 2011; Pidgeon, 1996). Stern (1980, p.20) suggests 'the strongest case for the use of grounded theory is in investigations of relatively unchartered waters'. Taylor and Bogdan (1998, p.137) summarise GT as a 'method for discovering theories, concepts, hypotheses, and propositions directly from data rather than from a priori assumptions, other research, or existing theoretical frameworks'. This sense of 'discovery' is therefore apt in this study as the aim is to build an explanation of the research area from data grounded in the working lives of the participants.

GT has its philosophical roots in Symbolic Interactionism (SI) (Blumer, 1969; Cooley, 1902; Mead, 1934) and this was largely Strauss's contribution to the formulation of GT, as he had studied with Blumer (1969), the originator of the term 'Symbolic Interactionism'. The central tenets of SI are that subjective meaning is derived from, and a product of, social interactions; interactions are both intrapersonal (based on the individual's capacity for

internal dialoguing) and interpersonal; reality exists in the form of shared symbolic meanings that are fluid and changeable depending on a changing environment (Aldiabat & Navenec, 2011; Charon, 2010; Wetherell & Maybin, 1996). Aldiabat and Navenec (2011) emphasise the congruency between GT and SI in their shared assumptions, goals and language. Although Glaser (1999) suggests that GT could be conducted outside the theoretical framework of SI, Milliken and Schreiber's response (2001, p.188) is that SI is 'inherent in GT whether the researcher is aware of it or not. If research is truly grounded theory, then it cannot occur in the absence of symbolic interactionism, which is intrinsic to the process'. The relevance to this study is that SI provides an ontological and epistemological framework and GT a corresponding methodological framework for co-constructing new understanding of the relationship between supervision and TOs.

Initial thought was given to using Interpretative Phenomenological Analysis (IPA) for the study but where IPA produces richness of description and interpretation of participant experience (Smith, Flowers & Larkin, 2009), GT emphasises 'richness of possibility for theory generation' (Fassinger (2005, p.157) and 'aims to generate theory, that is, a formal framework for understanding the phenomenon being investigated' (Mintz, 2010, p.2).

Fassinger (2005) believes that GT is particularly fitting for counselling psychology research because the theory emerges from the lived experience of the participants and suggests that it is a 'methodological exemplar of the scientist-practitioner model' (2005, p.165). Willig (2008), however, challenges the use of GT in psychological research. She questions whether it does more than describe participants' experiences, and suggests that it might not be as well suited to psychological research as to studying the social processes it was designed for. My response is that the philosophical roots of GT in SI, integrating the interpretative stance of the researcher, is instrumental in lifting the analysis from description to explanation, and this is strengthened by adopting a constructivist version (Charmaz, 2006) of GT (see below).

Grounded Theory

The publication of *The Discovery of Grounded Theory* (Glaser & Strauss, 1967) was a significant development for qualitative inquiry (e.g. Bryant & Charmaz, 2007; Denzin & Lincoln, 1994; Howitt, 2010), offering a research method that has a systematic framework for gathering and analysing qualitative data, and combining scientific rigour with the capacity to capture 'conceptual meanings' (Glaser, 1992, p.28).

Although Glaser and Strauss (1967) presented GT as an inductive method, it utilises a synthesis of both inductive and deductive approaches, inductive in the early stages as the theory emerges from the data and deductive as the theory is abstracted and developed

(Charmaz, 2006; Heath & Cowley, 2004). Data collection and analysis take place in an iterative process of constant comparison, moving from purposive to theoretical sampling until saturation of themes or categories is reached and theoretical integration is achieved (e.g. Charmaz, 2006; Glaser & Strauss, 1967; Holten, 2007). GT has undergone considerable development since its original conceptualisation, with profound differences developing between Glaser and Strauss (Heath & Cowley, 2004; Morse, Stern, Corbin, Bowers, & Clarke, 2009) played out with some public acrimony (e.g. Glaser, 1992). While Glaser stayed faithful to the original formulation, Strauss proposed a reformulation, including detailed guidelines for data analysis, absent from the 1967 version (Corbin & Strauss, 2008; Strauss & Corbin, 1990, 1994, 1998).

A key area of difference centres on the roles of induction and verification in GT (Bryant & Charmaz, 2007; Heath & Cowley, 2004). Glaser continues to maintain that induction is the key process whereby the research moves from the data to empirical generalisation and onto theory, and 'GT is not verificationable' (Glaser, 1992, p.1). Strauss, however, emphasised the need for systematic verification (Heath & Cowley, 2004; Strauss & Corbin, 1990, 1998). The split has concretised to the degree that a Glaserian or classic GT version (e.g. Glaser, 1978, 1992, 1998) exists alongside a Strausserian version (e.g. Corbin & Strauss, 2008; Strauss & Corbin, 1990, 1994, 1998).

Charmaz has developed a constructivist version of GT (Charmaz, 1990, 2000, 2006; Pidgeon, 1996), which is the version applied in this study. It has significant epistemological differences in that Charmaz (2000) sees both Glaser's and Strauss's versions as still imbued with the positivist stance of the original 1967 version of GT, although Strauss and Corbin's version leans progressively towards a more interpretivist paradigm (Corbin & Strauss, 2008; Strauss & Corbin, 1990, 1994, 1998). Charmaz's approach is unequivocally constructivist-interpretivist, and overtly aligned with the SI roots of GT (Charmaz, 2000, 2006; Pidgeon, 1996). Mills, Bonner and Francis (2006, p.6) sum up constructivist GT as 'ontologically relativist and epistemologically subjectivist'.

Critical differences in theories of GT (e.g. Annells, 1996; Birks & Mills, 2011; Fassinger, 2005) lead to both philosophical and methodological confusion (Bryant & Charmaz, 2007), creating procedural challenges in conducting GT studies (e.g. Becker, 1993; Elliott & Lazanbatt, 2005; Wilson & Hutchinson, 1996). Given these challenges, clarity of epistemological stance is crucial and the following section outlines my own epistemological stance and rationale for using a constructivist version of GT.

Epistemological Stance

Charmaz captures the appeal that a constructivist version holds for me, when she says it 'means more than looking at how individuals view their situations. It not only theorizes the interpretive work that research participants do, but also acknowledges that the resulting theory is an interpretation' (2006, p.130). The transparency of the interpretive stance and acceptance that researchers 'unconsciously adopt value-laden metaphor' (Charmaz, 2000, p.521) resonates fully with my own epistemological, ontological and axiological stance. It is in direct contrast to the view expressed by Hernandez and Andrews (2012, p.59), speaking from a Glaserian perspective, which demands 'no preconceptions (personal, professional, literature based)'. The aim in all versions of GT is to stay close to the data but I believe this is only possible through my own frame of reference. An interpretivist-constructivist paradigm acknowledges that 'the theory depends on the researcher's view; it does not and cannot stand outside of it' (Charmaz, 2006, p.130).

I have found it useful to turn to all versions of GT to inform and guide my understanding of its epistemology as well as its implementation. My intention has been to remain faithful to the core components of GT whilst applying an interpretivist-constructivist research paradigm and I trust that I have been able to create and represent a research project that is both philosophically and technically coherent. I have sought to find a fit between a research question, the appropriate research paradigm for that question, researcher values and contextual authenticity.

Reflexivity

According to Willig (2008) there are two types of reflexivity, personal and epistemological. Personal reflexivity invites us to reflect on the role of 'self' within the research process and I am aware of the degree to which personal values can impact both consciously and unconsciously (e.g. Shillito-Clarke, 2010). In endeavouring to be transparently reflexive, I have consistently attempted to apply the habits of the reflective practitioner role to the reflective researcher role.

The genesis of this research project lay in my professional practice so inevitably I approached the study with preconceptions and assumptions, and have by turns been surprised, enthused and confused as I have interacted with my participants and the emerging data. I have attempted to 'bracket' (e.g. Fischer, 2009) these preconceptions by several means, including keeping a research diary, memo writing and discussions in research supervision and with colleagues. Willig (2008) points out that we need to be reflexive about the language we use in research, and implicit meanings can be subtly nuanced and covertly

conveyed. I have attempted to raise my linguistic awareness by being consistently reflective in my sensitivity to participants' language, especially where I have used it to represent the findings.

Epistemological reflexivity requires a consistent congruence with the central constructs of the research paradigm. Being a researcher within a constructivist-interpretivist paradigm, with its roots in Symbolic Interactionism demands a particular kind of reflexivity. The researcher's assumptive lens is an acknowledged element within the co-construction of meaning and Charmaz (2004, p.982) advises that 'to learn participants' meanings we have to be reflexive about our own'.

Trustworthiness

Considerable efforts have been made within qualitative inquiry to parallel the standards of methodological rigour in quantitative methods, whilst remaining congruent with the underlying philosophy of qualitative methodology (Morrow, 2005). Demonstrating the credibility, or 'trustworthiness' (Lincoln & Guba, 1985) of a research study is a complex process (Mintz, 2010; Morrow, 2007) and guidelines for meeting standards of trustworthiness (e.g. Elliot, Fischer & Rennie, 1999; Lincoln & Guba, 1985; Mintz, 2010; Morrow, 2005; 2007; Pidgeon, 1996; Stiles, 1993, 1999) have been followed throughout the research process. A further check on the trustworthiness of the study is method specific and a GT study is evaluated for 'Fit, Grab, Workability, Relevance and Modifiability' (Glaser, 1978, 1992; Glaser & Strauss, 1967). An evaluation of the degree to which standards of trustworthiness have been met is presented in the Discussion section below.

Ethical Issues

Ethical approval for the research study was gained from the Senate Research Ethics Committee of City University and the research was conducted in accordance with The Code of Human Research Ethics (British Psychological Society, 2011) and the Data Protection Act 1998. Participants' identities, and contingent identities, have been safeguarded throughout and all participants were fully informed as to the nature of the project before being asked to give their consent to participate. In accordance with professional ethical guidelines, and given the professional status of the participants and the nature of the research question, the Consent Form (Appendix 4) contained the following item:

> *'I understand that if any ethical practice issues emerge during the interview that these will be addressed in accordance with the ethical guidelines and codes of practice of my professional body'.*

No such issues emerged. Participants were made aware of sources of support should any issues result from the interview and a debrief followed each interview, including the focus group. Considerable responsibility attaches to the researcher when working with human participants and throughout I have striven to apply the same standards of ethical mindedness (Bond, 2010; Gabriel, 2001, 2005; Shillito-Clarke, 2010) to the research process, as in clinical work.

Method

Participants

The participant sample consisted of thirteen psychotherapy supervisors, three male and ten female. Ten participants were interviewed individually and three participants took part in a focus group. Participants were regionally based in the South West of the UK and met the following inclusion criteria (Table 1. Participants' Demographic Information).

- Qualified and accredited with national professional organisation as a psychological therapist (counsellor, psychotherapist, clinical or counselling psychologist)
- A minimum of one year's experience working as a psychotherapy supervisor
- Experience of working as a psychotherapy supervisor in a minimum of two contexts

Participants were a representative sample of supervisors of psychological therapists. They worked in a range of settings with private practice being the predominant setting (*N*=13), diverse voluntary sector organisations (*N*=9), education (schools, further and higher education) (*N*=8), NHS (primary and secondary care) (*N*=5) and all participants had experience of supervising trainee therapists. They had differing amounts of experience as supervisors, across a wide range, from two years to twenty five years. Five were accredited as supervisors with professional organisations in the UK. All participants were practising as supervisors at the time of the interview except P1 who had taken a break from therapeutic work for personal reasons for a year prior to the interview. All had undertaken supervisor training but the length and type of training varied from short courses to certified training. Only brief information regarding supervisor training was sought as more detailed information was considered to be outside the remit of the current of study.

TABLE 1. Participants' Demographic Information

Code	Age Range	M/F	Therapeutic Orientation	Therapist Accreditation	Supervisor Accreditation	Supervisor Training	Supervisor Practice	Supervision Practice Contexts
P1	46-55	F	Counsellor/Integrative	BACP	No	Certificated	9 yrs	Private Practice; Voluntary Sector
P2	56-65	F	Psychotherapist/CBT	BABCP	No	Non-Certified	6 yrs	Private Practice; Education
P3	46-55	F	Counselling Psychologist/ CBT; EMDR	HCPC; BPS (DCoP); BABCP; EMDR Assoc	Yes	Certified	3 yrs	Private Practice; NHS
P4	56-65	F	Counsellor/Integrative	BACP	Yes	Certified	19 yrs	Private Practice; Education; Voluntary Sector
P5	Not known	M	Counselling Psychologist/CBT	HCPC; BPS (DCoP); BABCP; BACP	No	Non-Certified	2 yrs	Private Practice; NHS
P6	46-55	F	Psychotherapist/CBT	BACP; BABCP	Yes	Certified	11 yrs	Private Practice; Education; NHS; Voluntary Sector
P7	46-55	F	Psychotherapist/ Psychoanalytic	UKCP	No	Non-Certified	21 yrs	Private Practice; Education; Voluntary Sector
P8	56-65	M	Psychotherapist/CBT	BABCP	Yes	Non-Certified	17 yrs	Private Practice; Education; NHS
P9	46-55	F	Psychotherapist/Humanistic-Integrative	UKCP	No	Certified	14 yrs	Private Practice; NHS; Voluntary Sector
P10	46-55	F	Counsellor/Humanistic-Integrative	BACP	No	Certified	7 yrs	Private Practice; Voluntary Sector
P11/ FG	65-75	F	Psychotherapist/Relational-Integrative	BACP	No	Certified	19 yrs	Private Practice; Education; NHS; Voluntary Sector;
P12/ FG	56-65	F	Counsellor/Person Centred	BACP	No	Certified	20 yrs	Private Practice; Education; Voluntary Sector
P13/ FG	56-65	M	Counsellor/Integrative - Pluralist	BACP	Yes	Certified	25 yrs	Private Practice; Education; Voluntary Sector

Recruitment

Participants were recruited via online directories, professional networks in the South West and by word of mouth. Recruitment was reasonably straightforward as there was a good level of interest in the study because of its relevance to practice. Recruiting for the focus group presented the greatest difficulty due to the logistics of co-ordinating different schedules. My initial intention to run a focus group with four people proved too difficult to organise in the time available and so the focus group eventually took place with three participants.

Procedure

Whether or not to use a computer software programme for data analysis was an initial question especially since sophisticated packages are available. However, I chose to analyse the data by hand as I had a strong preference for interacting with it on a more personal level. Although the volume of data was overwhelming at times, the direct relationship with it, at every stage in the process, constantly triggered new insights and I believe it was the right decision for this study. There is support for retaining the traditional method of data analysis in GT (e.g. Glaser, 2003; Glaser & Holten, 2004) and Holten (2007, p.287) advises using the traditional method on the grounds that 'the coding process in classic grounded theory is not a discrete phase but rather an intricate and integral activity woven into and throughout the research process'.

A 'critical characteristic' (Pidgeon, 1996, p.79) of GT is the iterative process of constant comparison and Holten (2007, p.277) calls it one of the 'twin foundations' of GT. It entails data collection and data analysis taking place in a recursive cycle (Glaser & Strauss, 1967) and so, in accordance with GT protocol, analysis of the data took place alongside data collection. However, for purposes of clarity in this report, the two processes are described separately below.

Data Collection

All participants were supplied with details of the nature, scope and purpose of the study, consisting of Inclusion Criteria for Participants (Appendix 2), Information Sheet for Participants (Appendix 3), Consent Form (Appendix 4) and a Demographics Questionnaire (Appendix 5). The aim was to provide participants with comprehensive information about the study to enable them to make an informed decision about taking part. Interviews took place at the researcher's place of work (a university in the South West of England) or at the participant's place of work. The focus group took place at the workplace of one of the focus group members.

Interview Strategy

Time was allocated before the interview to providing the participant with relevant information, answering participants' questions and completing the Consent Form and Demographics Questionnaire (although in some cases this was sent to the participant later by email due to an oversight on the part of the researcher). Participants were reminded that they were free to withdraw from the study at any time without giving a reason and all participants were given hard copies of the Information Sheet and the Consent Form to keep for their own records. All interviews were audio recorded using a digital recorder and later uploaded to a password controlled private computer for future transcribing. The individual interviews lasted for 1.5 hours and the focus group lasted for an hour. The shorter time for the focus group was due to participants' time constraints. Participants were debriefed at the end of the interview and feedback on the interview process was elicited. All participants reported they had found the interview questions thought provoking and some reported that the interview had brought up issues they had not previously considered. Several reported that they believed it would change their approach to the practice of supervision. All agreed to taking part in a follow up interview if required.

Purposive Sampling

In GT sampling occurs in two phases: purposive sampling in the early stages and shifting to theoretical sampling later in the study (Charmaz, 2006). Data collection is not planned in advance but is directed by what emerges, in an iterative process of data collection and analysis (e.g. Glaser & Strauss, 1967). The aim in the initial purposive sampling stage was to gain descriptive information about participants' experience of the process of supervision with regard to the relationship between supervision and TOs. The Interview Schedule for purposive sampling was broad (Appendix 6) with two underlying aims: to avoid leading questions as far as possible (e.g. Glaser, 1992) and to use a funnel like approach (moving from the general to the specific) in order to elicit full and rich description. Prompts were kept to a minimum (e.g. Fassinger, 2005) to avoid leading the participants but were used to keep the interviews relevant to the research focus.

Purposive sampling continued with six participants, although emergent themes were followed up by the fourth interview. By the sixth interview, themes were more developed and strategic theoretical sampling was used to explicate them and follow up on negative cases (i.e. data sources who do not confirm or who contradict emerging hypotheses (Schreiber, 2001).

Theoretical sampling

The purpose of theoretical sampling is to fully explicate emergent themes until the categories of the emergent theory are saturated and no new data emerges. This means that in GT the sample size depends on the amount of data needed to saturate the main categories. Holten (2007, p.278) summarises theoretical sampling as 'the process whereby you decide what data to collect next and how to find it'. It plays a central role in GT (Glaser & Strauss, 1967) and its skilful use ensures that the emergent theory is fully developed (Elliott & Lazanblatt, 2005).

An early code to emerge from purposive sampling was *'believing in my therapeutic approach'*. In the first three interviews, questions had been very broad to allow themes to emerge, such as:

- Please give a brief description of your supervision practice
- Please tell me about a typical supervision session

Although participants had not been asked directly about their theoretical approach, as the focus was on supervision practice, participants volunteered information about their therapeutic model, referring to its influence on supervision practice. The following extract (Box 1.) from the second interview demonstrates how the participant emphasised the influence of her therapeutic approach on her supervision practice.

It was important to follow this up but I was cautious about asking leading questions in this early stage. I therefore followed this up with more open questioning by asking P4 about the key influences on her supervision practice (Box 2.).

BOX 1. Extract from P2 interview demonstrating the emphasis on therapeutic approach

P2: I'm not one that believes that the method doesn't matter, that you can supervise - I know that's the common belief, that you can supervise - that the technique of supervision can be across any methodology but I don't believe that. I don't know what the research says. I don't accept that premise. I guess if you're just going to just work with transference, I guess it's true and if you're just going to work with, you know, ethical issues. There's a lot of generic stuff but it's more than that; it's also skills, it's also understanding that you have to consider what you're trying to do and the depth you do it and processing. You can do it superficially or you can do it in a lot of depth and if I don't know the model then I'm not going to help people get that depth. We talk about relational depth and how am I going to help people get that depth if I don't know what that is, or the skills that support it, if I don't know that model. So I've never accepted that premise so widely accepted but - [stops].

R: And that's supported by your experience in supervision? That the therapeutic perspective does matter in your supervision practice?

P2: Well, it's supported the .... [trails off]. I don't know about outcome but that's what I do as a supervisor – I pay attention to those things – whether I need to or not I don't know ..... but I believe it makes a difference to outcome (P2, 36-51).

BOX 2. Extract from P4 interview demonstrating the emphasis on therapeutic approach

R: So what would you say are the key elements that form or shape your supervision practice?

P4: I suppose one of the key elements would be my Person Centred background. That certainly would be the strongest. Also, very mindful of the ethical framework, the BACP framework. I always feel this is a very holding bit of the supervision that I offer (P4, 43-45).

P4's response as demonstrated in Box 2 was developed further in the interview and was then the focus for more strategic theoretical sampling (Appendix 7: Theoretical Sampling Interview Schedule). The interview schedule for P5 began with the following question and prompt:

- Will you start with a brief outline of your therapy training and therapeutic models you have worked with?
- Prompt: How would you describe your orientation and profession as a therapist?

This theme continued to be developed and reached saturation with the focus group, ultimately becoming part of the category ***Being a Professional.***

Reflections on the interview process

The first challenge was addressing my own assumptions before structuring the interview schedules to phrase the questions as neutrally as possible. I also wanted to avoid pre-empting responses by introducing constructs from professional discourse. Given that I was exploring relatively unfamiliar concepts, my greatest concern was structuring the interviews in such a way that participants would feel comfortable enough to explore new thinking (e.g. Haverkamp, Morrow & Ponterotto, 2005; Morrow, 2007). I drew on counselling skills to help build a good rapport (e.g. Dallos & Vetere, 2005; Morrow, 2007). However, as it turned out, participants engaged with a sense of curiosity and openness, which contributed significantly to the richness of the data.

Data Analysis

Transcribing

All interviews were transcribed verbatim with pauses and non-verbal behaviours (e.g. laughter, tone of voice) noted in an effort to get as close to participants' meaning as possible. Sandelowski (1994) advises paying attention to punctuation when transcribing as it significantly influences meaning and thereby influences data analysis. She also raises an ontological issue, noting that 'transcribing is a process that involves the transformation of the object of duplication into another form (oral speech to printed copy) that is only partially representative of, but not isomorphic with it' (1994, p.311). However, feedback from member checking pointed out that representing the participants' responses in this way made it more difficult to read, so conversational tags and researcher descriptions of non-verbal communication have now been excluded, unless they are needed to convey the sense of the quotation. The initial epistemological and axiological stance, therefore, has now been replaced by a more pragmatic approach.

Initial Coding

This is the first stage of data analysis where the data are broken into small units representing actions, processes and meanings. Variously referred to as initial coding (Charmaz, 2006), open coding (Strauss & Corbin, 1998) and substantive coding (Glaser, 1978), it begins with

the first set of data and the simultaneous process of analysis and data gathering continues recursively throughout the research process. Initial coding is carried out in different ways depending on the type of data and according to the researcher's definition of a coding unit: word-by-word, line-by-line, or incident-by-incident, and researchers may use units as small as a word or as long as several paragraphs or pages (Fassinger, 2005). Another recommended linguistic device is to use gerunds (a verb that functions as a noun) to define initial codes, as this captures active processes within the data (Charmaz, 2006). This early coding is a way of interrogating the data, identifying and describing the phenomenon under investigation, whilst staying open to all theoretical possibilities.

Glaser and Strauss (1967) and Charmaz (2006) recommend line-by-line coding and this was the method followed in this study, beginning with the first interview. Charmaz (2006) suggests using 'in vivo' codes (participants' own words) and I found participants' language was both vivid and insightful, often capturing processes in a word, a short phrase or a metaphor. Examples of participants' phrases that became pivotal in the data were:

- *'just not part of the paradigm of supervision'* (P1, 196) which became a central defining quote for summing up the relationship between supervision and TOs and representative of the core category
- *'A client at the end'* (P8, 338) which contributed to the conceptualisation of the category ***The Client at the End of it All***
- *'Invisible clients'* (P7, 397) which became a property of the subcategory ***The Supervisor-Client relationship***
- *'that stalking person'* (P1, 99) which was used as a primary descriptor in the category ***Putting the Supervisee at the Centre***
- *'the good parent'* (P4, 302) which was used as a primary descriptor in the category ***Putting the Supervisee at the Centre***

The code 'leaving it to the supervisee' emerged in the line-by-line coding from the interview with P1 (Table 2.).

Table 2. Example of Initial Coding

LINE	TRANSCRIPT	LINE-BY-LINE INITIAL CODING
1	*I think it's a very ad hoc business generally.*	Monitoring outcomes being ad hoc
2	*Say a supervisee comes to you for supervision and you look at whatever's happening.*	Looking at what's happening now for the supervisee
3	*They may or may not bring it back next time*	Supervisees may not bring it back
4	*In my experience, if something's worked then it's a bit like, 'oh that's done now'*	Supervisees thinking it's done if worked out
5	*you don't need to bring that to supervision.*	Supervisees not bringing it back if it's worked out
6	*You bring your problems to supervision, not your solutions as such.*	Bringing problems not solutions to supervision
7	*So then it's a bit like how directive should you be as a supervisor and, to be honest,*	Wondering how directive to be as a supervisor
8	*from my point of view, I would leave it to the supervisee to come back and say*	**Leaving it to the supervisee**
8	*- once the client was presented again -*	Leaving it until the supervisee presents the client again
9	*– to say 'oh that that helped me' or whatever, maybe 'unblocked me' or whatever or 'when I made this intervention this is what happened'*	Leaving it to the supervisee to give feedback to the supervisor - to say if the supervision has been helpful
10	*but they may not bring a client that they've actually looked at for 6 months*	Supervisee may not bring a client back for six months
11	*if you've got a large caseload – and you feel like – if a supervisee -*	Depending on size of the supervisee's caseload
12	*If something, an intervention or something, a problem in whatever guise, that the supervisee feels has been solved or dissolved by supervision.*	Depending on whether the supervisee's problem (whatever it is) has been resolved by supervision
11	*My hunch, and from thinking about supervisees and myself,*	Thinking about her supervisees and thinking about herself as a supervisee
12	*I don't think I've got it on my agenda to say 'oh I must say thanks'. I might*	Not being on a supervisees' agenda to give feedback about supervisor's interventions
13	*I might but I think because it's such precious time, an hour and a half,*	Supervisees not doing it because supervision is a precious time
14	*it's no time at all actually in a month if you've got a big caseload and there isn't a lot of time to do the, you know, 'oh that was great'.*	Being no time for feedback with a big caseload

Focused Coding

The second coding phase entails 'using the most significant and/or frequent earlier codes to sift through large amounts of data' (Charmaz, 2006, p.57). A primary aim is to find patterns and relationships within the data. This was a rewarding phase as the overall shape began to

emerge and patterns of interconnecting relationships became clearer. Table 3 (P6) demonstrates the development of initial codes into focused codes, continuing the theme of 'leaving it to the supervisee' (and Appendix 8 for a further example of focused coding).

Table 3. Example of Focused Coding

TRANSCRIPT	INITIAL CODING	FOCUSED CODING
I've always, in the mainstay, I've always let the supervisee bring what they like to.	Letting the supervisee bring what they like	Leaving it to the supervisee
There might be times when we've touched on things like in previous sessions	Sometimes touching on things from previous sessions	
or there might be times when I do have to raise things.	Being times when the supervisor raises things	Taking the lead
You know for example I did have a supervisee in [states context]	Having an example of a time like this	
who did have some practice issues	Having a supervisee with practice issues	
you know some clients had raised some issues	Clients raising issues about a supervisee	
so it could not be addressed	Having to address it in supervision	Following up on a concern about practice
so our supervision did take on a completely different – because there was some policing – aspect to it.	Supervision taking on a different aspect Being some policing in supervision	Having a 'policing' role
And it had to be done	Having to be done	Having no choice
and thankfully, again I think the relationship really helped that mind, I really do, because that was fantastic	Being helped by a good supervisory relationship	Supervisory relationship being important
because I believed in the supervisee.	Believing in the supervisee	Believing in the supervisee
There were some training issues	Being training issue	
and there were some interpersonal issues	Being interpersonal issues	
and I'd found them myself	Experiencing the same herself with the supervisee	
and so I thought yeah, I could understand why clients might feel some of this	Understanding clients' feelings through the supervisory relationship	Using the supervisory relationship
and I think that's why the relationship and getting close to your supervisees is so important.	Getting close to the supervisee being important	Getting close to the supervisee

Memo writing

Memo writing is an essential element in constructing grounded theory. Glaser and Holten (2004, p.17) suggest that 'theory articulation is facilitated through an extensive and systematic process of memoing that parallels the data analysis'. Throughout the process of constant comparison (see below), the researcher uses memos to record ideas, analyse emerging concepts, develop relationships between categories and raise codes to higher levels

of abstraction. Charmaz (2006, p.73) notes that memo writing is 'the pivotal intermediate step between data collection and writing drafts of papers'. Because memos are written throughout the research process, they also form an important part of the audit trail (Birks & Mills, 2011). Memo writing played a key role in the analytic process and the writing up of this study (Box 3).

BOX 3. MEMO 12.06.2011
When and how do supervisors decide to take the lead?

I have just completed the 6th interview and am a little further forward regarding the focused codes 'leaving it to the supervisee' and 'taking the lead'. Early on, from the first interview, participants described leaving it to the supervisee to decide how the session should be used. There have been some puzzling contradictions since then, such as trusting the supervisee and yet, knowing that supervisees withhold difficulties. There is also an emphasis on being vigilant for issues of client safety so these two codes appear to have a complex relationship. P6 has stated that she 'leaves it to the supervisee' 75% of the time. It seems that supervisors are aware of issues and are making choices in the supervision sessions, so I want to follow up on what the process is with specific questions on the moment-to-moment decision making processes that supervisors are using. I wonder how much of it is in conscious awareness? P6 is the first to comment on a tension around the issue of 'trusting and not trusting' and she is a negative case in terms of have a more formal mechanism for following up on cases with a computer spreadsheet. Now that more data has emerged and opened this up, more strategic theoretical sampling in terms of supervisors' internal processes is next.

Constant Comparison Method

This method is a central and defining feature of GT (e.g. Charmaz, 2006; Glaser & Strauss, 1967; Glaser, 1978) and is summed up as:

> 'first incidents are compared to other incidents to establish underlying uniformity and the varying conditions of generated concepts and hypotheses. Then, emerging concepts are compared to other incidents to generate new theoretical properties of the concepts and more hypotheses. The purpose here is theoretical elaboration, saturation and densification of concepts. Finally, emergent concepts are compared to each other with the purpose of establishing the best fit' (Holten, 2007, p.278).

This process became a cornerstone of my analytic process, yielding constant insights and new perspectives as I compared fresh data with existing transcripts and examined new codes

in the light of existing ones. It was a crucial and central element in developing theoretical integration (see below). Bulmer's (1979) notion of the constant 'flip flop' between the data and researcher interpretation, reflecting the dynamic relationship between data collection and analysis, succinctly captures the process.

Theoretical Sensitivity

Theoretical sensitivity is the capacity to theoretically represent the phenomenon studied through coding, theoretical sampling and constant comparison. It combines interpersonal perceptiveness with conceptual thinking, embedded within a reflexive stance (Glaser, 1978; Wilson & Hutchinson, 1996). Charmaz (2006) asks how researchers acquire 'theoretical sensitivity' and I have experienced it as a challenging process, albeit a rewarding one. The first challenge was to make sense of the different configurations of coding across diverse versions (Appendix 9: Summary of different versions of GT analysis). A personal and professional congruence with a constructivist perspective was helpful as well as drawing on therapeutic skills to try to achieve the necessary elements of 'conceptual thinking', 'interpersonal perceptiveness' and 'reflexivity' required for analytic sensitivity.

Theoretical Coding, Saturation and Theoretical Integration

Theoretical coding is 'a sophisticated level of coding' (Charmaz, 2006, p.63) and the final stage, where the categories are defined at the highest level of abstraction. According to Glaser (1978, p.72) 'theoretical codes ... weave the fractured story back together'. To assist analysis Glaser (1978, 1998) proposes a set of coding families, referring to the following 6 Cs as the 'bread and butter' coding family (1978, p.74). Box 4 summarises the 6 Cs coding family, demonstrating how they are used to assist in interrogating the data.

BOX 4. USING THE 6Cs (Glaser, 1978)

Causes - indicating sources, reasons and explanations; guides defining the causal relationships between categories.

Contexts - defined by Glaser as ambience; investigate setting and environment.

Contingencies - contingencies and conditions interact with the cause-effect dimension and investigating them contributes to explicating categories.

Consequences - outcomes and effects; look for anticipated and unanticipated outcomes to develop categories.

Co-variances - interact with the causes and provided further explanations.

Conditions - defined by Glaser as qualifiers; factors or events that lead to development or change

Different emphases are put on the when and how the core category emerges in the different versions of GT. Charmaz (2006) places less emphasis on identifying a core category, rather placing more emphasis on describing the process of theoretical integration of categories and sub categories and this reflects the process of theoretical integration in this study. Figure 1. Development of Initial Codes to Higher Order Categories (below) demonstrates the emergent process. Appendix 10: Diagrammatic development of theoretical integration Versions 1 - 10 presents a the development of theoretical integration in diagrammatic form.

A fundamental aim in GT is to 'saturate' each category, which means that the researcher continues theoretical sampling until no new information emerges. Once saturation of a category is reached no further data collection is needed as it will not develop the theory further (Glaser & Strauss, 1967), and Charmaz (2006) adds that another way of looking at it is when no further insights are triggered for the researcher.

True saturation can never be reached because new information continues to emerge (Glaser & Strauss, 1967; Morrow, 2007), and Glaser (1978) concedes that the perception of saturation is inevitably transient. In this study, the two categories reaching saturation first were ***Making Choices*** and ***Putting the Supervisee at the Centre***, whilst the other three (***Being a Professional, The Client at the end of it all*** and ***Finding Connections and Missing Links***) reached saturation with the final data collected from the focus group.

Once saturation is achieved, theoretical sorting continues until theoretical integration has been reached (Charmaz, 2006; Glaser, 1998). Theoretical completeness eventually occurs when the researcher is able to account for 'as much variation in a pattern of behaviour with as few concepts as possible thereby maximizing parsimony and scope' (Glaser, 1978, p.93).

Glaser's words appropriately capture the moment of theoretical integration in this study, 'the theory thus explains sufficiently how people continually resolve their main concern with concepts that fit, work, have relevance and are saturated' (Glaser, 2004, para.74).

The following section presents the findings.

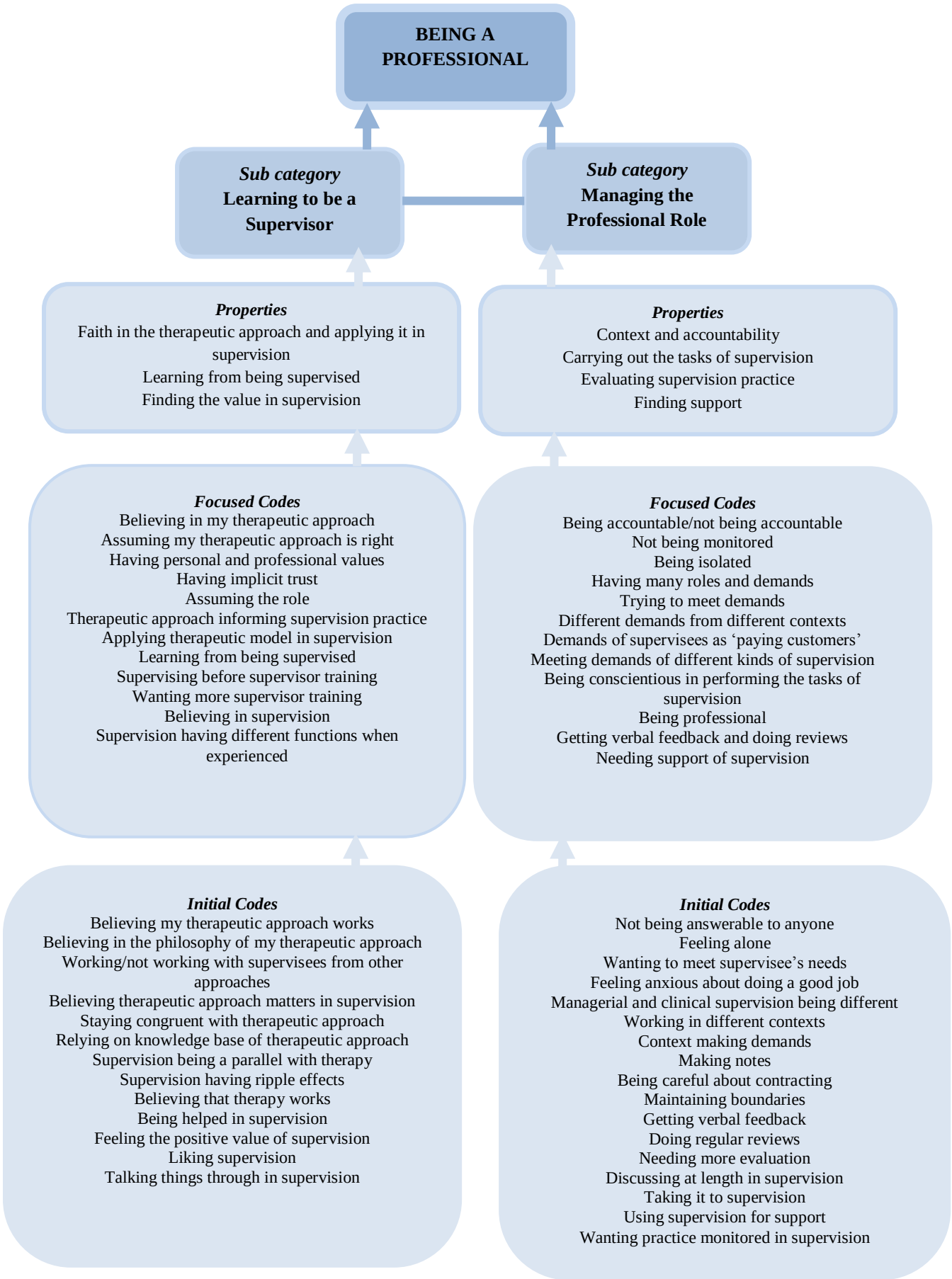

Figure 1. Development of Initial Codes to Higher Order Categories

FINDINGS

Introduction

The unfolding of the findings represents the story (Strauss & Corbin, 1990) of the participants' perceptions of the relationship between supervision and Therapeutic Outcomes (TOs), and reflects the little known nature of this field of inquiry within the supervision research literature. The section begins with a brief overview of the core connecting category and the five main categories (Figure 2), followed by a detailed presentation of the categories with their sub categories and properties. The section ends with an explanatory model of supervisors' perceptions of the relationship between supervision and TOs.

The study introduced the participants to some unfamiliar concepts and they engaged with a generous spirit of curiosity, demonstrating a willingness to reflect on areas of professional experience not previously considered. Our joint pursuit of meaning, in previously unexplored areas, has provided the richest part of the data and contributed to posing the deeper questions that future supervision research needs to address, while also lending a sharper clarity to the traditional and current constructs of supervisory practice.

To maintain participant confidentiality all participants are referred to by an abbreviation (e.g. P1) and the three participants who took part in the focus group are referenced using the further suffix 'FG' (Focus Group). As all participants were psychotherapy supervisors, the participants are referred to as 'participants', 'supervisors' and participant supervisors'. Quotations from interviews are referenced using line numbers from the interview transcripts. Any potentially identifying examples or references have been removed to protect the identity of the participants and all contingent identities. Nevertheless, every effort has been made to retain the authenticity of the participants' voices, and where possible I have used direct quotes from participants to represent categories or properties of categories in order to capture participants' meanings as fully as possible.

Overview of the Core Connecting Category and the Main Categories

Making Sense of Paradox and Inconsistency in an Indirect Relationship				
Being a Professional	**Making Choices**	**Putting the Supervisee at the Centre**	**The Client at the end of it all**	**Finding Connections and Missing Links**

Figure 2. Core Connecting Category and 5 Main Categories

Core Connecting Category: Making sense of paradox and inconsistency in an indirect relationship

'it's almost not part of the paradigm if you like' (P1, 196).

The above quotation from P1 captures many of the participants' sense of detachment from the notion of a relationship between supervision and therapeutic outcomes. All participants struggled to make sense of the relationship, as paradoxes and inconsistencies emerged, while they attempted to explain how supervision influenced their supervisees' clients' outcomes. Since participants were not focusing on or prioritising TOs, the crucial question became what were participants prioritising over TOs and what was their primary frame of reference in supervision? Therefore, understanding participants' frame of reference and primary purpose in supervision practice was critical. It became a central focus of the study and a key defining factor in how the relationship between supervision and TOs was perceived.

A second key defining factor was how participants interpreted the concept of 'therapeutic outcome' and this was broadly determined by their therapeutic orientation. However, the definition was often blurred by the concept of therapeutic outcome being a largely unexplored factor, not only within supervision but also within the psychological therapies. An explanation of these key determinants, their implications and consequences, are elaborated in the main categories below.

Category: Being a Professional

This category formed the starting point for understanding the nature of the relationship between supervision and TOs. The participant's therapeutic orientation emerged as a major influence on the participant's sense of professional identity as a supervisor and was highly influential on how supervision was conceptualised and practised. The depth of participants' belief in their therapeutic approach was profound and I interpreted this as amounting to both a professional and a personal value system. Its influence was often implicit and unexpressed but nevertheless, far-reaching and was a core factor in how participants construed the relationship between supervision and therapeutic outcomes.

On a more explicit level, participants presented a 'professional' framework for supervisory practice in their attention to the tasks of supervision such as note-taking, listening for risk to the client, attending to boundary issues and clear contracting. On the other hand, the findings show an unsophisticated approach to the evaluation of supervision practice, largely focusing on evaluating the supervisee's satisfaction with supervision gained through informal verbal feedback or more formal self-report reviews. Supervisor accountability was

perceived by participants to be generally minimally monitored and context dependent. This category presents a mixed picture of supervisory practice, with explicit professional diligence operating alongside implicit and often unexamined assumptions about wider practice issues.

Category: Making Choices

The supervisors' formative influences, sense of professional identity and professional framework impacted on the choices they made in the day to day implementation of routine practice. This category focuses on how supervision was operationalised and elaborates on what supervisors prioritised, the choices they made, their decision-making processes and the implications of their choices. Participants described typical supervision sessions, where the supervisor left it to the supervisee to decide what to bring to supervision and how the session should be used. This led to something of a paradox emerging. Participants initially stated that they 'trusted' supervisees and 'assumed' they would bring what they needed to the supervision session and yet when I probed further, they acknowledged that they were aware that supervisees did not always disclose difficulties. This led to a confounding moment in a number of interviews where the participant had an awareness of the issues involved but did not have an articulated sense of how they fitted together and how they were managed in practice. Therefore, it seemed that the paradox tended to occur and be addressed on an implicit level in supervision. Supervisors did not address the issue directly with supervisees but addressed it indirectly by striving to create and maintain a close and trusting supervisory relationship and a 'safe' supervisory environment, in which supervisees felt more able to disclose difficulties. However, supervisors did choose to take the lead when they 'sensed' something amiss relating to a risk to client welfare or a breach in ethical behaviour on the part of the supervisee. Aside from these occasions, participants were concerned not to be overly directive, choosing not to infringe on the supervisee's space by following up on clients or issues, even when this would have been their preference.

Category: Putting the Supervisee at the Centre

Putting the supervisee at the centre of supervision was the natural consequence of the choices that supervisors made. This category pivots on the concept of supervision being the supervisee's space and examines how the space is managed by viewing it within the framework of the functional model of supervision (Proctor, 1988). The formative function is determined according to the supervisors' therapeutic orientation and is relatively straightforward but there is a tension at the interface of the normative and restorative functions. As with the paradox of 'trusting' the supervisee and yet also 'knowing' about

non-disclosure, participants were aware of the tension of holding both the 'restorative' and the 'normative' roles and a number of participants expressed relief at not having had to invoke the 'policing' role. In preference to explicitly addressing this tension in supervision, supervisors again drew on the quality of the supervisory relationship, focusing on making evaluation of supervisee's practice 'collaborative' and fostering a trusting supervisory environment. The findings present an examination of this problematic interface as supervisors make efforts to create a 'safe' supervisory space for the supervisee with no 'judgment' and yet, at the same time, take responsibility for 'best' practice and client safety.

The supervisory relationship was a close bond, where supervisees were able to bring personal issues, though within a clear awareness of the boundary between supervision and therapy. There was some sense of supervisor-therapist role fusion with some slips of the tongue and supervisors referring to supervisees as 'clients'. The importance placed on the quality of the supervisory relationship and its role in resolving dilemmas has an important consequence for the perceptions of the relationship between supervision and TOs, insofar as participants were concerned that having a monitoring role in relation to TOs could potentially jeopardise the quality of the supervisory relationship. The close dyadic bond inevitably has implications for the triadic relationship and raises questions about how might the closeness of the supervisory relationship detract from attention to the client and, consequently, the relationship with TOs. This is the subject of the next category.

Category: The Client at the End of it All

'there's a client at the end of this supervision meeting' (P8, 338).

This comment by P8 seemed to sum up the sense of the client being positioned at the end (rather than at the heart) of the supervisory process and, equally, to serve as a reminder that psychological therapy exists for the purpose of serving the client. This category, therefore, brings the focus back to the client 'at the end of it all' and examines what 'putting the supervisee at the centre' means for the triadic relationship, the supervisor-client relationship and the client's outcome. Earlier categories demonstrated that client welfare was a consistent priority for the supervisor and this category examines the implications of this in greater depth, leading to a making a distinction between client welfare and client outcome. The supervisor-client relationship is construed as indirect, mirroring the indirect relationship between supervision and TOs.

The term 'therapeutic outcome' presented considerable difficulty for participants and they grappled with 'finding the right language' to define it. How 'therapeutic outcome' was defined and understood was ultimately profoundly influenced by the participant's

therapeutic orientation. How TOs should or could be monitored was unclear for the participants and they feared that if this task was brought to supervision it could present them with an unmanageable administrative task, as well as there being concern for damaging the supervisory relationship.

Category: Finding Connections and Missing Links

Themes from previous categories are drawn together in this final category, as connections are found, missing links identified and professional choices are questioned, explained, rationalised and thought through. Participants grappled with making sense of supervisory responsibility in relation to TOs and concluded that overall they did not have responsibility for the client's outcome, particularly in the light of not having full knowledge of the supervisee's caseload. As with the issues related to supervisee non-disclosure and the tension between the normative and restorative functions, participants were aware of the extent of their knowledge of their supervisees' practice, but again there were confounding moments in the interviews as participants thought through the implications of not having the 'full picture'. These implications are examined in this category and link to the previous category.

Participants made sense of paradox and inconsistency in the relationship between supervision and TOs according to their therapeutic orientation and its underlying philosophy. Finding connections in this relationship was challenging, although some direct connections were perceived, in the shape of specific supervisor interventions made in supervision sessions. Other connections were more tenuous, because they were perceived to be by way of the supervisor's contribution to the supervisee's professional development and although contributing to making the supervisee a 'better' therapist was highly valued, participants found it more difficult to gauge the effect on the client's outcome. Bringing the findings back to the start of it all, this category sheds light on supervisor's frame of reference and supervisory purpose.

Mirroring the indirect supervisor-client relationship, supervisors perceived the relationship between supervision and TOs to be indirect and they expressed their belief that enabling the supervisee to become a better therapist is how supervision indirectly contributes to improved outcomes for the supervisee's clients. It is captured by P9 when she sums up the relationship between supervision and TOs as being *'through a step'* (P9, 461-2).

Presentation of the Findings

BEING A PROFESSIONAL

Being a Professional	
Learning to be a Supervisor	**Managing the Professional Role**
Having faith in the therapeutic approach	***Context and accountability***
Learning from being supervised	***A professional framework***
Finding the value in supervision	***Evaluating supervision practice***
	Finding support

Figure 3. Being a Professional

SUBCATEGORY: Learning to be a Supervisor

This subcategory presents the theoretical and philosophical foundations of supervisors' practice and how they are derived.

Having faith in the therapeutic approach

Faith in one's therapeutic approach emerged very early in the research as a primary influencing factor, becoming an early focused code *'believing in my therapeutic approach'*. As this was developed through theoretical sampling and the constant comparison method, it became clear that there were both explicit and implicit assumptions underpinning a strong faith in the efficacy of participants' therapeutic orientation for both therapy and supervision alike. There is a direct relationship between the participant's therapeutic orientation and the meaning assigned to a TO (see the category ***The Client at the End of it All:*** *Deliberating about Therapeutic Outcomes: Finding the right language*).

One participant expressed her confidence in her therapeutic approach and her hope that she could imbue her supervisees with a similar confidence:

'I've got the confidence and I think it's because I know the therapeutic techniques work' (P3, 26-7) adding:

'I think sometimes if I'm confident it'll rub off on them' (P3, 429).

This participant practised from a Cognitive Behavioural perspective (CBT) and those practising from other approaches had the same faith in their own models. A psychoanalytic psychotherapist confirmed that her therapeutic approach *'strongly'* influenced her supervision practice (P7, 111) and a relational therapist concluded:

'it proved to me ultimately that it was all about the relationship' (P12/FG, 421).

A Person Centred counsellor affirmed the same:

'I suppose one of the key elements would be my Person Centred background. That certainly would be the strongest' (P4, 42-45).

I was so struck by repeated expressions of faith in a therapeutic approach, as well as the way in which it seemed to shape and frame responses, that I probed further. The therapeutic approach reflected a much deeper belief system, amounting to a statement of personal philosophy and professional values, operating at a more profound level than simply an understanding of mechanisms of psychological change. Faith in one's therapeutic approach, therefore, operated both as a worldview and a methodology for practice. Saturation was reached with the focus group interview, where it is clear that a deeper philosophical stance is inherent in the therapeutic approach:

P13/FG: 'but that doesn't answer the bigger questions within all this is nested ... what is this life about.
P12/FG: .... it's about affirming humanity. It's like being another somebody who is in contact ... and affirming someone's existence in the world' (FG, 383-387).

Other participants voiced this too:

'I believe a lot about the philosophical understanding of it' (P6, 27-8).

'because it's based on my values and ethics' (P10, 298-9).

Given the allegiance to a theoretical model, participants were asked to what degree they would consider working with supervisees from other therapeutic orientations. This was considered relevant because the wide differences in conceptualising TOs could potentially have an adverse impact on the overall efficacy of supervision unless specifically articulated, contracted for and managed.

There were some differences of opinion about the extent of working with other approaches in supervision but the differences clustered around therapeutic orientation. Both CBT and psychoanalytic practitioners believed that it was important to stay with their own model:

'you can do it superficially or you can do it in a lot of depth and if I don't know the model then I'm not going to help people get that depth' (P2, 42-3).

Unlike P2, P7 would work with other orientations but only where she continued to work from her own psychoanalytic perspective and where this was explicitly contracted for at the outset, so there was clarity for both supervisor and supervisee:

‘*where is the dividing line between helping that person to grow and just shoving my perspective [on them]?’* (P7, 162-3).

P9 supported this differentiation:

‘I think if they were CBT or psychoanalysts they wouldn’t come to me for supervision. They would go to their own modality because they are tighter around their own trainings and they’re working to a specific model’ (P9, 123-6).

Integrative practitioners were more likely to work with other therapeutic perspectives on the basis that working with the relationship was more inclusive across therapeutic orientations:

‘I don’t think it matters because ultimately I think what matters in all this work is relationship and that’s as much for the supervisor-supervisee relationship as client-therapist relationship. (P9, 95-6).

‘I think that’s fine. I quite like working with people who come from a different therapeutic background because somehow it’s fresher. There are no unspoken assumptions’ (P11/FG, 416-7).

The following is a brief extract from a discussion in the focus group:

P11/FG: ‘... because he was the expert in the psychoanalytic approach so he doesn’t need that, he needs a place to reflect.
P13/FG: I think it’s a strength because you end up being able to look at things in more depth from different viewpoints. And you can compare and contrast those different perspectives and most of my work, I often think, is about reframing things ... because what I’m hoping for is that we’ll find a third point of view, or that the supervisee will find a third point of view’ (FG, 424-9).

However, some participants cautioned that there are limitations:

‘I can’t be what they what they want me to be entirely, I’ve got to be how I am in supervision’ (P4, 85-6).

‘I felt that I’d be able to work with people slightly on the edges of my comfort zone because, it’s a bit like counselling itself, it’s the core relationship’ (P1, 62-3) but she notes that the essential point is that:

‘it’s in my level of competence’ (P1, 57).

All the participants had completed some kind of supervisor training, ranging from short workshops to certificated courses so supervisor training was potentially a further plank in participants' theoretical base. However, it played a far lesser role in comparison with therapeutic training; in addition, allegiance to one's therapeutic approach was emphasised in an expressed preference for supervisor training congruent with the therapeutic approach:

'The resistance is to supervisor training that draws from a lot of therapeutic approaches that I don't really use ... it would feel like a wasted effort, like talking two completely different languages' (P5, 76-9).

'and my training as a supervisor was Person Centred so that's been an influence' (P4, 56-57).

A negative case is P6 who currently practises as a CBT supervisor but did a humanistic supervisor training and she says:

'It really, really has given me a good training' (P6, 58-9).

By far the most frequently used models of supervision were psychotherapy-based models (e.g. Bernard & Goodyear, 2009), further emphasising the influence of the therapeutic approach on supervisory practice. In general, the psychotherapy-based model was informally applied, simply mirroring the structures and working with the concepts of the therapeutic approach:

'CBT is based on learning theory and supervision's about learning and I use CBT principles, basically' (P8, 63).

'I've been very influenced by CBT' (P3, 57).

Using a psychotherapy-based model was thought to give greater theoretical consistency and facilitate therapeutic adherence, in the sense that it supported the supervisee's ability to faithfully implement the constructs of the theoretical approach in practice.

'[I] make my supervision as close as I could to a CBT therapy session ... so from the start the supervision would be congruent with the way people work in individual therapy' (P5, 42-3).

Participants also used psychotherapy-based models more formally, when they had received training in that model:

'I do use psychoanalytic models of supervision' (P7, 228).

Participants worked within the framework of developmental models (e.g. Stoltenberg & Delworth, 1987) although again the developmental framework was only loosely applied in the sense of adapting supervisory practice to the developmental stage of the supervisee:

'I would attend to developmental stages as I think it's important not to treat all supervisees the same ... offering ideas more tentatively, just being respectful, [a] slightly more collegial feeling, rather than that heavy educational focus in the early stages' (P2, 79-82).

'So they are learning ... especially the trainees. Probably less so the really experienced therapists' (P9, 132-4).

The development process is noted as *'subtle processes'* (P3, 323) and supervisory interventions are *'looser at this end [experienced end]'* (P6, 118).

Participants made reference to the use of several integrated models of supervision but the most frequently referenced was Hawkins and Shohet's 7 Eyed Model (Hawkins & Shohet, 2012):

'*I'm really immersed in the 7 eyed model and that's what I really like about it because you can just work through that and ... I think that would be good supervision'* (P9, 137-40).

A counter argument to the above was posited by one participant who emphasised that the use of a psychotherapy-based model is preferable to integrated models:

'*I know that's the common belief that ... the technique of supervision can be across any methodology but I don't believe that'* (P2, 36-37).

It is noteworthy that there was a general absence of reference to professional codes of ethics as influencing supervision practice, with the following exception:

'also very mindful of the ethical framework, the BACP framework. I always feel this is a very holding bit of the supervision' (P4, 43-45).

Learning from being supervised

When asked about key influences on supervision practice, participants identified learning from being supervised themselves:

'supervision I've received shapes it' (P4, 47).

'much more so than theory I would say' (P5, 471).

This is an important point in terms of how we develop new ideas in supervision and is relevant to this study, which is focusing on less familiar perspectives in supervision. While supervisors rely on their experience of being supervised to inform their own practice, there is a risk that new developments will be slow to filter through to practice. Although participants emulated the practice of good supervisors and avoided replicating what they perceived as bad supervision, as in the extracts below, it means that we are risking working with a small and regurgitated knowledge base. One participant describes his experience:

'my least useful [supervisors] ... ones who have spoken a completely different therapeutic language to me and it's been like being at the UN or something ... so it's been really important for me in my own supervision to learn from that and that the style of supervision needs to fit with the therapy that you're actually offering' (P5, 90-5) and he later concludes:

'not to do the things I didn't like and do the things I do like' (P5, 474-5).

Finding the value in supervision

Since the research focuses on finding the value of supervision in relation to the client, this property adds meaning by identifying its importance for participants. Drawing on their experiences as both supervisor and supervisee, participants identified key benefits. There are links to the previous property *Learning from supervision* as these areas of perceived benefit then become integrated into supervisory practice. On a more subtle level, identified benefits point more broadly to participants' frame of reference in supervision practice and a significant omission was a reference to improvement in clients' TOs as a benefit of supervision, implying that it is unlikely that supervisors will intentionally focus on TOs or will have mechanisms in place to address it.

Participants expressed finding considerable value in supervision:

'I wouldn't want to be in practice without supervision' (P5, 526).

'if someone does difficult work with clients, then it's obvious that they need to be supported in that ... we don't even need to do research in that' (P11/FG, 394-6).

Its value as a reflective space, a safe space and a personal space reflects traditional notions of supervision and form part of our professional discourse (addressed more fully in the category ***Putting the Supervisee at the Centre***):

'the main job of the supervisor is to create a supportive reflective space' (P5, 462 – 3).

'Safety. Trust. Respect' (P10, 119).

'supervision gives me personal space' (P6, 417).

Yet this contrasted with other views expressing some scepticism regarding the contribution supervision had made to their practice and questioning the necessity for regular supervision when the supervisee is experienced:

'when you reach a certain level of training, you don't need to keep having supervision for the rest of your life ... there's this assumption that it's good for you ... but I don't know that my supervision has made me a better therapist' (P2, 470-3).

'why am I sitting listening to this person all this time when they really know what they need to do and ... it becomes social ... more like peer supervision' (P3, 354-68). This participant takes it further and says there is a moral issue:

'it doesn't feel like I'm earning my money'(P3, 372).

This same collegial sense was expressed by P6 who, in contrast, found the experience a positive one:

'it's more like two people having a great conversation' (P6, 116).

SUBCATEGORY: Managing the professional role

Context and accountability

This theme is developed further in the category ***Finding Connections and Missing Links:*** *Working out Responsibility.* Participants discussed working in different settings as supervisors and the diverse demands they experienced. Working in private practice as a supervisor or working with supervisees who are in private practice, appeared to be an area where there was least sense of accountability but more responsibility:

'working with a supervisee in private practice, it takes out the element of there being someone else or something else involved, which has positive and negatives for me ... having to be more vigilant, perhaps, with a supervisee in private practice with gatekeeping and monitoring and all of that. It's down to me to flag up anything I feel isn't as it should be, whereas with an organisation there was someone else ... to go to for both parties. So I think there is something about the responsibility' (P10, 93-6).

'I was external supervisor ... I wasn't answerable to anyone in some ways and that's how it felt, to be honest, being an independent supervisor and not having a line manager above me ... the buck stopped with me'' (P1, 13-20) and this meant:

'all you have is self trust and integrity, because actually you could be doing anything in there and you're not really accountable to anybody' (P1, 105-10).

P4 linked accountability to authority and responsibility in a private practice setting:

'but the weakness of independence is that it can't be accountable ... it can't be accountable to the client, it can only be accountable to the supervisee ... you can't exert any authority about what the counsellor does or doesn't do like a manager can ... as a supervisor, an independent supervisor, you don't have that authority or sanctions like that' (P4, 393-9).

Working in organisational contexts also presented challenges:

'the organisation have said that the staff needed to have clinical supervision and the staff have not been very convinced that they need to have clinical supervision or come from a quite strongly different kind of perspective ... [resulting in] resistance to the supervision process' (P7, 172-5).

This participant is speaking about the blurred boundaries when working as an internal supervisor in an organisation:

'It puts people in really difficult situations and raises all kinds of questions like who you should and shouldn't socialise with outside the organisation and ... just really blurred ... I'd much rather have external supervisors' (P5, 277-80).

Two participants referred to the public perception of supervision and its role in protecting clients:

'the public at large, I think they assume it's much, much tighter because the word supervision at large is a much tighter process, like on the factory floor, it's a much tighter process, about quality and outcome and it's not like that and it can give us the illusion that we're covered' (P2, 453-7).

'I can understand supervision being some kind of protective net' (P3, 356).

P6 raised fears of litigation and disciplinary procedures, reflecting a sense of unease in this area:

'I do have a read back of the notes and they ... help me to think, "oh yeah, I did address risk" - for litigation for myself, because, touch wood, it hasn't happened to me but [reading about incidents of litigation] have made me a little bit anxious' (P6, 190-4).

She described having worked with a supervision sheet where the supervisee signs off on the content of the session, as a self protection:

'I wouldn't say it's the most trusting way of working because you both sign off what you talked about but there are lots of ways of looking at' (P6, 229-30).

P5 speculates on the extent of his responsibility within the law:

'my understanding is that the supervisor is not responsible for the work and I think that's the position in law as well ... but it is a complicated situation' (P5, 288-90) and he reports documenting his actions as a protection:

'it should be documented as well that that has been [done] and I presume that my own thoughts of this should be documented and presumably it's because I do perceive at some level I do think I want to discharge a duty of care, and to be seen to have done that as well' (P5, 300-3).

Three of the participants commented on the necessity for Continuous Professional Development for supervisors:

'this is about the supervisor being responsible for their own development' (P1, 366).

'if the client is there in order to change then the supervisor likewise needs to be open to change and development' (P13/FG, 9-10).

'I'm learning new things all the time' (P10, 112-3).

A professional framework

Participants were diligent in carrying out the tasks of supervision and clear contracting was seen as a cornerstone of ethical practice with collaboration and clarity being crucial factors in the contracting process:

'I do rely on the supervisee and I might say this in my contract' (P6, 156-7).

'I'd go through a contract. My written contract is very short. Then I would talk through about things like coming prepared, what expectations were ... where we meet and how often we meet' (P9, 164-5).

'I think that does come down to very clear contracting' (P10, 184).

'I might have a 3 way contract particularly if the organisation wants it or if I felt that that it was needed for the nature of the work' (P4, 345-6).

Keeping notes was another task of supervision that participants were conscientious about doing and was considered essential when monitoring supervisees' practice for signs of breaches in ethical behaviour:

'[notes about] what they're working towards, what the focus was in that session, unless there's an ethical issue that comes up in that session then it's more detailed' (P2, 54-6).

'in those sorts of instances I would write a few more notes' (P1, 286).

'every single supervision session has got notes' (P3, 35).

'I do look at the notes ... even if it's a quick flash but I do need - remembering, like was there a risk issue or were they talking about an ethical dilemma' (P6, 183-5).

Evaluating supervision practice

Evaluating supervision practice is potentially a key factor in tracing the relationship between supervision and TOs. The most commonly reported method of evaluating supervision practice was getting informal verbal feedback from supervisees, either elicited or volunteered:

'They ... say "oh after our last supervision session I went back and I did this and the response was really good and" ... but I don't monitor that so I don't know how often that happens ... that's not really enough but you do get verbal feedback' (P2, 515-8).

There was some scepticism expressed about verbal feedback:

'the feedback I'm getting is that it's helpful whether it's clients or supervisees and I suppose on some level this is what people are telling me – whether it's true or not you'd have to ask them' (P5, 484-5).

Evaluation was largely focused on gaining information about supervisees' satisfaction or otherwise, with supervision and some participants referred to structured reviews with supervisees:

'I tend to do a yearly review with supervisees and it's often quite light hearted. I say," ok, what's your worst mistakes here?" – as well as, you know, what's gone well, and I'll say "what was the real kind of clanger you did this year?"' (P9 213-8).

'I like to evaluate how the supervision itself is going from time to time and, in fact, we contract how often we do that and then we can talk about how we are working together - so evaluate. So they're assessing me and I'm assessing them' (P11/FG, 249-50).

'part of the organisational need was to have a yearly appraisal and we always did it together' (P12/FG, 253-4).

The following participants described the purpose of the review:

'is there anything they'd like more of from me as a supervisor? Did they get their needs met?' (P6, 169).

'getting feedback regularly and doing reviews regularly and finding out if it's working for people, getting the right emphasis' (P2, 419-20).

P4 summed up reviews in this way:

'roughly annually, I like to do a review of ... the supervision process rather than how effective it has that been in contributing to the effectiveness of the therapeutic process so it doesn't really measure the impact on the therapeutic process' (P4, 271-4).

P6 comments on the difficulty of tracking the effect of specific supervisory interventions:

'I think that did happen and I think that would have an overall effect as well. I think ... how would we ever track that?' (P6, 385-8).

However, this participant was the only one to refer to evaluating supervisor's efficacy or competences:

'Padesky talks about evaluating practice and there's a nice tool in her clinical book about evaluating practice ... and in the last service we did have to do yearly supervisor's audit of practice' (P6 392-7).

P1 referred back to her supervisor training, pointing to the lack of emphasis on measuring efficacy of supervision practice there, either in terms of supervisor competences or effects of supervision on TOs:

'there wasn't a lot of emphasis on how do we measure efficacy in supervision' (P1, 114-5).

Finding support

A number of participants pointed out the isolation factor in therapeutic work (also see the category ***Putting the Supervisee at the Centre:*** *The Supervisee's Space: A space to be nurtured*) and this is equally important for the supervisor:

'I think the problem is, learning to be a supervisor, or anything in this field, is that you actually feel so alone when you're doing it' (P1, 53-4).

Support was sought from supervision of supervision:

'I did take her to my supervisor and we did discuss it at length' (P3, 226).

'Currently I have more than one place where I take ... my supervision of supervision' (P4, 33-34).

P9 accessed support from supervision but also reported feeling well supported by peers:

'Personally, right now, I feel very well supported, mostly through my peers and I do go to my own supervision' (P9, 407).

One participant also commented that she would use therapy to deal with difficult issues that arise in the work:

'work through in therapy and in my own supervision what was happening' (P7, 139-140).

MAKING CHOICES

Making Choices	
Leaving it to the Supervisee or Taking the Lead	**The Trust Paradox**
Leaving it to the supervisee	***Choosing what to take to supervision***
Attending to client welfare	***Trusting and assuming***
Wanting to follow up	***Knowing the 'dark side'***
Limited by time and context	***Holding the tension and managing the paradox***
Negotiating with the supervisee	

Figure 4. Making Choices

SUBCATEGORY: Leaving it to the Supervisee or Taking the Lead

This subcategory emerged from the question: 'Please tell me about a typical supervision session' with prompts such as: 'How is it decided how the supervision session is used? Might you bring an issue to the session?'

Leaving it to the supervisee

All participants responded by reporting that it was left to the supervisee to decide how to use the time and space:

'I like my supervisees to set their own agenda' (P9, 153).

'the routine is they explain the case they want to talk about it' (P8, 133-4).

'it's up to them with the time we have' (P2, 70-71).

P6 however, noted that it was not always left to the supervisee to decide:

'I think a good 75% of my practice is "what do you want to bring? What's important to you?"' (P6, 200).

This indicated that a decision-making process was in operation and I probed further to elicit the mechanisms that were operating, and used the process of constant comparison to refer back to earlier interviews. It emerged that there were specific occasions when the supervisor would take the lead and become more directive. The next four sections trace the process of making choices, which was elaborated on through theoretical sampling through to saturation.

Attending to client welfare

Taking the lead become non-negotiable when the participants perceived risks to the client's welfare or where they suspected the presence of unethical behaviour on the part of the supervisee, indicating these areas were given high priority:

'there might be times when I do have to raise things. You know for example ... practice issues' (P6, 150-2).

'you're on full alert – there's more attention because again I think it's that job of making the client safe and ... where you think, I'm not sure whether this client is in safe hands at this point' (P1, 221-8).

P9 saw the following as one of the most important elements of supervision:

'supporting safe practice between supervisee and client' (P9, 83) and later reinforced it:

'one of the functions is to help supervisees to create a safe space for their clients' (P9, 222).

Whilst all participants prioritised taking the initiative if there were concerns about the supervisee's ethical behaviours, one participant described how her supervisee developed in ethical maturity over the course of the supervision relationship:

'I did have ... a supervisee who ... at the beginning ... would get really panicky so there would be many crises with her but what I noticed by the end of the year ... she just left a message on the phone and ... she ran through the process, then "everything is fine now, bye". Now that was progress. So that was a good piece of learning and if you talk it through as it happens they learn that' (P3, 283-7).

Wanting to follow up

The supervisors' decisiveness in following up where there they suspected risk to the client's welfare suggested no inherent reluctance to do so. However, participants chose not to take the lead in following up on clients previously brought to supervision or on non-risk issues, unless it was explicitly agreed with the supervisee. This emerged in the first interview in early purposive sampling:

'well I can only speak for myself because I don't think I check out myself ... it's what they need to bring rather than for one's own benefit to ask. I tend not to [follow up]' (P1, 83-5). However, she did acknowledge that:

'there's also part of you that has to keep an overview' (P1, 92-3), but, nevertheless, continued to leave it to the supervisee to decide:

'I wouldn't then look at the notes in say five sessions time and think "gosh, they've mentioned all these people but they haven't ever brought B back and I don't even know if B is with them anymore" and so that would happen quite a lot, to be honest ... I'm not sure without really thinking about it, is that a good thing, is it a bad thing, is it just a thing?' (P1, 309-12).

Other interviews continued the theme, bringing more clarification. For example, P2 as a CBT supervisor, modelled a CBT structure in her supervision sessions and this included 'bridging' from the previous session, which is a term that means linking the current session with the previous one:

'I would start off trying to create the opportunity to find out if possible' (P2, 66) but she admitted there were difficulties in doing this including time constraints. When asked how she decided to follow up she replied:

'With individuals it's automatically on the table as something we can do and ... if they've seen that person usually they would give me some follow up unless they've dropped off the system or they're really pressed for time' (P2, 87-89). Further than that, she said:

'I think I'd leave it to the supervisee. I mean once in a while somebody may stick in my head and I'd refer back out of interest' (P2, 121-2) but her method of following up on supervisees' clients' progress remained '*very informal'* (P2, 356).

During the interview, P2 became more interested in the notion of following up on clients brought to supervision, especially as it mirrored her model, and she concluded that:

'the more I'm talking to you the more important it seems that you do follow up' (P2, 461).

P4 had a rule of thumb in deciding when to take the lead, indicating that she would only follow up in unusual circumstances:

'if something's strong then I bring it [up] or otherwise I don't' (P4, 152-4).

P3, P5 and P6 each had access to their supervisees' computerised client notes in their workplaces, and each approached it differently. When asked about following up, P3 replied:

'In what way, how would I do that – just from the person's feedback? Do you know what – I never do' (P3, 146-9), and with regard to having access to the computerised notes, she responded:

'I have access to ... all their clients and I could read all their client notes ... and I never have and I don't know why' (P3, 162-3).

As part of her work role, P6 is required to check her supervisees' client notes on the workplace system so does not have the option of not accessing them, but she deals with it in a collaborative way:

'I've been up front with it ... I have told them before I've done it ... I'll say, I will be looking at the notes over the next month; how is that for you?' (P6, 219-20).

P5 is flexible about checking the notes:

'I'll generally ask them how they've got on so I think I could probably tighten up a bit on this ... in the group supervision I was much more explicit about the process about systematically reviewing any changes in outcomes since the previous supervision session in regard to the cases we have already discussed' (P5, 209-11).

Theoretical sampling was used to develop a greater understanding of the mechanisms involved in making these choices and P9 was asked: 'How do you make those decisions and those choices?' Her response indicated that it had to be a situation of some urgency to choose to follow up:

'I felt that something quite deep needed to be addressed' (P9, 254) and *'I don't think I've ever worked with such extreme process'* (P9, 260).

It was evident that the participants' conviction that the supervision space belonged to the supervisee outweighed their occasional preference to follow up on previous work. This meant that the participants had to remain alert to any indication that an intervention was necessary:

'supervision feels busy' which meant she needed *'lots of these antennae'* (P6, 7-99).

Limited by time and context

Time and context were significant factors in structuring supervision sessions and influencing participants' choices. P1 described supervision as *'precious time'* (P1, 77) and other participants described being responsible for time-keeping:

'I took on that responsibility' (P10, 153)

'so the task of supervision for me is sticking to time' (P6, 425).

Group supervision entailed more scrupulous attention to timekeeping:

'then we think who went first last time and we swap around because the person who went last gets a little short measure ... if you're not careful about keeping to time, that can happen very easily, so that's why I do that' (P8, 131-2).

Despite attention to timekeeping, P7 noted:

'there never being enough time to really look – it's a very reactive kind of process' (P7, 391), which further constrains the supervisor's inclination to follow up on previous work.

P8 reported that time issues curtailed his preference to develop supervisees' learning by using a Socratic approach, forcing him to opt, at times, for a less time consuming didactic approach:

'the other thing that's actually difficult is time, because it takes longer to ... think and use questions and Socratic method than to say, "ok, here's what you could do"... and sometimes you have to do that just because time's running out' (P8, 85-7).

Participants consistently reinforced the notion that the time belonged to the supervisee:

'because it's about their time' (P10, 166).

The amount of time between supervision sessions was a further pressure:

'I like to follow up ... it's hard to do because my ... private supervisees ... tend to be only every month and so by the time I see them again that client might be gone or other things have taken over' (P2, 57-60).

The context of supervision further limited the participants' flexibility in following up, as the following participant described:

'I seem to end up working in contexts which ... are very high pressure where you are never ever going to be able to ... think about each client, which obviously has its disadvantages' (P7, 393-6).

Supervisees' training requirements were a further demand on the supervision space:

'I have been in situations where they HAVE [emphasised] to bring particular clients and that is a tension' (P6, 201-2).

'It's been slightly skewed by the requirements of the training courses' (P5, 166-7).

Negotiating with the supervisee

Although managing the time appeared to be a constant pressure, only one participant expressed feeling the tension inherent in choosing when to take the lead or leave it to the supervisee:

'I've noticed that tension sometimes in supervision. I'd push to hear about that and they say "oh I want to talk about this one" but I do feel it's important to tie these loose ends up. You know, I'll negotiate with them. I might only be touching base on that but it could be an important point for me, whereas they might have moved on and seen the client two or three times since then' (P6, 187-90).

Participants expressed greater concern about being overly directive:

'then it's a bit like how directive should you be as a supervision?' (P1, 72).

'I don't think I became very directive but I spent an awful lot of time sort of reflecting' (P13/FG, 97).

However, P3 was not concerned about being directive when she believed her supervisees needed prompting to implement therapy correctly:

'you have to get working ... get on with the job ... I'm a bit demanding of my supervisees' (P3, 420-5).

Making choices by negotiation was the preferred method for the participants:

'"would you mind if we made space to talk about that" or I might say "do we need to talk about that?" ... giving them the choice' (P4, 205-7).

'we might contract to, you know, "actually we need to follow this up"' (P7, 354).

'I'll ask if "you want to come back to that?". I don't insist but I want to keep it joined up so I ask them if they want to because they might have things that are a little more pressing, and sometimes we'll come back and they'll give me some update on what's happened with that patient' (P8, 150-2).

'then I'd set an agenda "what are we going to talk about today" and I'd put my things in there as well as theirs' (P9, 144-5).

In summary, although participants expressed a preference for following up on clients or issues, at times, their primary purpose was to enable the supervisees to *'set their own agenda'* (P9, 153).

SUBCATEGORY: The Trust Paradox

As with the previous subcategory, *Leaving it to the supervisee or taking the lead,* this subcategory also emerged from the question: 'Please tell me about a typical supervision session' and different prompts were used to take the inquiry in a different direction, such as: 'How do supervisees choose what to bring?' 'Is there any occasion when the supervisee may not choose to bring a difficulty or an issue?'

Choosing what to take to supervision

Initially the participants expressed little concern with the issues presented here until further probing revealed discrepancies, resulting in some consternation being expressed during the interview. In response to the question 'how do supervisees choose what to take to supervision?' one participant exclaimed, frankly:

'Oh goodness, I don't know' (P4, 157–159) suggesting it was an issue rarely considered.

P2 surmised that we all make choices in a similar way:

'I don't know the mechanisms, I assume that that we all do it this way. It's something you're stuck with or not sure what the next step is or there's an ethical dilemma or presses some button in us or there's something in the relationship that's not working' (P2, 147-9).

There was a consensus that supervisees generally take difficulties to supervision:

'You bring your problems to supervision, you don't bring your solutions' (P1, 71).

P7 was curious about how the choice was made:

'I have a sense why do we choose to bring who we choose to bring when we choose to bring them and the other client sits in the backwater and so I think that's all worth exploring' (P7, 393-4).

The developmental stage of the supervisee was a factor in what was brought to supervision, with more experienced supervisees (like the participants themselves) using supervision less for problem-solving and more for reflection:

'What I take to supervision might be different ... I'm not always stuck, it's more I want the time to reflect or just talk through' (P2, 158-9).

Trusting and assuming

The paradox emerged with the participants assuming trust in their supervisees on various levels: trusting that they will bring difficulties to supervision when they need to, trusting they will consistently work for the best outcome for their clients and trusting this is happening unless the supervisee states otherwise:

'I have quite a high level of trust that they'll bring issues to me' (P5, 180-81).

'So I kind of trust them, " you get on with your work and only bring me the things that you think are number one"' (P3, 62-3).

'you're trusting the supervisee, really, aren't you? I mean they are the ones who have the relationship with the client' (P11/FG, 45).

'I suppose that is about trusting that she'll bring what she needs to bring. I guess' (P12/FG, 55).

Participants were aware that this led to making assumptions about a supervisee's practice, which were not explicitly raised with the supervisee:

'there's a lot of assumption making – I think when you don't have the information you're bound to think "oh, that must be ok then"' (P1, 86).

One of these assumptions is that the supervisee will produce positive outcomes:

'if you feel that you trust the supervisee then there's a whole bunch of assumptions that goes with that "oh I trust the supervisee ..to be an effective therapeutic practitioner", therefore "there's probably going to be a positive outcome for the client"' (P1, 215-7).

However, a negative case was P9, who had experienced non-disclosure with a supervisee and took a different view:

'you can't make assumptions' (P9, 197).

Knowing the 'dark side'

> *'Obviously the other part of me knows the other – the dark side of people not telling supervisors what's really going on' (P1, 2904-5).*

This quotation from P1 captured the inherent paradox of the situation. Investigating more deeply revealed that participants were aware that supervisees did not consistently bring difficulties and that non-disclosure was a reality. However, there was a sense of avoiding

bringing this paradox out into the open and dealing with it instead on an implicit and unspoken level.

'I mean I've got to be honest, I've done it myself ... I'd like to think I'm an ethical practitioner but ... (P6, 260) *'I think it's human nature and I think it doesn't always come from a bad place'* (P6, 267-8).

'there is always the temptation not to take the difficult stuff ... there's that "why do I want to do that, I know that I should be doing this differently" or "I've got my doubts but I don't really want to take it to supervision to have that confirmed"' (P5 510-12).

'there's hundreds of other reasons why a client may not be presented, not because it's actually fine and ticking over nicely – it could be all sorts of reasons "oh god, that didn't work and what's my supervisor going to think about me because I've got a block?"' (P1, 89-91).

P3 expressed her surprise when she discovered that, contrary to her own practice of taking mistakes to supervision, her supervisees might not do this:

'she was the kind of person who would help me out of trouble. I always used to find that I felt comfortable taking her all the booboos as it were ... but I suddenly realised that not all supervisees are like that – they'd rather hide the booboos' (P3, 122-7). She noted how non-disclosure can escalate into a crisis:

'if they've hidden clients then they only bring it to supervision when it's hit the fan' (P3, 273).

Supervisees' difficulties with an organisational policy limiting the number of client sessions, was raised as leading to non-disclosure:

'where they are working in a way that's not entirely in line with the service's protocols' (P5, 231).

P4 discovered non-disclosure by chance when a supervisee: *'popped in something about this client'* (P4, 222) and she emphasised:

'you can't control what people bring to you, you can't know what they're withholding, you can't know' (P2, 403).

Holding the tension and managing the paradox

P4 summed up the tension in holding the paradox of trusting and yet not being sure:

'you have to trust that your supervisee's telling you the truth, that they are doing what they say they're doing or not doing. You can't be sure. You can never be 100% sure' (P4, 374-6).

The paradox evoked an unsettling ambivalence:

'I contradict myself often if you see what I mean and I don't always understand myself but there is something about – [pausing to think] – if I - I TRUST [emphasised] and I still of course – you know and sometimes I notice if I'm worrying about that trust ... but I do, I do trust that supervisee' (P6, 236-7) and she picked this up later:

'I do worry about them. I don't know. I'm all a bit mixed up there' (P6, 243-4).

Participants reflected on how to minimise the possibility of its occurring. The quality of the supervisory relationship was seen to be the most crucial factor:

'But then that brings up the whole relationship between supervisor and supervisee and why they couldn't bring it to you in the first place and that's important too' (P1, 205-6).

The need to build a supportive and encouraging supervisory relationship within an open and safe supervisory space was emphasised:

'by creating a really open and honest space where people can bring mistakes' (P9, 213).

'I think that the line I try to walk with that is to create an atmosphere in the supervision that's supportive you know rather than punitive' (P5 229-30) but:

'what I don't know is how successful that has been because the ones they are concealing - I don't know they are concealing necessarily' (P5, 241–3).

'you can raise that and talk about it and then I think trust becomes an easier issue' (P6, 242).

P1 pointed out that it is part of the supervisory role:

'to ascertain whether the supervisee can be trusted to work in a therapeutic way that isn't going to harm the client' (P1, 213).

'I try to tune in to what's being avoided. But ultimately I don't know what's being avoided' (P9, 184) and:

'ultimately, there's going to be stuff you just don't know' (P9, 192).

P3 described how she handled a problem of non-disclosure, which she had received some prior knowledge of:

'I just kind of let it run, I don't know why and [later] she really brought all the cards on the table and said she'd made a mistake, was really honest and genuine, and maybe by giving her the time with the process, to get to that point, she didn't feel like she was being targeted too much' (P3, 125-7). She says that during the whole process:

'I just took extra care' (P3, 132).

Having an overview of the supervisee's caseload was a further strategy:

'because then I can see if there's clients that are being left out' (P9, 182).

P6 used an innovative approach to give her supervisees confidence to disclose difficulties: *'what I've done then is to take [my own] bad work, you know ... "oh last week I had a struggle" and yes, it has worked. It has really worked'* (P6, 208-11).

A participant who had served on ethics committees added a cautionary note:

'Well I know that from the ethics committees. I've known that some therapists do not take – therapists that have ended up in inappropriate relationships with their clients. They haven't been taking that to their supervision ... I can't sit here and say that will never happen to me and I'd like to think it'll never happen to me ... I bet their supervisors thought that too' (P9, 209-211).

PUTTING THE SUPERVISEE AT THE CENTRE

Putting the Supervisee at the Centre	
The Supervisee's Space	**Managing the Supervisory Relationship**
Defining the space	***The supervisor-supervisee bond***
A space to grow	
A space to be nurtured	
The safe space paradox	

Figure 5. Putting the Supervisee at the Centre

SUBCATEGORY: The Supervisee's Space

The way in which supervisors define and manage the supervision space is a key factor in understanding the relationship between supervision and TOs. The properties of this subcategory contribute to explaining what supervisors prioritise and what supervisors' frames of reference are as well as supervisory purpose. Previous categories have indicated that the central operational assumption in supervision is meeting supervisees' needs and this subcategory expands on how participants did this.

Defining the space

This is the facilitative space where supervisees are supported in their professional role, in order to offer *'best practice'* (P2, 174) to their clients. One participant suggested:

'it's a bit like the nursing triad, holding the supervisee who is holding the client' (P1, 142-4).

The term 'nursing triad' is based on Winnicott's (1958) notion of the primary caregiver being sufficiently held by another in order to care for the baby. Winnicott's model of father-mother-baby has been adapted to capture the interactional triad of the supervisor-supervisee-client relationship (Casement, 1985; Hawkins & Shohet, 2012).

Although the space is the supervisees', the supervisor has responsibility for defining and creating it:

'what's really important is how your supervisor defines that space' (P5, 513).

There is the same implication in the following comment:

'but mainly I will let the counsellor or the supervisee bring it to the session' (P6, 159).

The assumption is that the supervision space offers a 'container' in which the supervisee can examine the work and the 'self' within the work:

'I always think of supervision as this sort of holding container for the work' (P4, 289-90).

'explicitly talking about the kind of container we are going to create for the process' (P7, 249)

A Space to Grow

'space for them to grow' (P4, 410)

The above quotation seemed to appropriately capture the sense of the formative function of supervision (Proctor, 1988), explained as:

'formative in the sense that people are in the process of development and growth and their skills and abilities are developing all the time, so we are involved in a process of ... encouraging people to ... learn and to develop' (P5, 341-5).

'I think a lot of what I'm doing is just offering a space for people to be able to learn from their practice so that they can become better' (P9, 132).

Participants' narratives demonstrated that the developmental element was a primary function of routine practice:

'I'm creating a structure for the work ... supporting the knowledge, skills acquisition, supporting professional development, whether that's supporting the trainee or a more experienced person, to be professional' (P9, 229-30).

'supervision either teaches the skills or models a pattern? How else can you look at it – I don't know, I've never really thought about this – so is there another way of looking at how supervision works?' (P2, 310-11).

Providing an opportunity to reflect on practice was considered an important aspect of this function:

'the main job of the supervisor is to create a supportive reflective space' (P5, 462–3).

'to help the supervisee to reflect, properly reflect, on their practice and I think that's the main thing and everything else will come from that' (P11/FG, 2-3).

'I think it [the ability to change and bring about change in the client] comes out of the notion of critical reflection' (P13/FG, 10).

The nature of the supervisee's learning is largely determined by and dependent on therapeutic orientation and the following quotes represent CBT, Person Centred and psychoanalytic perspectives, respectively:

'It's not so much with the supervisor but just talking it through out loud, having that place to reflect, helps me be clearer, but that should still translate into the practical skills and things I'm doing in the session' (P2, 313-16).

'by valuing your supervisee and offering this very valuing presence you are modelling something to your supervisee and ... I would hope this filters through to a valuing of the client' (P4, 284-5).

'what I'm aiming for is to help people feel more confident about actually responding to their internal responses ... the kind of mechanics of what might be going on in sessions ... encourage supervisees to have the confidence in their own responses to material and to dare to be wrong or to dare to explore' (P7, 255-8).

What is valued and encouraged by supervisors in relation to the material brought and the method of presentation, is also influenced by therapeutic orientation. The following relational practitioner described how he valued spontaneity, as presenting an opportunity to explore what might sit outside the supervisee's immediate focus:

'we had a little joke and we played with that joke for most of the session ... and what came out of that was all sorts of connections to the work ... the joke was highly relevant to how this supervisee is in the world' (P13/FG, 213-8).

Where a supervisee fails to prepare for the supervision session, this too can be seized as an opportunity:

'someone who says "I don't know what to talk about today I haven't come prepared", I think "oh great, we're going to get somewhere today", because it's not something that's polished and presented' (P13/FG, 211-2).

Whereas a CBT practitioner values a more formal theory of learning:

'that comes out of reflection and thinking, that's more of a Socratic method as opposed to a didactic method. We tend to think that's a higher value type of learning' (P8, 70-71).

Working from this orientation the supervisor prefers the supervisee to present with a supervision question (Padesky, 1996).

'I try to encourage them to bring a supervision question. "So when you bring this person what do you want from this?" ... So they need to know why they are bringing them' (P3, 63-5).

However, this clustering of preference around therapeutic orientation was not common across the participants and this was a negative case. P9, working from an integrative approach, said:

'I like them to come prepared for supervision ... having already thought about what it is they need to get out of the session, what are the key questions they've got or what concerns they've got or what they just feel needs airing' (P9, 153-5).

Some attention was paid to the supervisees' developing competence but there was a notable absence of linking this to TOs, a point that is developed below in this category ***Putting the Supervisee at the Centre:*** *The Supervisee's Space: The safe space paradox.*

The following extract summarises participants' aspirations for the creation of *'a space to grow'*:

'speaking as a supervisee of supervisors whose inputs I've really valued, often what they've given me is that the relationship's been stimulating - supportive and stimulating- and that's what's really made me feel that I'm growing as a therapist, and I suppose that's what I'm trying to provide for supervisees – a reflective stimulating space where they can get support and where they can feel more confident in their own abilities but with new ideas to try things out' (P5, 466-9).

A space to be nurtured

'honestly he was so nurturing' (P6, 506)

The above quote is how one participant described a supervisor with whom she had an exceptionally supportive, though challenging, supervisory relationship early on in her professional career. Essentially this is the restorative function of supervision (Proctor, 1988), summed up by one participant:

'Remoralisation of therapists when they get stuck would be a major factor that supervision would have; more than anything else. That would be my gut feeling from what I know' (P5, 396-7).

'the encouraging aspect of supervision for trainees ... the holding bit that lends them some confidence to go back ... the supervisee feels very safe, held, valued and encouraged. I

think all those things are quite nourishing, and then go with them when they go back into the space' (P4, 284-292).

'it's about connection that I get that is important as well; knowing that ... somebody cares what I do; and in somebody to be a witness. It's solitary, isn't it? It's one to one' (P10, 311-7).

The solitariness of the profession is highlighted by others:

'supportive in terms of the ability to help them heal the wounds ... after all that client work and the pressure of it and to feel that they are not alone with the work because individual work can be very isolating' (P5, 341-5).

' I think that because counselling is such a solitary and isolating activity' (P4, 296) and she goes on to echo P5's reference to the therapist's:

'own woundedness' (P4, 414).

An aspect of the isolating nature of being a therapist is carrying the confidentiality and P2 suggests that supervision offers supervisees support in managing this:

'there's a place for offloading and being safe and because we carry all that stuff because of confidentiality it is nice to just have a place' (P2, 445-6).

However, this participant noted that there is the potential for the supportive function to go too far and be detrimental for both the supervisee and the client:

'that supportive function ... it might help the practitioner stay in practice and feel comfortable themselves and in that sense it can be almost counter-productive because it can lead the supervisee to believe they're doing fine and feel better and that doesn't necessarily translate into what they are doing in sessions at all' (P2, 448-50).

Participants voiced their active differentiating between therapy and supervision. Although they were prepared to work with some personal material, even inviting the disclosure and processing of personal material, they stressed that this should only be done in the service of enhancing the efficacy of the therapeutic work:

'if the supervisee has their own personal issues then yes, that's important but actually that's not where I come in' (P1, 143-4).

'but the point of that is not personal development per se – it's to get an insight into the skills and to clear their own beliefs out of the way so they can practise' (P2, 327-8).

'Often I would check in with how they are ... to give them an opportunity to bring their current context because I think it's quite important to know their current context' (P4, 125-6).

'Having said that, there may also be quite a lot of general supportive listening if there are any difficulties coming up in their personal life and their academic study as well' (P5, 137-8).

P6 described moments of relational depth in the supervision sessions:

'having those sort of moments again, it's usually about a client or about them, something might attach to their stuff' (P6, 132-3).

However keeping the boundary between the personal and professional is:

'a fine line' (P9, 237) and sometimes the supervisor has to draw a boundary:

'she wanted me to work with her on the issues which was quite a charge for her but I just thought I'm just getting into being a therapist if I do that ... it does happen a bit in supervision but I like to keep it a lot cleaner' (P9, 247-9).

The safe space paradox

'the good parent' (P4, 302) – 'that stalking person' (P1, 99)

The juxtaposition of the two quotations from P4 and P1 eloquently captures the problematic interface of the restorative and normative functions of supervision (Proctor, 1988). The restorative function was examined above and this property essentially focuses on the normative function, highlighting the challenge for supervisors in trying to manage the dual functions of the 'good parent' and 'that stalking person'. Previous sections have identified supervisors' efforts to create a supportive and 'safe' supervisory 'space' that would enable and encourage supervisees to bring their difficulties and setbacks (see the category ***Making Choices:*** *The Trust Paradox*). Understanding the nature of the 'space' is central to understanding the nature of supervision and participants made repeated reference to the importance of supervision being a 'safe' space for the supervisee:

'a safe place in which the supervisee can just go "whoomph!" You know, this very honest state. Certainly this is something I seem to have been able to establish, this safe place ... because the supervisee feels very safe, held, valued and encouraged' (P4, 290-1).

'I try to create a really safe space so people can bring their mistakes' (P9, 206).

A psychoanalytic view of the 'safe' space is rather different but still dependent on the supervisory space allowing the supervisee to feel able to bring difficult issues:

'I think there's a difference, isn't there, in that we provide a container. It might not feel safe but it is a container' (P7, 311) and she explained further:

'I don't want my clients or my supervisees necessarily to feel comfortable, I want them to grapple with things' (P7, 325-6).

Working with trainees presented particular challenges:

'not having too high expectations and not assuming knowledge that they might not have' (P2, 413) as this would:

'come across as critical and it would have stopped being a safe place and then people don't feel free ... safe to talk about what's not going well' (P2, 388-9) but finding a balance is essential:

'It's more important that I'm helping them to develop to be the best they can be than like me, but they do have to feel safe ... in supervision, so it's getting that balance' (P2, 554-6).

P5 also tried to find a balance:

'so that they can disclose – safe to disclose difficulties that they won't be punished for but supported to make the right decisions. So it's about empowerment and their autonomy and respect for their clinical judgement' (P5, 239-42).

Although there is an impetus to offer a 'safe' and 'contained' space in supervision for the supervisee, the earlier category ***Making Choices:*** *Leaving it to the Supervisee or Taking the Lead* demonstrated that supervisors responded quickly when they sensed risk issues. Again, there is a paradox. On the one hand, there is the goal of offering a safe space:

'a safe place to bring difficult feelings without fear of repercussion' (P4, 364).

On the other hand, there is the requirement to attend to client welfare and be alert to any ethical breaches on the part of the supervisee. If these occur, it is unlikely that the supervisor can realistically offer 'no repercussion' and must lead to supervisors feeling very conflicted. One participant had grappled with this role conflict and he expressed his struggle in these terms:

'you're being some sort of supportive semi therapist, and helping them to learn and then some kind of regulator. You know it's very complex' (P8, 358-9).

I asked him what the alternatives might be and he responded:

'Well, we just have to do it. It just seems to be part of it. Who else? There's nobody else who can actually comment on individual supervisees. The supervisor is the one who can say whether their therapy is good enough or not' (P8, 373-4).

Other participants expressed their relief that they had not been called upon to wrestle with this dilemma:

'I'm really lucky in that I haven't yet had any experience of anyone behaving in a way that I thought was hugely unethical' (P5 231 -6).

I followed this up in theoretical sampling with P9, to discover her view of these dual functions:

P9: Well, it can be tricky. I don't – touch wood, I haven't come across a huge problem with it because we both know that that's what we're there for' (P9, 264-5).

However, the following participant did have to follow up on an ethical issue with a supervisee and she notes how this changed the relationship:

'so our supervision did take on a completely different – because there was some policing – aspect to it. And it had to be done and thankfully, again I think the relationship really helped' (P6, 152-4).

Later in the interview, she too expresses relief that this has been the furthest she has needed to go and says:

'I've been lucky that I've never really had to, that I've never had to – never met really terrible, difficult therapists' (P6, 239-40). However, she did express her ability to meet the demands of this should it occur:

'I don't deny my responsibilities and I can quickly shoot there and be firm but I try and do that in the most Person Centred way as I can' (P6, 299-300).

Establishing clear lines of responsibility in the role is also difficult:

'[when a supervisee is] not directly unethical but certainly not entirely in line with what the overall procedures for the organisation are, I don't see it necessarily as my job to police that although again that's a somewhat difficult area around supervision because what is my responsibility to the person there?' (P5, 250-2).

Aspects of the normative function involves dual roles and the same participant described his experience as a supervisee with a supervisor, who has a dual role as manager and supervisor:

'they maintain a dual role so there's one part of them that's wanting to support you in your therapeutic role and another part of them that's saying you can't do any more work with that person, you've got to discharge them. So those two roles don't sit easily because that policing role and that clinical skills development role are quite inhibiting' (P5, 262-50).

Several participants had experience of the dual role of supervisor and tutor:

'I think it is about creating that kind of relationship where people can feel that they're not going to be penalised or judged for it. Although that's tricky when they're trainees and there is an element of judgement there' (P9, 213-8).

Report writing was a task requiring sensitivity in order not to rupture the supervisory relationship and there was some contradiction inherent in participants' responses (highlighted in bold) reflecting how difficult it is for supervisors to balance both functions:

'we both know that I'm going to be writing a yearly report and ***I say you can change it, you can put your views in there. And I don't mean they can change the content*** *but they can answer back if they think I'm completely wrong, but I think it's also a trick of trying to write really balanced reports and really focusing on people's strengths as well as challenge'* (P9, 269-71).

P12/FG commented that although the supervisor-tutor made the final judgement, the assessment provided the trainee-supervisee with an opportunity for growth and development:

'and ultimately ***we have this final decision about whether they pass or fail but I think even the way that we do that does offer them an opportunity to take some ownership*** *and some responsibility and to hear from their* peers' (P12/FG, 259-60).

P9 suggested that the professional integrity of the supervisee ameliorates the difficulty:

'there's an integrity to a lot of the therapists and counsellors ... they have done a lot of work on themselves ... so there is an openness to not seeing it as a conflict [being challenged in supervision], just recognising for how it is' (P9, 286-8).

Some participants referred to monitoring the supervisees' level of competence, particularly in relation to the supervisee's developmental stage and its impact on the supervisory work.

It was interesting to note that a supervisee's clients' outcomes were not used as a benchmark for measuring competence.

'Yes, so I do put a lot of emphasis on competence myself but not on assessing competence in a formal way ... that is a primary function for me of supervision; building competency but not assessing it or being responsible for it. I don't know, it's a funny distinction' (P2, 266-8). She also posed another difficulty regarding the supervisor's responsibility and supervisee competency:

'there could well be an ethical issue if they're completely incompetent ... if they were really incompetent and working as ethically as they could ... I don't know what I'd do with that ... I'd probably take that to supervision' (P2, 253-7).

These were difficult issues and not ones that participants found an answer for. A comment from another participant prompted me to consider an alternative interpretation of the 'safe' space and a way that brings the two functions together. P6 had summed up what her supervision meant to her and made the point that supervision was a safe place in that it monitored the ethical safety of her practice. Rather than suggesting that there will be no 'judgement' or 'repercussion', the more realistic interpretation of the safe space is that it is a place where the supervisee feels safe in the knowledge that his/her work is being evaluated and therefore is 'safe' to practice:

'a safe place to go and say this is me as a practitioner, have a look at me - so safe. It can be educative, it can be caring, it can be caring for me but I know my supervisor is also caring for the client. Am I, you know, doing what I say I'm doing' (P6, 540-1).

The above interpretation of the 'safe' place suggests rather that supervision is a 'safeguard' for practice, and that by keeping the client safe, the supervisee is kept 'safe' as a therapist. Although this may be a more realistic concept of the safe place, the data suggests that there is a deeper problem. Expecting supervisors to perform two potentially conflicting functions may be unrealistic and other solutions may be needed.

SUBCATEGORY: Managing the Supervisory Relationship

The supervisor-supervisee bond

Developing and maintaining a good working relationship with the supervisee was seen as crucial and, given the participants' dominant skill set is therapeutic, there were many examples of its application (see also the above property *A space to be nurtured)*:

'I kind of picked this up and what I did was take extra care - I just took extra care when I gave him feedback and I tried to do it on a more nurturing level than a critical level' (P3, 131-2).

Participants clearly wanted to develop a trusting relationship and conveying their sense of trust in the supervisee was a critical element:

'I think it feels like I'd be checking up. I've never gone to their work and checked up ... I've never gone behind their back and sat and looked at their work, ever' (P3, 179-81).

Building an equal relationship is important:

'You know that we're not here as the "expert" ... I really like the idea that we're co-creating something' (P7, 265-7).

There was evidence of the influence of the participants' therapeutic orientation in their approach to the supervisory relationship, demonstrated in the following example, where P4 emphasises how her Person Centred approach frames her supervisory relationships:

'it's different with every supervisee. I don't think any of my relationships with my supervisees are the same – they are very particular to the supervisee' (P4, 71-3).

Participants emphasised the need to engender trust in the supervisor:

'they have to have some kind of trust of the supervisor to do that' (P8, 192).

Not being trusted as a supervisor can have a deleterious effect:

' particularly if you've got a poor supervision relationship and someone doesn't really trust you and I can think of times I've felt extremely frustrated with supervisees and I don't think I've necessarily been particularly supportive towards them' (P5, 533-4).

Dealing with one's own frustrations with supervisees is also commented on by P2:

'there are times I feel frustrated at the same issues ... so it's hard sometimes to not be impatient and come across as critical, but I try to look at ... what's going on - there's something in the way here and do some personal development work' (P2, 556-8).

The depth of the supervisory relationship is often evident:

'the supervisory relationship is a complex one and a lot goes on beneath the surface' (P5, 528).

P6 described the closeness of the bond that develops in the supervisory relationship:

'very much in tune with that person' (P6, 83) and:

'I do really try to get quite close to my supervisees and get to understand them ... their rules, how they work, what bugs them, what irritates them and in an organisational setting looking out for, you know, the contaminations' (P6, 94-6).

She felt very moved in the interview as she recalled profound moments in supervision:

'[there] can be really profound moments ... it's when you see shifts either for the therapist or the - [leaves this in the air]. They are my greatest moments and I feel really emotional and [pauses] and I am feeling it while talking about it now, yes, very profound' (P6, 136-9).

The closeness of the relationship created a deeper faith in the supervisees and P6 suggested that dealing with a difficult ethical situation was easier because: *'I believed in the supervisee'* (P6, 154) though she admitted that the deep bond needed to be worked at:

'I don't always meet people and think "oh I really like you" and it might be sometimes I'll work with that' (P6, 431-2).

Another participant expressed her belief in her supervisees, placing faith in the meaning and strength of the supervisory bond:

'I've got some supervisees who I've never heard a recording [of] but I don't know why I feel confident with their practice. I suppose it's the feedback or the way they are in supervision which makes me trust them with their clients' (P3, 204-5).

The following extract demonstrates the depth of the relational bond:

'one of my supervisees said to me recently "it strikes me, [uses P4's name] that you know me better than anybody knows me" and I was quite startled to hear it. "You really know me" she said "and that is so important when I am then in with the clients. I go there having been understood and heard and that then supports me when I'm with my client"' (P4, 296–99).

She went on to describe how supervisees have internalised the person of the supervisor:

'I have heard supervisees say to me "oh I hear you on my shoulder" and "I find that very supporting" or "I find that very encouraging" or "I heard your voice say and that enabled me to do" and "that really helped" (P4, 292-4).

This is echoed by the following participant and is a reminder that supervisors can be a powerful influence on a supervisee:

'but I think there's something about the relationship I have with my particularly long term supervisee; the way they view me and my values and who I am in the world and who I am to them. I think ... I must impact on [them] ... because I've been influenced very much by my two supervisors in particular, very influenced ... so I think that I must somehow affect or impact some of my supervisees, that they must embody something of me, or my values' (P12/FG, 322-6).

'You know there are landmark supervisors who always seem to have been you know particularly powerful influence on me' (P5, 502-3).

The above extracts point to the relational depth of the supervisory alliance and this may lead to some unconscious fusing of the supervisee-client roles for the supervisor. There were a number of slips of the tongue (s-o-t), where the participant misspoke 'client' for 'supervisee' or misspoke a contextual reference, indicating some unconscious fusing of role:

'because I think it's very much client centred – [amends s-o-t] very much supervisee centred' (P1, 84).

'is this client (s-o-t) going to do harm' (P3, 218).

'as the therapeutic relationship(s-o-t) developed' (P3, 32-1).

'to move therapeutic practice – [amends s-o-t] supervision practice into ...' (P5, 432).

'I have also noticed that if my client – sorry if my supervisee' [amends s-o-t] (P6, 205).

'with a couple of private clients (s-o-t) (P7, 383-5).

'that's part of when I first see a client (s-o-t)' (P9, 164).

There is a potential for some tension within the interactional triadic matrix of supervisor-supervisee-client (e.g. Hawkins & Shohet, 2012; Page & Wosket, 2001), as the above references demonstrate. However, the following participants express a good degree of clarity regarding supervisory purpose in relation to the triadic matrix:

'the supervisee is as important as the client' (P6, 77).

'Yes, hopefully it [supervision] will have an impact on clients but really to support, you know, the three functions of supervision' (P11/FG, 3-4).

'My view is that you are responsible to your supervisee for giving them the very best supervision that you possibly can. My view is that you are not responsible to the client. (P4, 328-330).

A further factor explaining the close bond with the supervisee, may lie in the category ***Being a Professional:*** *Learning to be a Supervisor: Having faith in the therapeutic approach.* Participants' primary theoretical foundation derives from the therapeutic training, which is likely to have taken years, compared with the relatively short duration of supervision training. This might indicate an unconscious role preference, which leads to adopting a therapist-like stance in the supervisory relationship on an unconscious level.

THE CLIENT AT THE END OF IT ALL

The Client at the End of it All	
The Supervisor-Client Relationship	**Deliberating about Therapeutic Outcomes**
An indirect relationship ***The invisible clients***	***Finding the right language*** ***Measuring and monitoring therapeutic outcomes***

Figure 6. The Client at the end of it all

SUBCATEGORY: The Supervisor-Client Relationship

This subcategory contrasts the nature of the direct and close bond of the supervisor-supervisee relationship with the indirect 'one step removed' relationship with the client.

An indirect relationship

The following participant described the quality and nature of the supervisor-client relationship :

'I think, you know, as a practitioner you forge a relationship that can be ... quite charged ... I think part of being a supervisor is to pick that up that charge ... so that you can ground the practitioner in their emotional relationship with the client and ... I can't say I remember having any deep feelings about them [her supervisees' clients] – I can't remember thinking "oh I do worry about" - but if you asked me about clients I go "absolutely" and I'd remember it just in the moment ... I don't think I have the emotional investment or need to know ... because you have so many more. I mean you have one practitioner bringing maybe ten or twelve ... and you can't hold all those clients emotionally dear to you – you just don't have the emotional availability' (P1, 176-184).

The following interview extract also reflected some of the ambivalence in the supervisor-client relationship:

P6: I am definitely listening out for my client and when I say client I think I do mean that sometimes in supervision because the client is very important.

R: So do you mean the supervisee's client?

P6: Yes, because I know I did say mine but it does feel a bit like that as well, because especially if we're supervising students really early on, and sometimes I've supervised students who have just come off a counselling certificate and this is their first time of touching a client to this degree - and so my eye is definitely on the client, though as I've

said, I really do try to balance this with getting to know the supervisee because if I get to know the supervisee I can see the client' (P6, 86-93), and:

'I know we're all there for the client and ethical practice and professional practice but I'm very much in tune with that person [i.e. the supervisee] as well if there's anything going on with them' (P6, 81-2).

Participants emphasised the indirect quality of the relationship with the client:

'because there is one step removed ... you don't have the same bond or curiosity at some level' (P1, 174-5).

On the other hand, P8 expressed more of a sense of connection with the client, making the client's therapy a main focus:

'the supervisee's got their professional development and issues but ultimately that's - probably the main thing to my mind that the client's getting the right treatment' (P8, 338–42).

The traditional way of bringing the client to supervision is through the supervisee's narrative, which necessarily shapes the supervisor-client relationship, since the supervisor receives the client as a construct of the supervisee's experiencing:

'as a practitioner ... you bring that client to your supervisor but already there's that whole contamination - is too strong a word - but there's already the person filtering what they bring to you ... it's so muddy ... how do you sanitise that?' (P1, 135-7).

P9 acknowledges the importance of trying to get a good sense of the client:

'If you can get a really good sense of the client in the room then it's easier to see if their needs are being met through the therapy' (P9, 316).

Understanding the supervisee-client relationship through the medium of the supervisor-supervisee relationship was indirectly related to furthering the supervisor-client relationship by trying to understand the client's experience of the supervisee. This was achieved by forging a close relationship with the supervisee:

'there were some interpersonal issues [feedback from the supervisee's clients] and I'd found them myself and so I ... could understand why clients might feel some of this and I think that's why the relationship and getting close to your supervisees is so important' (P6, 154-6) and she picked this up again later:

'because if I'm noticing things about this supervisee ... if this was a client how would they manage that and you can raise that and talk about it' (P6, 241-3). She described a novel way of helping the supervisee to be more in tune with her/his clients:

'we've got a human being in the room ... you've just got to use this little prompt and say "now just tell me about Joe" I'm using this anonymous name – "just tell me about Joe"..... sometimes you just have to shift them – "do you remember what cardigan he was wearing"' (P6, 124-30).

P9 encouraged her supervisees to see the wider picture of their clients' lives outside the therapy room:

'helping them see that what their clients bring is what they are bringing to their therapy, it doesn't mean that that is how they are in the outside world ... it doesn't mean that they do that in their life outside all the time'(P9, 198-201).

Parallel process was named as a way of understanding the client's process:

'The process between me, the supervisee and the client ... if I can identify what's happening between me and the supervisee it parallels what they are doing to the client and by ... reflecting it back, it does wonders for the supervisee'' (P3, 97-9).

Bringing in video or audio recordings potentially brings the supervisor closer to the client and the following quotation is interesting as it captures the primary emphases for the supervisor which are supervisee development and client safety:

'if you've got the video recording then you can see if they're pretty ok with a client and if you've got the video recording you don't worry so much' (P3, 202-3).

P6 also reported using psychometric instruments to measure client progress and using them in supervision:

'there's like triangulation – because the client's in there as well' (P6, 490).

P7 however, is sceptical of the accuracy of self report measures:

'where clients often say, "well, we told you what we thought you wanted to hear. We couldn't tell you about how bad we felt and had we told you how bad we – you know, we couldn't do that"' (P7, 562-3).

The invisible clients

'and what about the invisible clients, you know' (P7, 396-7).

The above comment brought into sharp focus the fact that, in 'leaving it to the supervisee' to decide how to use the supervision session, the supervisor may never 'see' many of the supervisee's clients and participants reported having knowledge of their supervisees' caseloads to varying degrees:

'I don't have the full picture' (P2, 565).

'I never look at the big picture ... I can't carry that load. Basically they have to carry their own' (P3, 303-4).

'because it's like having lots of plates and ... that one's spinning quite nicely and that one's doing quite nicely but that one's about to wobble so I'll turn my attention here' (P1, 217-9).

The extent to which the supervisor has knowledge of the 'full picture' of the supervisee's practice and, in particular, the supervisee's clients' outcomes, is crucial in the context of understanding the relationship between supervision and TOs. Theoretical sampling was used to determine what this meant and identify supervisory purpose and intentionality more precisely. It emerged that what participants were focusing on was having the 'full picture' of the supervisee's practice, not a 'full picture' of the supervisee's clients' outcomes and this is a critical distinction.

Gaining information from supervisees about the numbers of clients in a caseload, overall workload or work contexts, provides the supervisor with a knowledge of the supervisee's practice, an indication of the supervisee's developmental level and competence, and an understanding of personal and professional well-being. It does not, however, equate to a clear knowledge of the supervisees' clients' TOs. The extent to which each participant manages this clearly varies but the similarity of intention was consistent:

'so the whole context is quite important actually' (P4, 189).

'so I might have got an overview' (P1, 309).

'More or less, more or less [knowing about the caseload]. I don't keep a really close eye on their case load' (P5, 180).

'[he] might have twenty clients and he might only bring three to supervision' (P3, 62-3).

During the interview, P7, experienced quite an 'identifying moment' (Charmaz, 2006, pp.59-60) in relation to this distinction. She had been talking about how she liked to know

fully about her supervisees' caseload but as she reflected, she became uncertain as to what this really meant:

'I have a need to know everything and I know I can't know everything so I'm just wondering how much this is – what do I actually really do?' (P7, 405-6).

As we saw earlier, supervisees tend to bring difficulties to supervision, *'a kind of squeaky wheel kind of phenomenon'* (P5, 222-3), so some participants asked their supervisees to bring examples of work they were pleased with to give a more balanced picture:

'if my supervisee is always bringing difficulties I will say what about your good work and let's negotiate that for next time' (P6, 205-6).

Participants pointed out the practical difficulties involved in having more than a general idea of the supervisee's caseload:

'I don't think you can do that [have detailed knowledge of TOs] with a huge case load (P9, 339).

'I'd need a different mechanism if I were to do that [have detailed knowledge of TOs]. (P2, 121) and added later that it is:

'not typically done to my mind' (P2, 143).

P9, however, routinely ensures that all clients in a caseload are given space in supervision, meaning that the phenomenon of 'invisible clients' did not occur, though this was not perceived as monitoring client outcomes:

'we would allocate at least quarter of an hour to each client and every so often we'd allocate at least three quarters of an hour. Most of my supervision sessions are an hour or an hour and a half, so probably every month or so, we might spend time going through one client in depth' (P9, 147-9).

On the other hand, P6 was a negative case in that she described a spreadsheet method she used:

'I've developed a ... spreadsheet, who they're working with now, diagnosis, when did I see them last, what session are they on now and I'll have it in front of us like this and ... they'll [supervisees] find that really useful' (P6, 256-8).

Not having the 'full picture' is at odds with the supervisors' intentions to prioritise client safety (see the category ***Making Choices:*** *Leaving it to the Supervisee or Taking the Lead*) and supervisors have to rely heavily on their ability to sense when something may be amiss.

'that sounds very woolly but something about - I would intuitively feel that something is being missed or something isn't happening' (P10, 224-5).

'I think once in a while I might just get a sense and that's how the supervisee is with me and I might think, " oh, do I have to be concerned about this person?" Yes, I'm trying to think how I've resolved this in the past' (P3, 207-8). At this point the participant gave an example of an incident where she had had concerns and concluded:

'But I didn't get the sense that he's going to hurt anybody' (P3, 215-6).

'I pick them up with a felt sense. It's a felt sense of concern in me and so I will bring that to the relationship' (P4, 200-1).

A crucial aspect to relying on empathic sensitivity for gauging concerns, is that supervisors need to be able to trust their own instincts:

'*you've got to trust yourself as well'* (P6, 241).

SUBCATEGORY: Deliberating about Therapeutic Outcomes

This subcategory presents the participants' perceptions of TOs, how they grappled to define the term and tried to make sense of how, where and by whom TOs were or should be measured and monitored.

Finding the right language

The term chosen to represent the client outcome was 'therapeutic outcome' (see PART B Introduction for a discussion of a definition). It was a term that created a good deal of debate and diverse linguistic interpretations were the result, clustered around therapeutic orientation. TOs were more readily defined by CBT orientated participants, as being closely related to the client's goals of therapy:

'working towards goals is working towards outcomes' (P2, 371).

'mainly in relation to patients' goals ... in terms of their therapy ... did they get what they were hoping for' (P8, 456-8).

Though different, P3 also found a straightforward definition:

‘*outcome is how long does it take for the patient to get better’* (P3, 404) and she refined it by adding:

‘reduction in distress and increase in quality of life and the shortest amount of time’ (P3, 409).

For others it was more complex and therefore more difficult to define:

‘it’s really hard to know from a supervisor’s – or even from a counsellor’s point of view – what these therapeutic outcomes actually are’ (P1 332–5) and there are:

‘millions of therapeutic outcomes because there are millions of clients’ (P1, 339-40).

The further along the relational spectrum, the more difficult the term became to define, becoming increasingly complex and elusive, making it:

‘it’s very tricky stuff ... I feel like a piece of work is finished when a client feels ready to go; when they can be themselves in the outside world the way they wanted to be’ (P9, 294, 301-3). She noted the way in which therapeutic approach colours the interpretation of TOs.

‘I think a lot of humanistic integrative therapists probably don’t think of it in terms of outcomes ... I don’t think it’s a familiar word to them so ... it’s really hard to know what a good outcome is because a good outcome might be things not getting worse’ (P9, 339-343).

This was confirmed by the following response from a humanistic practitioner when asked for a definition of a TO:

‘I don’t really know what that means ... I guess every session is a therapeutic outcome. So is that about being ... heard and witnessed in some way?’ (P10, 319-321).

I asked P9 if there was a different word or term she might use and her answer reflects the philosophical roots of her psychotherapy orientation as she ponders the question:

‘I don’t know. I mean ultimately, you see, I’d like everybody to feel ... comfortable with the people they are ... able to build good relationships ... but with some people those outcomes are not possible ... if we were into clinical psychology we’d be saying, “ok on a scale of 1 to 10 how anxious do you feel?” before the start and when we finish ... and in 6 months time ... which maybe we should do in psychotherapy, actually ... I think we should be more - more evidence based, and it probably has to be self reporting and it probably has to be done more than just when therapy finishes but along the line too’ (P9, 344-53).

P13/FG goes further when he says:

'I was thinking that fundamentally I don't really believe in outcomes ... I think that boils down to the notion of therapy as treatment versus therapy as meaning making. We can't determine the meaning making that people make out of therapy and that is a more fundamental aspect of counselling and psychotherapy than I see the treatment model' (P13/FG, 369-80).

On the other hand, he suggests that getting clients to describe what they want from therapy and what has changed in behavioural terms is:

'a useful way of helping people clarify things they want to achieve' (P13/FG, 381).

The emphasis on meaning making as being the essence of a TO is expressed in the following description of a positive TO:

'Client experience and client's ability to verbalise that experience ... yes, what has been good for them about their therapy' (P4, 261-3).

One participant cautioned against making too premature a judgement about the outcome of therapy:

'it might give us a snapshot of a place where it really hasn't ended, where it's still growing. It's that therapy doesn't just stop ... so where are we looking when we are thinking about outcomes? It's like it's not an end point you know' (P7, 587-8).

Two participants raised the following question:

'who defines the outcome?' (P9, 301).

'it's very difficult to know who defines the outcome' (P8, 294-7).

<u>*Measuring and monitoring therapeutic outcomes*</u>

The difficulty in defining a TO makes attempting to evaluate the impact of supervision on TOs a very complex business. One method of approaching this is a system of tracking the effects of supervisory interventions on the progress of therapy, which was absent in the data. However, a focus of some discussion in the interviews was how TOs are measured within clinical practice, and this combined with a discussion about the role supervision might have in monitoring supervisees' clients' TOs. There was a puzzling inconsistency relating to measuring TOs as one participant (P10) who had expressed uncertainty about defining TOs, also expressed familiarity with instruments of measurement:

'When you say outcome, I always think about being able to measure something' (P10, 322) and *'and I know that some of my supervisees use ... [naming a psychometric measure]'* (P10, 324).

The way in which measuring TOs was integrated into practice was again linked to the individual's therapeutic orientation:

'ultimately it is about how can we serve the client to live more effectively as far as they're concerned and it's about how do you measure that?' (P1, 144-5).

'that they know how to get support when they need it; and they are resourced enough ..... that they've got resources actually to fall back on if things go slightly wrong again. So those would be my good outcomes. How you would measure that? I don't know' (P9, 302-305).

'it makes me think of how difficult – how challenging - to measure therapeutic outcomes' (P4, 434-5).

Whilst there was a broad recognition of various ways of measuring TOs in clinical practice, the idea of monitoring, or keeping a record of them was more problematic and participants' responses suggested that this was an area that they had previously given little consideration. The following responses appear to suggest that not only is it an unfamiliar concept in supervision but it is equally so in clinical practice:

'Do we monitor our own outcomes? I do have a general sense of who's doing well, people making progress or not, but I don't have statistics of that, I don't have a record and I don't keep track of it' (P2, 182-3).

'[monitoring outcomes is] a very ad hoc business generally' (P1, 69).

I asked participants how much they knew about the TOs of their supervisees and responses indicated further uncertainty. One participant pointed out that a supervisee:

'could fail disastrously with that person and I wouldn't know unless they chose to bring it' (P2, 142-3).

Responses to questions about the possibility of supervisees bringing the TOs of their clients to supervision, in some form, or the possibility of monitoring TOs in supervision, reflected the fact that it was an unfamiliar and unconsidered notion:

'I don't know if there are expectations of me that I am monitoring all that' (P8, 394).

Overall, there was a sense of unease:

'It seems ... a bit draconian really to be kind of monitoring outcomes ... I suppose as part of a reflective process – maybe that's something I could be doing more and saying "once every quarter we're going to review all your clients ... and have a look at their scores" ... I guess it's about creating that sense of a shared project' (P5, 324-8) and he continued:

'But the bit of me that resists that ... doesn't want to police people too closely and I guess the fact that I frame that in terms of policing as opposed to framing it in terms of a joint learning opportunity perhaps makes that difficult' (P5, 331-2).

For P1 it did not fit at all with her concept of supervision:

'it doesn't feel like it's a very formal part of supervision' (P1, 112).

P4 was especially concerned that bringing the monitoring of TOs into the practice of supervision would have a serious adverse impact:

'your interview has raised the question of ... should supervision or could supervision have a role in monitoring therapeutic outcomes. I'm not sure what I think about that ... because I don't think it's helpful for potentially supervision to become a place of shaming people' (P4, 358-60) and she added later:

'we would become more towards the policing end and I think that would be to the real detriment of counselling supervision (P4, 401-2).

However, two participants had proffered alternative views suggesting a more collaborative way of monitoring outcomes within supervision. P5 (above) suggested the '*sense of a shared project'* (P5, 328) and P6 (above) described the spreadsheet she uses in supervision, charting supervisees' clients' progress and reported that supervisees found it '*really useful'* (P6, 258).

The fear of 'policing' within the profession was the strongest factor deterring any suggestions of monitoring TOs in supervision and resonates with some of the responses identified in connection with the normative function of supervision (see category ***Putting the Supervisee at the Centre:*** *The Supervisee's Space: The safe space paradox*).

FINDING CONNECTIONS AND MISSING LINKS

Figure 7. Finding Connections and Missing Links

SUBCATEGORY: Working out Responsibility

This subcategory draws together participants' perceptions of responsibility for TOs and connects with earlier themes of purpose and accountability. Participants grappled with defining boundaries of responsibilities, which necessarily included considering responsibility for client safety and supervisees' practice. The overall picture tends to be inconsistent with participants often oscillating between viewpoints as they express their doubts. A key issue was whether it is reasonable to be responsible for what you do not know nor have any intention of wanting to know.

The participants demonstrated greatest conviction in accepting responsibility for supervisees' professional practice and all shared the view that they were responsible to and for the supervisee to varying degrees. One participant was unequivocal about this:

'My view is that you are responsible to your supervisee for giving them the very best supervision that you possibly can. That means that if you do see that they are doing something that is unethical or questionable that you state it and you work with it and you keep working with it whilst the concern remains' (P4, 328-330).

Others expressed a general responsibility for the supervisee's practice and development:

'you as a supervisor adopt responsibility for good practice [of the supervisee]' (P1, 98-9).

'they are in supervision to improve competency so I'd take some responsibility for that development [of the supervisee]' (P2, 258).

Responsibility for the supervisee's ethical practice was the most often stated area of responsibility and participants saw this as a primary responsibility:

'I do see that as a responsibility ... [recounts an example] ... he left me, as a result of it, but I just thought I'm just not comfortable working with you unless you are addressing some very specific issues' (P9, 239-41).

Participants also expressed some degree of clarity about what they did not feel responsible for:

'I don't take responsibility for what they don't bring to supervision' (P3, 92-3).

'My view is that you are not responsible to the client. The supervisee is responsible to the client and the supervisee is responsible for what they do with the supervision that you offer - or don't do with the supervision and that that responsibility stays with them' (P4, 330-1) and later she concluded:

'I don't think I can be responsible for what the counsellor does with the client' (P4, 379).

Taking responsibility for TOs was a complex issue. Participants were trying to make sense of taking responsibility for client safety and supervisees' 'ethical' practice, for supervisee competence and development and yet clearly seeing inconsistencies in having any responsibility for TOs. The next two quotations from P2 capture participants' indecision:

'how responsible can we be for outcomes, given we don't have direct contact with the clients? [we] only[know] second hand what they [supervisees] choose to bring, and that's making me think as we're talking you can only assume so much responsibility. It doesn't make sense to assume more than that because you wouldn't have the evidence to back it up. I think you'd be overstepping boundaries of the role to try to take that on board' (P2, 395-400). Later in the interview I asked her to summarise her views and she responded:

'That's one we kind of talked about, didn't we – what did I say before? I don't know. Not very, not very technically but, yeah, I guess that I don't feel I am responsible but I think it's part of my role. So it's a contradiction that – it really is a contradiction' (P2, 561-64).

Other participants reflected on the dilemma of where the parameters of responsibility lay for the supervisor:

'I know they've got a caseload of this many and they haven't brought Sally or they haven't brought John for several months and I know there was an issue about that so there might be a responsibility from the supervisor's point of view to sort of maybe wonder and ask 'you haven't presented and how are things there?' (P1, 92-5).

'Well, I guess you can't know everything if you're not told. So I think – if the supervisor were negligent or had themselves concealed something or clearly colluded in supervision then they would share responsibility ... but it is a complicated situation' (P5, 287-90).

'Well if they've [supervisees] got a client that's really in a difficult place and they don't bring it they take responsibility for that. I don't take responsibility. (P3, 92–93) and she developed this later:

'I don't feel responsible for the outcomes. As long as I'm doing a reasonably good job I don't feel responsible and ... I treat my supervisees the same' (P3, 188-90).

Participants gave clients some responsibility for the outcome of therapy:

'*we do expect clients to be proactive towards change'* (P2, 343-4).

'But then I do think that responsibility for outcome ... has to lie with the client' (P11/FG, 321).

Sharing responsibility within the supervisor-supervisee-client triad was suggested:

'I think directly they are the three [i.e. responsible] - client, supervisee, supervisor' (P3, 269).

'Ultimately it lies with the client, then the therapist, then the supervisor. I'd probably put it like that. And then if there's an organisation, I'd put that on the outside, probably a bit like concentric circles' (P9, 380-1).

One participant also pointed out that trainers or training establishments should take some responsibility:

'I do think that the trainers have responsibility for the supervisee's outcomes' (P3, 259).

SUBCATEGORY: Trying to Make Sense of it All

This subcategory presents participants' explanations of the connections between supervision and their supervisees' clients' outcomes. Since none of the participants indicated that they had considered this relationship prior to the interview, there was a good deal of reflection on the subject during the interview. The participants' accounts of their perceptions reflect the fundamental complexity of the relationship between supervision and TOs. The following are examples of participants' reflections:

'I've not really thought about that specific outcome, and how do we measure it, how do we find out about it' (P6, 405-6).

'Well my own view is that again supervision has a part to play and again it's unquantifiable ... I don't measure it ... I suppose it's more fantasy that it does do so [contribute to the client's outcome]' (P4, 271-5).

'Not knowing' how supervision related to TOs was a recurring theme throughout the data as stated by these participants:

'I don't have a clue. It'd be nice to think it made a difference' (P2, 284) and she continued later:

'I don't know that there is [a relationship between supervision and TOs] and my guess is that there isn't. Yes, my guess is that there isn't' (P2, 453-7).

'if I reflect on my experiences as a supervisee, if I've gone and done things differently as a result of supervision, or think I have ... I wonder how much, you see. It's really difficult to know how much that genuinely actually contributes' (P5, 384-6).

Some believed that supervision did have an effect but were unsure what this effect was or how it occurred:

'it would be difficult to say if it did or it didn't but I feel confident that it must have because what could have happened if I didn't have that supervision and that new insight? Well, it's a bit difficult to say what could have happened because it's a tough one because I might have needed to monitor it but it just seemed to work' (P6, 358-60).

'I don't know a similar body of research that demonstrates whether supervision has any direct effect on client outcomes. I suspect not. Actually, really, fundamentally ... You might see some difference in the outcomes of the therapists – you know, how soon they burn out' (P5, 353-8).

'That's an interesting question. Does my own practice influence the therapeutic outcomes of my own supervisees? Yes, it's bound to. No, I don't know, it should but I don't know' (P2, 506-7).

P10 typified the general uncertainty in response to the question 'what relationship, if any, do you see between supervision and a therapeutic outcome?':

'I do see a relationship. I would hope that it is a supportive relationship and I suppose that the parallel process around what's happening for the client and then the relationship with the client and the supervisee and then there's me and so that brings in the 7 eyed model, I mean that's general practice. Sorry, I don't know if I answered it then' (P10, 343-7).

Participants offered examples of where they perceived a direct connection with a supervisory intervention and its implementation in the supervisee-client process:

'For example when we're being more specific like helping people to use particular models ... and I might say but this works and get a research paper out and say, "so apply this"' (P6, 329-31).

'I think there will be those instances in which those supervisees leave supervision with greater clarity about the formulation, the direction of therapy, the types of intervention they use, and will therefore leave here and go and do something different with their client as a result of the supervision they've received. So the assumption I'm making is that there will be a behaviour change and in the absence of supervision they would have continued to do something that wasn't particularly necessarily working whereas they will go out and try something different' (P5, 363-6).

In the following example, P6 surmised that giving feedback after listening to an audio recording of a supervisee's therapy session, would have had an impact:

'I'm sure that must have helped ... and I said "you could be really honest with the client and say... when I went to supervision, I noticed that" and I think that would have an overall effect as well. I think' (P6, 383-86).

In a return to faith in one's therapeutic approach, participants found direct connections in the relationship between supervision and TOs:

'Yes, working towards goals is working towards outcome' (P2, 371).

'if I ensure that their therapeutic practice is according to what the empirical evidence says I'm thinking I can influence therapeutic outcomes ... if they get really good at it there must be better outcomes, so that teaching part, I do feel I've got a big input in outcomes' (P3 379-82).

'wiping the mirror clean so the therapist can be the mirror and it's not all splodgy with their own stuff ... that's part of my job ... helping them see the transference and the counter-transference' (P9, 397-9).

P4 referred to verbal feedback from supervisees to support the impression that supervision contributed to therapeutic process:

'occasionally I get back from supervisees "oh I did this and as a result of this we did that", "that really worked" or "that didn't" ... so you do get something, some feedback as to how it may have helped the process between counsellor and client and therefore how it's helped the therapeutic outcome' (P4, 275-8).

The major way in which supervision was perceived to impact on client outcomes was by supporting the supervisee or developing the supervisee's practice:

'It's kind of mediated I suppose by other processes ... therapists' enthusiasm for their work, for example' (P5, 446).

'I see supervisory function as a place to support best practice which does equate to good outcomes' (P2, 174).

P4 felt strongly about the issue and returned to it again later in the interview and the following extract draws together many of the themes within the data:

'the way it adds value to therapeutic outcome is all those indirect ways that we were talking about earlier ... supervision offers is a very developmental space for the counsellor ... to grow and it is only by the counsellor growing and developing in their therapeutic practice that they are going to be offering better and better and better practice that will have better and better therapeutic outcomes' (P4, 401-412).

In conclusion, the participants' overriding conclusion was that supervision contributes to and has an effect on TOs in indirect ways, as summed up by the following participant:

'do I think my supervision helps their clients? Yes, I do. I think it helps them be better therapists for their clients. Does my supervision make client's outcome better? ... It does it ***through a step*** *because my job is to make sure they are doing really good psychotherapy or counselling and if they are doing really good psychotherapy and counselling, it means their clients' outcomes are better'* (P9, 460-3).

Summary

The above quotation is a fair representation of the consensus conclusion reached by the participants regarding the relationship between supervision and TOS. However, as the above extracts from the transcripts demonstrate, it was a conclusion reached after a good deal of grappling with issues previously unconsidered in the context of supervision - as one participant put it *'thinking on my feet'* (P1, 21). Thinking things through in the interview gave the responses a quality of freshness and authenticity, appropriate when investigating unfamiliar concepts.

The participants' strong sense of commitment to professional principles, honed by their years of supervisory practice, contrasted sharply with those moments of being confounded as they tried to make connections. Trying to make sense of the relationship between supervision and TOs was a pervading theme throughout the data and the following

explanatory model captures this process, demonstrating the relationships between the categories, sub categories and their properties.

EXPLANATORY MODEL

Supervisors' Perceptions of the Relationship between Supervision and Therapeutic Outcomes

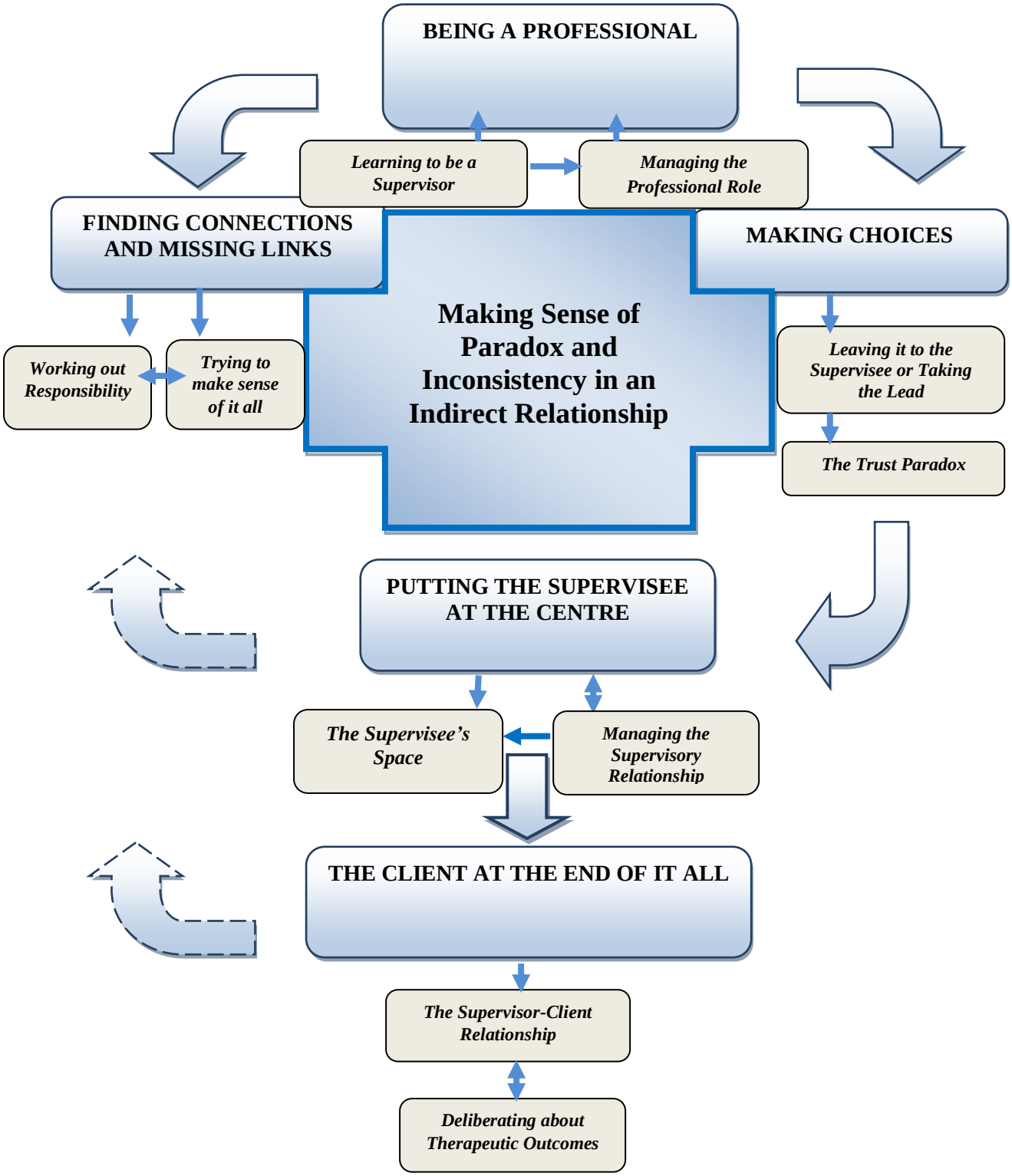

Figure 8. Explanatory Model of the Relationship between Supervision and Therapeutic Outcomes

DISCUSSION

Introduction

The aim of the study was to develop an explanatory theory of supervisors' perceptions of the relationship between supervision and TOs using a constructivist version of Grounded Theory. This section presents a conceptualisation of the emergent theory of this relationship based on supervisors' perceptions and describes how the theory developed, together with an explanation of the meaning of the key factors impacting on this relationship. In developing a meaningful and useful theory of the relationship between supervision and TOs, I hope that it will have a practical applicability for counselling psychologists and be of value to supervisors, to supervisees and ultimately our clients. To this end, recommendations for practice and for supervision training are proposed in this section. The findings are reviewed and connections are made to the literature on the relationship between supervision and TOs, identifying how this study contributes to the research base in this area. The study is evaluated and standards of trustworthiness are examined. The section concludes with methodological and personal reflections on the research process.

Overview of the Findings

The findings from this study highlight the complex issues relating to the relationship between supervision and TOs, reflecting Inman and Ladany's (2008) conclusion that the relationship is difficult to measure because of its complexity. A key finding was that a relationship between supervision and TOs is not part of a supervisor's frame of reference in supervision practice. Instead, the supervisor focuses on supporting the supervisee and enhancing the supervisee's professional practice, as well as, additionally, prioritising client safety. An absence of focus on client outcome was apparent in numerous ways, such as the absence of following up on clients brought to supervision and the distinction between having an overview of the supervisee's practice though not having a specific awareness of the supervisee's clients' outcomes. The lack of focus on client outcomes led to difficulty in defining the relationship between supervision and TOs, as well as difficulty in defining parameters of responsibility for TOs.

A key factor was the continued dominance of the supervisor's therapeutic orientation in providing a theoretical base for the practice of supervision, as well as the continued reliance on learning from the experience of being supervised. Training in psychological therapy overshadowed supervisor training just as the therapy model overshadowed a supervision

model, suggesting the picture remains similar to what it was thirty years ago (e.g. Baranchok & Kunkel, 1990; Bernard, 1981; Bernard & Goodyear, 2009; Drapela, 1985; Hess, 1987; Loganbill & Hardy, 1983). The reliance on therapeutic orientation was far reaching, and an important feature was how this influenced the individual's interpretation of the term 'therapeutic outcome' (TO).

A number of other factors impacted on the relationship between supervision and TOs such as attempting to reconcile 'trusting' the supervisee with issues of non-disclosure and balancing the restorative and normative functions of supervision.

The Core Connecting Category: Making Sense of Paradox and Inconsistency in an Indirect Relationship

One participant reflected that a relationship between supervision and TOs was *'almost not part of the paradigm'* of supervision (P1, 196). Fundamentally, this set the tone for the research findings, as participants sought to make sense of the relationship, which did not appear to fit with their frame of reference for the practice of supervision. The literature reflects a similar sense of disconnection and confusion. The empirical base demonstrating how supervision influences TOs in the psychological therapies is sparse (Roth & Pilling, 2008; Watkins, 2011b) and generally methodologically problematic (e.g. Ellis & Ladany, 1997; Freitas, 2002; Inman & Ladany, 2008; Watkins, 2011b; Wheeler & Richards, 2007a, 2007b).

Mirroring the empirical base, there was an observable absence of any explicit understanding of whether or how supervision influenced TOs and no indication that the participants had previously considered this relationship in relation to their supervision practice. Furthermore, inconsistencies emerged such as participants having a tacit awareness of supervisee non-disclosure and yet expressing that they 'trusted' supervisees to bring what they needed to supervision and 'leaving it to the supervisee'. Another anomaly was the active prioritising of the issue of client welfare, yet by 'leaving it to the supervisee' to bring concerns it emerged that participants did not consistently have the 'full picture' of a supervisee's practice, leading to some clients being 'invisible'. It also meant that supervisors needed to rely on empathic sensitivity to discern potential problems or shortcomings.

Reflecting on what these inconsistencies and paradoxes meant, together with the absence of focus on TOs, led to a turning point in the research (see below *Reflections on the Research Process*) pointing the inquiry in the direction of discovering what participants prioritised in supervision practice and identifying supervisors' active frame of reference. Participants were professionally aware, attending to the tasks of supervision such as contracting,

boundary issues and note-taking, and actively alert to risks to client welfare. In addition, they prized the relationship with the supervisee and placed the supervisee's professional development at the centre of supervisory practice. This latter priority proved to be the key to identifying supervisors' underlying sense of purpose in that serving the supervisee, whose role was to serve the client, emerged as a primary purpose of supervision, and this was a crucial insight. Since supervisory focus lay in this direction, it went a long way towards explaining the struggles that participants were experiencing in articulating the relationship between supervision and TOs, which was indirect and predominantly viewed through the prism of the supervisee's practice, making it more difficult to discern.

Although this went a long way towards explaining participants' difficulties in making sense of it, there were other confounding factors. For example, interpreting the term 'therapeutic outcome' was problematic and eventually it emerged that the interpretation was founded on the theoretical base of the participant's therapeutic orientation. This, in turn, led to exploring how therapeutic orientation influenced the implementation of supervisory practice.

A further confounding factor lay in the implementation of the three functions of supervision, restorative, normative and formative, as conceptualised by Proctor (1988). The restorative function is a good fit for experienced psychological therapists, who are able to bring a significant battery of therapeutic skills to the supervisory relationship (Borders, 2005). The normative function calls upon the supervisor to adopt a 'quality control' persona and there is potential for conflict for the supervisor in managing these two functions (O'Donovan et al., 2011). Client welfare was clearly a high priority for the participants but some participants voiced their anxieties about being called upon to take action and enforce measures that would safeguard the client but conflict with a trusting and holding supervisory relationship. These were the key factors leading to the paradoxes and inconsistencies with which participants grappled.

The final process of making sense of the relationship between supervision and TOs involved reflecting on parameters of supervisory responsibility for the TO within the triadic matrix of supervisor-supervisee-client. Several direct connections between supervision and TOs were identified but the overall conclusion was that supervision indirectly influenced TOs, and achieved this through the agency of improving the supervisee's skills, professional development and competence.

The factors captured in the core category provided the framework for conceptualising the emergent theory, which is represented diagrammatically in Fig. 9 below. It demonstrates that the direct relationship is between supervisor and supervisee, with the indirect relationship with the client filtered through and by the supervisee. The indirect supervisor-

client relationship mirrors the indirect relationship between supervision and TOs. The overall conclusion was that the supervisor indirectly influences TOs by enabling the supervisee to become a better therapist. The theoretical model captures the nature of the relationship between supervision and TOs along with the salient factors that impact on the relationship:

- Developing a professional framework for supervision practice (including therapeutic orientation, supervision training, the implementation of ethical practice)
- Supervisee-centred supervision (i.e. the placing of the supervisee at the centre of the supervision process) leads to issues such as those involved in the triadic relationship, trust and non-disclosure and supervisee-centred evaluation
- Finding a common language for 'therapeutic outcome' or the benefit derived by the client from the therapy.

The theory, together with the key factors, is described in the following sections.

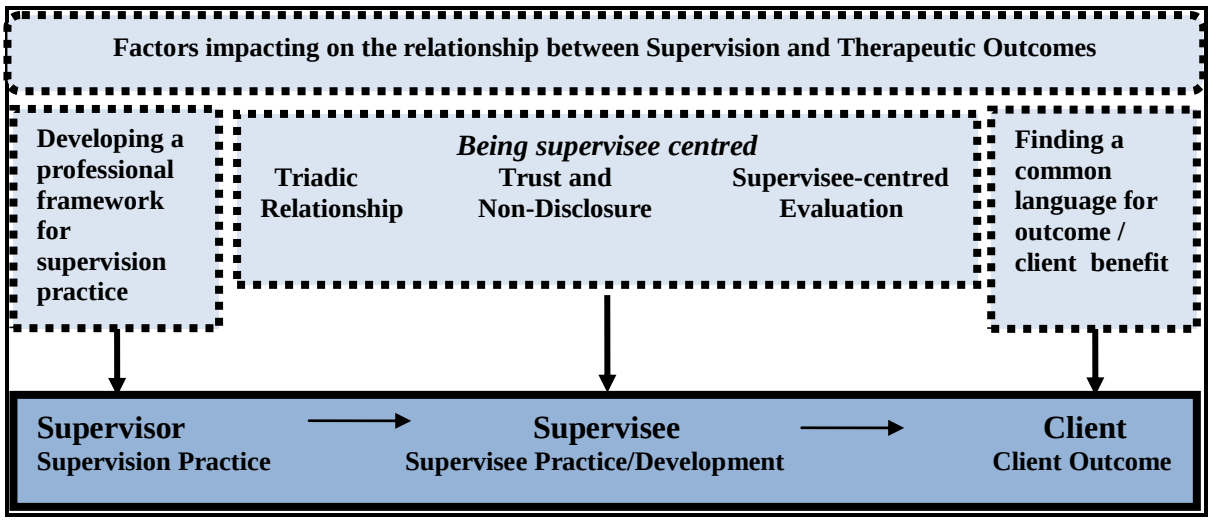

Figure 9. Theoretical Model of the Relationship between Supervision and Therapeutic Outcomes

Developing a Professional Framework for Supervision Practice

As far back as 1981 Bernard (Bernard, 1981) regretted the fact that supervisors had to rely too heavily on their psychotherapy training to inform their supervision practice and Ladany et al. (2005) point out that therapy and supervision are different activities and therefore require different theoretical bases. More recently, Watkins (2011a) suggests that supervisors have now come to rely less on their therapeutic model and more on models of supervision. The findings in this study, however, suggest that supervisors may still be adhering to their

therapeutic orientation as their chief learning base for supervision practice and this is more in line with the earlier literature of the 1980s and 1990s (e.g. Baranchok & Kunkel, 1990; Bernard, 1981; Drapela, 1985; Hess, 1987; Loganbill & Hardy, 1983). Participants demonstrated a strong faith in their therapeutic orientation, amounting to a personal worldview guiding professional practice, and it had an extensive and pervading influence on participants' approach to supervision and their perceptions of the relationship between supervision and TOs.

In contrast, supervisor training and supervisor models appeared to have a limited influence, being overshadowed by the participant's reliance on therapeutic orientation. A reason for this could be the contrast in the investment (personal, temporal and material) between therapeutic training and supervisor training. Therapeutic training is likely to occur over several years, either full time or part time, and it will often include personal therapy, which may also lead to fundamental intrapersonal and interpersonal change. Immersion in the chosen theoretical orientation continues across the many years of a professional lifetime, with clinical practice, supervision and continuous professional development. Supervisor training is more likely to be short term, over several days or weeks although there are longer, certified courses available (see PART D Critical Literature Review) and so the impact of the supervisor's therapeutic orientation should not be underestimated.

The strong belief in therapeutic orientation meant that psychotherapy-based models of supervision were most commonly used, although these were often only loosely applied. However, all participants employed a developmental approach to some degree, despite the continued lack of an empirical base (Bernard, 2005).

The implicit emphasis on the supervisor's therapeutic orientation was a key factor in how the term 'therapeutic outcome' was understood and, consequently, is a significant factor in the emergent theory of the relationship between supervision and TOs. The findings suggest that the interpretation of the 'therapeutic outcome' or more broadly, the benefit the client derives from therapy, is determined by the supervisor's therapeutic orientation, and that this is understood on a tacit, rather than explicit, level. This has important implications for the efficacy of the supervision work and its impact on client outcome, especially where supervisor and supervisee work from different orientations or disciplines. The recommendation is that an explicit dialogue should take place to establish mutual definitions and underpinning philosophies in order to make best use of the supervision work.

A further influence on 'learning to be a supervisor' was the experience of being supervised, where participants drew on both good and bad experiences of being supervised in developing their own practice. This raises some concerns in that it limits the integration of

empirical developments in supervisory practice (Worthington, 1987) and ties the supervisor to a relatively narrow theoretical base (Holloway, 1995). It also raises two other points: firstly, there is an assumption that what works well for one individual will necessarily be as effective for another and secondly, what a supervisee likes in supervision is not necessarily synonymous with effective supervision (Radcliffe & Milne, 2010).

Although participants largely drew on their therapeutic orientation for a theoretical base, nevertheless implementing professional tasks with diligence and commitment was a high priority of the supervisory role. Participants routinely accessed professional structures of support, seeking regular supervision for their supervision practice and placing a high value on finding support for therapeutic and supervision practice. However, some participants criticised the requirement for regular mandatory supervision for qualified and experienced practitioners by some professional organisations (e.g. BABCP; BACP; DCoP) as being too rigid, preferring instead to access support when it was needed rather than arbitrarily mandated. This indicates that more research in this area would be useful and especially in relation to identifying the differing needs of experienced and trainee therapists (e.g. Page & Wosket, 2001; Wheeler & Richards, 2007a, 2007b).

The lack of external accountability, in private practice especially, was highlighted, indicating the need for further research relating to accountability and context. In addition, further inquiry into parameters of supervisory responsibility is needed, particularly with regard to TOs. The findings showed a lack of clarity in this regard, with participants vacillating between some certainty, not knowing and surmising. All participants agreed that supervisors were responsible for delivering competent supervision, for supervisees' professional development and for monitoring supervisees' 'ethical' practice. However, there was a large degree of uncertainty around parameters of responsibility for TOs, which was complicated further by problems with defining the term. The extent of the supervisor's knowledge of a supervisee's clients' outcomes emerged as the guiding principle in deciding supervisor responsibility for TOs. Participants acknowledged that, although they were likely to have a general overview of the supervisee's caseload, they did not have the full picture of the supervisee's clients' outcomes, so could not take responsibility for them. One participant (P4) was very insistent that a supervisor is responsible only to the supervisee and not the client, and it is the supervisee who is responsible to the client. P9 suggested a model of shared responsibility for TOs:

'Ultimately it lies with the client, then the therapist, then the supervisor ..... if there's an organisation, I'd put that on the outside, ... like concentric circles' (P9, 380-1).

Whilst uncertainty regarding areas of responsibility exists, there is a risk that clients' welfare is equally uncertain.

Being Supervisee-Centred

Borders (1993) advised that in order to acquire the role of supervisor, therapists should shift from a client-centred to a supervisee-centred position and her suggestion is widely reflected in current supervisory practice. Essentially the supervisor defines the supervision space (e.g. Omand, 2010) creating a supervisory environment that will enhance a supervisee's professional development and support him/her in delivering 'best' practice. A strong message from the participants throughout the data was that the supervision space 'belonged' to the supervisee and the notion of the nursing triad (Casement, 1985; Hawkins & Shohet, 2012; Winnicott, 1958) underpinned the triadic relationship. Choices made in supervision were based on this premise insofar as the supervisor attended to the supervisee who, in turn, attended to the client. The following sections explore the implications (both strengths and difficulties) of placing the supervisee at the centre of the process, raising the question of whether a re-balancing of supervisee-centred and client-centred is needed.

The Triadic Relationship

The supervisor-supervisee relationship

Proctor's (1988) functional model of supervision serves as a useful framework for examining how the supervisory relationship works in practice. All three functions (formative, restorative, normative) were evident in the supervisory practice of all participants and present in each of the interviews even where they were not directly named. Supervision has been called the 'signature pedagogy' (Bernard & Goodyear, 2009) of professional psychology and all participants integrated elements of the formative function into their supervisory practice, according to the tenets of their therapeutic orientation.

In implementing the restorative function of supervision, where the supervisee is 'nurtured', the supervisor is able to draw on therapeutic skills (Bernard & Goodyear, 2009; Hoffman et al., 2005). There was agreement that this supportive function of supervision was an important central element in supervision provision.

The normative function proved to be more challenging and, in particular, the tension inherent in the relationship between the restorative and normative functions of supervision, which participants defined respectively as being *'the good parent'* (P4, 302) or *'that stalking person'* (P1, 99). In effect, the supervisor is trying to balance the restorative and the normative functions of supervision, and participants expressed relief that they had not been

called upon to act in the 'gatekeeper' (Holloway, 1995) role. O'Donovan et al. (2011) suggest that supervisors attempt to address the challenge of the normative function by being lenient in their feedback. One participant (P2) pointed out the risk of the supervisor giving the supervisee a false sense of confidence by giving lenient feedback. This concern is emphasised by Gonsalvez and Freestone (2007) who point out that providing lenient feedback not only potentially damages the client but also hinders supervisee development.

Other research has shown that supervisors tend towards leniency (Karpenko & Gidycz, 2012) and are swayed by the quality of the relationship with the supervisee (e.g. Steward et al., 2001; Turban et al., 1990). O'Donovan et al. (2011) suggest that the supervisor's responsibility for the normative function of supervision is at the root of supervisee non-disclosure as this is how supervisees resolve the problem for themselves. They suggest that the role should be split, taking away the evaluating role and leaving the supervisor with the restorative function, but P8 (373-4) accurately pointed out that supervisors are uniquely qualified, by their intimate knowledge of the supervisee's practice, to comment on the supervisee's ethical and competent functioning.

The tension between these two functions emerged in explorations of the supervision environment, or the 'supervisee's space'. In terms of defining this 'space', supervisors valued the notion of supervision offering a 'safe' space, and participants explored what it meant for them. P7 and P6 offered slightly different definitions to other participants. P7 suggested that it meant a space *'contained'* enough to enable the supervisee to *'grapple with things'* (P7, 326). P4's definition was a space *'without fear of repercussion'* (P4, 364), and this phrase alerted me to the difficulties that supervisors were struggling with, leading to my formulation of 'the safe space paradox'. On the one hand, supervisors were striving to create a trusting and supportive environment for the supervisee and the supervision work and, on the other hand, carrying the responsibility of the 'gatekeeper' (Holloway, 1995) role. While the supervisor is taking responsibility for the supervisee's 'ethical' practice and guarding against risk to client welfare, it is difficult to see how supervision can be a 'safe' place with no 'repercussion' for the supervisee.

In the light of the findings and the supporting literature, a more realistic rendering of the supervision 'space' needs to be considered, taking into account these dual supervisory functions. P6 described her own supervision as a 'safe place to go' (P6, 540) but went on to say that she valued supervision as an opportunity for her supervisor to observe if she was doing *'what I say I am doing'* (P6, 541). This suggested that she used the space as a 'safeguard' and this is a conceptualisation of the 'safe' space that could usefully be developed further.

Developing the supervisory relationship was important for all participants, across all therapeutic orientations and the findings are supported by the literature, which identifies the quality of the supervisory relationship as a key factor in effective supervision (e.g. Bernard, 2005). An illuminating feature of the nature of the supervisor-supervisee relationship was the number of slips of the tongue that occurred, where the participant misspoke 'client' for 'supervisee'. This indicated a tendency towards supervisor-therapist and supervisee-client role fusion, which has the potential for creating collusion between supervisor and supervisee and may partly account for leniency of supervisor feedback as noted above. It also has implications for the supervisor-client relationship since the closeness of the supervisory bond, fuelled by role fusion, has the capacity to create further distance in the indirect supervisor-client relationship, with the potential for torn loyalties on the part of the supervisor and detracting the supervisor's attention from the client.

The supervisor-client relationship

The diagrammatic theoretical model (Fig. 9) shows that the supervisor-client relationship is inevitably negotiated via the supervisee-client relationship and the study explored key elements of the supervisor-client relationship. The supervision outcome literature questions whether the primary focus of supervision should be supervisee development or client welfare (e.g. Holloway & Carroll, 1996; Omand, 2010; Page & Wosket, 2001; Vallance, 2004; Wheeler & Richards, 2007a,). The findings suggest that participants placed a high priority on both these functions, by placing the supervisee at the centre of supervision practice and by following up on any concerns about client welfare.

Supervisors appeared not to hesitate to 'take the lead' where they had concerns about client safety or 'ethical' issues, and this is supported by the literature identifying addressing risk issues or potential breaches in ethical practice being primary tasks for the supervisor (e.g. Omand, 2010; Vallance, 2004). Participants indicated that despite the fact that supervision was for the 'supervisee's benefit', they would not hesitate to pursue such issues in order to protect the client. An incidental issue to emerge in this respect, was the supervisors' reliance on empathic antennae or 'sensing' concerns regarding client welfare or supervisee practice, including non-disclosure (see below). Although supervisors are generally experienced clinicians, with a highly developed capacity for insight and empathy, it may be helpful to consider having more robust structures for supporting supervisors in this task, and this could be an area for further research.

Further issues emerged with regard to client welfare. Participants were aware, to varying degrees, of the overall caseloads of their supervisees and one participant (P4) was attentive to the spread of her supervisees' workplaces, including non-therapy workplaces, in order to

monitor workload and supervisee wellbeing. A number of participants pointed out that they tried to get a balanced overview of their supervisees' practice by asking for examples of good work as well as difficulties in the work.

This was a key indicator that supervisors' focus in attending to supervisee caseload was the supervisee's personal wellbeing and professional practice. This is significantly different from having knowledge of the supervisees' clients' outcomes and is crucial to understanding the relationship between supervision and TOs. Not having the 'full picture' also impacts on client welfare, since some clients are 'invisible' (P7, 397) and another participant (P2, 142) pointed out a supervisee could *'fail disastrously with that person'* and she would only know if the supervisee chose to bring the work. This raises serious questions for the system of supervision as a 'gatekeeping' function as well as raising concerns for the heavy demands and unrealistically high expectations placed on supervisors.

In terms of negotiating the supervisor-client relationship via the supervisee, research shows that therapists are often inaccurate in evaluating client progress (Hatfield et al., 2010; Lambert, 2010), overestimating progress and underestimating deterioration (Grove et al., 2000; Worthen & Lambert, 2007). Despite this, the findings indicate that supervisors still tend to rely on supervisee verbal report although there were variations across the participant sample, such as P7 using written reports and others using audio or video recordings (P2, P3, P5, P6). It is interesting to note that again this shows a clustering of therapeutic orientation with the psychoanalytic and cognitive behavioural orientations being the ones using the alternatives. These orientations were also less likely to work with supervisees from other therapeutic orientations. A further 'quality control' point on the issue of recordings is that it is generally supervisees who choose the work they bring to supervision, so there is scope for covert non-disclosure in the choosing of recordings. A useful research project would be investigating how supervisees choose which recordings to take to supervision.

Trust and Non-Disclosure

A significant consequence of being supervisee-centred is that the supervisee is encouraged to choose how to use the supervision session, and this was strongly indicated throughout the findings. Asking participants to describe a typical supervision session revealed the common practice of leaving it to the supervisee to choose how the session would be used. This proved to be a key indicator of supervisory purpose, contributing to the conclusion that the supervisee is placed at the centre of the supervision frame.

Supervisors chose not to have a strong directive presence within the supervisor-supervisee dyad, indicating that they 'trusted' supervisees to bring difficulties when needed. However, on further inquiry, all participants revealed that they were aware that supervisees did not consistently disclose difficulties. Several participants admitted to non-disclosures in supervision themselves, which would correspond with the empirical data for non-disclosure (e.g. Ladany et al., 1996; Mehr et al., 2010; Webb & Wheeler, 1998; Yourman, 2003; Yourman & Farber, 1996), and one participant noted that it was 'human nature' (P6, 267) not to want to disclose uncomfortable truths. Participants sought to address the paradox by focusing on creating a trusting and safe supervision environment where the supervisee would feel more able to disclose difficulties, in preference to explicitly addressing the subject of non-disclosure with supervisees. Accordingly, building a trusting supervisory environment appeared to be a central aim. There were confounding moments for some participants during the interviews as the implications of the paradox were considered and the notion of 'trusting' the supervisee absolutely was recognised to be unrealistic. How this paradox could be managed in supervision practice remained unresolved and several participants commented on the issue in the member checking feedback as a matter for further development in their practice.

One participant (P6) encouraged her supervisees to disclose their difficult material by bringing in recordings of her own 'less good' therapeutic work. She found that the strategy prompted her supervisees to feel more able to disclose their own difficulties and this strategy is supported in the literature (Knox, Burkard, Edwards, Smith & Schlosser, 2008).

Supervisee-Centred Evaluation

The emphasis in supervision evaluation was consistently placed on measuring the level of supervisee satisfaction with supervision, which reflects the supervisee-centred nature of the supervision process. Exceptions were where the supervisee was a trainee and assessing supervisee performance was an integral element of the supervision contract. Participants gained informal verbal feedback from supervisees and some conducted more formal regular reviews, which comprised self report feedback from supervisees with regard to their degree of satisfaction with supervision. Participants' focus on supervisee satisfaction reflects a similar emphasis on supervisee satisfaction in both the discursive and empirical literature (Britt & Gleaves, 2011; Carroll & Gilbert, 2010; Goodyear & Guzzardo, 2000; Holloway & Neufeldt, 1996; Inman & Ladany, 2008; Watkins, 2011b; Wheeler & Richards, 2007a, 2007b). There are a number of issues with this. Radcliffe and Milne's study (2010) demonstrated that what supervisees want from supervision may not equate to effective supervision and Ladany et al. (1996) found that negative feedback to the supervisor was one

of the most frequent items of non-disclosure in supervision. This makes it difficult to rely on the quality of self report feedback from supervisees.

Restricting evaluation to supervisee satisfaction means that opportunities are lost for developing broader and more informative evaluation process. Supervision can potentially be evaluated on a number of levels, depending on what is being measured, such as the competence level of the supervisor (Milne, Sheikh, Pattison & Wilkinson, 2011) or the effects of supervision on client outcome (e.g. Bambling et al., 2006) or the effects of supervision on supervisees and their practice (Wheeler & Richards, 2007a, 2007b). The lack of psychometrically tested evaluation measures is a major obstacle in all areas of supervision evaluation (Ellis et al., 2008) and may, in part, account for the absence of systematic evaluation in the findings.

Evaluating the effects of supervision on TOs was absent in the data and is indicative of what participants saw as the primary purpose of supervision, which was to focus on the supervisee's professional development.

Finding a Common Language for Therapeutic Outcome

Finding the right language to capture the meaning of the client's outcome was a complex process. It was a difficulty I had not anticipated and proved to be one of the more unexpected findings, revealing that participants interpreted the term 'therapeutic outcome' according to their therapeutic orientation. Participants practising from a cognitive behavioural perspective found the briefest and most succinct way of interpreting the phrase by equating the term TO with the client's immediate goals for therapy. For relational, integrative or Person Centred participants, it was more complex with P13/FG (369-380) suggesting that he did not think in terms of 'outcomes' since therapy was about 'meaning making' for the client and the outcome is emergent and unplanned. From a psychoanalytic perspective the outcome only evolves over time and the therapist may never know fully what the outcome is.

The critical point is that supervisor and supervisee share their understanding in an explicit dialogue, however the term is understood (i.e. 'client goals', emergent and unplanned 'meaning making' or other interpretations). In identifying this issue, I believe the study has revealed an important factor in understanding the relationship between supervision and TOs. In addition, in terms of supervisor-outcome research, the findings indicate that a clear definition of TO is required before the implementation of a research study. Bambling et al. (2006) addressed this by rating symptom change and measuring the effectiveness of the

working alliance, but without such pre-determined definitions of TO there are bound to be methodological difficulties in research studies.

A further complicating factor in capturing the meaning of the TO, is that it is a relatively unknown quantity in therapy itself. This topic is beyond the scope of this study, but the findings highlight the need for a more sustained dialogue about therapeutic purpose and a language that may be understood across therapeutic orientations. The lack of a shared language potentially presents a major obstacle to effective supervision as well as to supervision outcome research. Supervision could provide a forum for just such a dialogue given its central role in the delivery of the psychological therapies. The value of developing a shared understanding of 'therapeutic outcome' in the supervision context has already been noted earlier, and this was emphasised by one of the participants (P5, 590-595) who highlighted the need for supervisor and supervisee to *'speak the same language'* in a reference to a shared therapeutic approach.

Although the findings show that participants reported some familiarity with instruments for measuring therapeutic outcomes, the issue of whether supervision had a role to play in monitoring outcomes, caused unease. Participants were concerned that it was more of an administrative role but the main concern was that supervision would potentially become 'unsafe' and become a way of shaming the supervisee. However, one participant (P6) had experience of using a spreadsheet to monitor her supervisees' clients' outcomes and reported favourable responses from her supervisees. There is also empirical support for the benefits of using outcome measures in therapy. Lambert et al. (2001) found the deterioration rate for clients, whose therapists were receiving client feedback information, was significantly reduced and McNaughton et al. (2006) suggest that introducing the client CORE (Clinical Outcomes in Routine Evaluation) measures into the supervision process would have positive effects on client outcomes. This has potential benefits for increasing supervision efficacy and warrants further research.

Summary

Given that the findings consistently reflected an ongoing sense of unfamiliarity with the concept of a relationship between supervision and TOs, it was apparent that many issues surrounding supervision and client outcomes were previously unconsidered. Participants had to grapple to sum up the relationship between supervision and TOs and relied on theoretical underpinnings from their therapeutic orientation to frame a definition of TO and thus an elucidation of the relationship. The interpretation of the concept of the 'therapeutic outcome' was a central determining factor in how the relationship between supervision and TOs was eventually construed. Some direct links were identified though they were generally

tenuous and not knowing was a common response. The consensus was that the relationship was indirect and that supervision contributed to TOs by enabling the supervisee to become a better therapist, which ultimately leads to improved outcomes for the supervisee's clients.

The emergent theory has some congruence with both the discursive and empirical literature but also highlights where research is lacking and demonstrates that there are areas where research may be slow to filter through to practice (e.g. professional frameworks for supervision practice such as supervisor training). There remain tensions and inconsistencies in the supervisory process as demonstrated in the theory presented in this section, and supervisors need more robust structures in place to help them meet the demands and expectations of the supervisory role.

Evaluating the study

Strengths and Limitations

The aim of the study was to gain an understanding of participants' perceptions of the processes of the relationship between supervision and TOs, in order to develop an explanatory theory. The study sought to address a perceived gap in the research base by identifying supervisors' frames of reference and priorities in supervision practice in relation to the relationship between supervision and TOs. The rationale was to provide an explanation based on practitioner supervisor data, of supervisory practice in relation to client outcome, which would contribute to our understanding of this area of supervision and offer a basis for further research. Using grounded theory for simultaneous data collection and analysis allowed the research to stay close to the participants' voices while facilitating the development of an explanatory theory and diagrammatic model. I believe the research study has achieved its aims, with some limitations.

Different language might have been used to define the concept of the client outcome. The choice of the term 'therapeutic outcome' used in the study proved to be problematic and whilst it initiated a rich dialogue as participants reflected on what the concept meant for them, with the benefit of hindsight I might have chosen a more neutral term such as 'client benefit'. However, whilst this might have been more straightforward, the original term allowed the full complexity of issues around client outcome to be explored. On a personal level, I recognise that the choice of the term 'therapeutic outcome' reflected my own implicit assumptions at the outset of the study and the research process has broadened and deepened my understanding of the concept of 'therapeutic outcome' (see further sections below).

There were limitations in the size of the study in that this was a small scale study with a sample of thirteen participants. While this is an acceptable sample size for a grounded theory study, where the aim is to achieve saturation of the categories, a larger sample might have lent the study greater transferability. For example, while the current sample size established the principle that the meaning of the client's outcome is determined by the supervisor's therapeutic orientation, a wider sample might have yielded further information about a wider range of interpretations. The generalisability of the study is also limited by the fact that the majority of participants were either counsellors or psychotherapists rather than applied psychologists. Only two of the thirteen participants were applied psychologists (both counselling psychologists). A different sample consisting of a broader category of applied psychologists, such as clinical psychologists or health psychologists, may have produced different data. For example, in the current study, the participants 'worldview' was largely determined by their therapeutic orientation and a different sample may have revealed alternative 'worldview' constructs.

A further limitation with the current sample is that all the participants were experienced supervisors and all currently practising as supervisors with one exception. Including less experienced or newly qualified supervisors may have provided other perspectives. In addition, all the participants in this sample had received training in supervision (although it varied from a certified course to shorter trainings) and this again might have influenced the data. The focus of the study was not to investigate the effects of training on supervisors' perceptions of the relationship between supervision and TOs, but, with hindsight, further demographic information regarding participants' supervisor training may have shed more light on its influence and informed the findings.

A cultural dimension is an omission in this study. I am aware that this may be a reflection of sharing a cultural heritage with my participants (all white and living and working in a small area of the UK) and thereby denying ourselves the privilege of exploring the issues focused on in this study, in the context of a wider cultural diversity. Further research is recommended in this area, particularly in terms of broadening an understanding of the concept of therapeutic outcome.

Little has emerged from the findings with regard to differences between group and individual supervision although most participants were actively engaged in both. No issues were explicitly expressed and therefore this did not become a focus for further sampling but, on reflection, this might have been explored further and certainly is an area requiring further research.

Finally, although little emerged in the data regarding evaluation of supervision, one participant (P6) volunteered the information that she had at one time used a measure to evaluate the efficacy of supervision and this was not followed up. This had the potential to inform the findings with regard to the issue of supervision evaluation and could have pointed to an avenue for further data collecting.

Standards of Trustworthiness

Glaser and Strauss (Glaser, 1978, 1998; Glaser & Strauss, 1967) suggest that a grounded theory study should be evaluated in terms of several key constructs: relevance, fit, grab, workability and modifiability. I have attempted to meet these criteria and the degree to which this has been achieved is evaluated below:

1. **Relevance:** There is relevance in the sense that the research area emerged from a problem area in my own supervision practice, prompted by developments in supervision practice and investigated using a sample of experienced supervisors. I believe reasonable relevance has been demonstrated (and see below Recommendations for Practice)
2. **Fit:** Glaser (1998) defines 'fit' as validity in a grounded theory context and guidelines for ensuring rigour in qualitative inquiry have been followed (see Table 4 below).
3. **Grab:** This is considered a central element of grounded theory; it gives the study a wider resonance and is essentially a way of testing the study's pragmatic validity. There is evidence that the study has a wider resonance to some degree. For example, feedback from participants (see below and Appendix 12), feedback in wider consultations with colleagues, and one of my supervisors (Peter Hawkins) has suggested that the findings have prompted the need for these issues to be addressed in the fifth edition of *Supervision in the Helping Professions* (P. Hawkins, personal communication, July 5th 2013).
4. **Workability:** Glaser and Strauss (1967, p.245) define 'workability' as the ability of the emergent theory to be relevant and accessible enough to 'make its application worth trying'. Every effort has been made to collapse theoretical integration to its most workable format (see Appendix 10 and Appendix 11) to achieve optimum 'workability' but this remains untested.
5. **Modifiability:** Glaser (1978) acknowledges that saturation of categories cannot be permanent and that, at best, it is a snapshot of the situation at the completion of the research project. To address this, the study should be flexible enough to allow for

future ‘modification’. The aim of the study has been to saturate the categories whilst retaining flexibility within the final model, but this remains untested.

Although the above summary demonstrates that the study has met these criteria to some degree, wider consultations would have tested them out more effectively. For example, I had intended to run a second focus group once the findings were available, but this did not occur owing to time constraints.

In addition to Glaser’s suggestions for establishing credibility in a grounded theory study, guidelines for ensuring the ‘trustworthiness’ of the study (Elliot, Fischer & Rennie, 1999; Lincoln & Guba, 1985; Mintz, 2010; Morrow, 2005, 2007; Pidgeon, 1996; Stiles, 1993, 1999) have been followed throughout the research process and are summarised in Table 4 below. Participants from purposive sampling were asked to comment on the accuracy of initial coding and three out of six responded, confirming that initial coding accurately reflected and represented their meaning. Excerpts from the findings were distributed to all participants for member checking (see Box 5 below) and some alterations were made in response to feedback. For example, the word ‘ambivalent’ had been used to describe participants’ perceptions at various points and this was reviewed and revised following feedback from P11/FG and P13/FG. P11/FG also made the point that choice of therapeutic orientation may be linked to personality and this has resonance with the notion of therapeutic orientation being linked to the individual’s personal value base.

BOX 5. QUESTIONS FOR MEMBER CHECKING

The following questions are suggested to guide, but not to limit, your feedback:

- *To what extent do the findings resonate with your experience of the research topic?*
- *Are there any connections or missing links that have particular resonance for you?*
- *What connections have I made that you might want to challenge?*
- *What connections have I made that you would like to expand on?*
- *Is there anything you think I have not included?*
- *Do the findings offer you greater clarity on the issues involved in the research?*
- *Is there anything you would change in your supervision as a result of these findings?*
- *Is there anything you actually did differently as a result of the interview?*

On reflection, the above questions could have been worded more neutrally to avoid any sense of seeking reassurance but rather to invite critical evaluation. Ten of the thirteen participants responded, four offered only brief responses but seven provided more detailed

feedback. All confirmed that the findings held resonance for them to some degree and several suggested that the findings would influence their supervisory practice. The following are very brief extracts (see Appendix 12: Member Checking Feedback):

'the findings do resonate with my experience' (P1).

'It fits with my impression that most supervisors do not consider therapeutic outcomes, which is worrying' (P2).

'You have drawn out common themes' (P4).

'On the whole all the themes resonate' (P6).

'I've read through [the extracts of the findings] a couple of times and ..... I'm sure you have it right' (P8).

'the findings give me greater clarity on the issues involved in the research' (P10).

I am not sure that ambivalent is the right expression here' (P11/FG).

'Has made me think more carefully about the impact and effect on "outcomes"' (P12/FG).

'I'm not comfortable with the word "ambivalent" as a characterisation of my perception of the relationship between supervision and therapeutic outcomes' (P13/FG).

TABLE 4. Summary of Trustworthiness Procedures

Credibility Check	Action Taken
Support descriptions with direct quotes	This is demonstrated throughout the Findings section and elsewhere in the report.
Describing the context of the participants	There is a description in the Methodology Section including Table 1 Participant Demographics Information.
Describing the context of the study	This is provided in the Introduction Methodology Sections.
Providing clear and comprehensive description of research procedures throughout the study	This is provided in the Methodology Section and supplemented in the Appendices.
Building an audit trail	Every stage of the research process has been documented. In addition all stages have been discussed with research supervisors. Documentation includes memos, theoretical integration diagramming, transcripts, and a research journal. See Appendices for supporting documentation.
Being consistently reflexive	This was addressed through reflection in research supervision sessions, discussions with peer researchers and colleagues, memo-writing and keeping a reflective journal (Appendix 13 for excerpts).
Checking back with participants to ensure that participants perspectives are fairly represented in the findings	Member checking completed (see above and Appendix 12)
Self reflective journals	A reflective journal was kept throughout the research process (see Appendix 13)
Checking with peer researchers or colleagues	Meetings took place with colleagues and peer researchers throughout the process of research in two university settings and there were regular meetings with two research supervisors. Presentations at two conferences with early research findings and PART D: Critical Literature Review
Include Negative Case Analysis	This has been addressed in the Findings and Discussion sections.

Further Research

Given that supervision generally, and the relationship between supervision and TOs in particular, are under-researched areas, there are many avenues for further research. More research is clearly needed in the area of understanding therapeutic outcomes as a whole but this study has specifically highlighted the influence of therapeutic orientation as a factor in defining and interpreting the client's outcome. Supervisors' attitudes to working with supervisees from different therapeutic orientations was explored in this study, and given the divergence of interpretation of 'therapeutic outcome,' this is an important issue for the quality and effectiveness of the supervision work. An interesting preliminary study would be an investigation of how supervisor-supervisee dyads interpret the term 'therapeutic outcome' measuring the extent of difference or similarity before developing this further to measure the effects of differences or similarities of definition of therapeutic outcome on the efficacy of supervision.

Supervisors' perception of a broadly indirect relationship between supervision and TOs highlighted three areas of potential impact of supervision: supervisee practice, client welfare and client outcome. More research is needed to understand the interaction between these areas as well as investigating the efficacy of supervision on the individual areas.

Evaluation of supervision and, in particular, supervisor competences continues to be a neglected area of investigation. The study identified that supervisors were using relatively informal methods of evaluation and these were primarily focused on evaluating supervisee levels of satisfaction with supervision. Developing our understanding in all areas of supervision evaluation would deliver great benefits in furthering our understanding of the efficacy of supervision.

Relevance to the Profession

I believe this research has immediate relevance for the psychological therapies including counselling psychology. Supervision is central to the profession and is a major resource in implementing therapy across a range of therapeutic orientations, as well as being mandatory for practitioners who want to gain and maintain accreditation with a number of professional organisations (e.g. BABCP; BACP; DCoP).

Theoretically, it has contributed to our understanding of the processes involved in how supervisors attend to client outcome. In doing this it has not only added to the body of knowledge in this area, but has contributed to addressing the ethical imperative (Lichtenberg, 2007) for evidencing the centrality of supervision within the psychological therapies. I think the study has provided fresh perspectives on traditional constructs in supervisory practice, such as the 'safe space', the relationship between the normative and restorative functions of supervision and the continued prevalence of the influence of therapy training and the experience of being supervised as primary influences on supervision practice. It has also opened new areas for further investigation such as the lack of clarity in defining a therapeutic outcome and the need to acknowledge supervisors' frames of reference in relation to supervision's influence on client outcome.

In addition, as a qualitative study grounded in the subjective experience of the participants, it is particularly fitting for a piece of research within counselling psychology where 'respect for the personal, subjective experience ... is prized' (Corrie, 2010, p.46). Up to this point, the majority of supervision-outcome studies have utilised quantitative methodology, measuring diverse variables within the supervision-therapy process. In utilising a qualitative study and, in particular, applying constructivist Grounded Theory, my aim was to give voice to the subjective experience of the supervisor-participants in order to understand

supervisors' frame of reference in supervision practice through investigating their 'real-life' experiences. This aim is congruent with the values of counselling psychology, which 'pays particular attention to the meanings, beliefs, context and processes that are constructed both within and between people' (British Psychological Society, 2013, p.15).

Demonstrating its pragmatic validity, the study has immediate relevance for practice and in the following section I outline recommendations for practice along with an explanation of how these recommendations have evolved throughout the research process.

Recommendations for Practice

Reflections on Recommendations for Practice

The recommendations for practice set out below have been the result of considerable private reflection and discussions with colleagues and supervisors. The extent of my deliberations reflects how my own stance has developed and shifted as I have engaged with the research process and with my participants. I came to this research with my own implicit assumption that the term 'therapeutic outcome' would be readily embraced and accepted by others and it was a surprise to find it the subject of prolonged debate. My own therapeutic practice has included a Cognitive Behavioural approach for the last ten years, and I am now aware that I, like my participants, spoke from an implicit 'worldview' influenced by my therapeutic orientation. Interaction with participants, the data and the literature has broadened my thinking and deepened my understanding. It has reconnected me to my own psychodynamic roots and brought about a conscious awareness of my preconceptions and assumptions. I honour and am grateful for the different insights my participants have shared with me throughout the research process, which have challenged old assumptions and shaped fresh perspectives.

My understanding of client outcome is broader and less rigid than when I began this journey and I share some of the participants' concerns that the benefits of supervision should not be jeopardised by a reformulation of supervision that integrates a greater emphasis on client outcomes. However, I also believe that more can be gained from supervision, for all stakeholders, by a greater awareness of client outcome in the supervision process and by readily embracing the challenge posed by some of the inconsistencies revealed in the study. I therefore offer these Recommendations for Practice in a spirit of humility and am hopeful that they will contribute to a healthy dialogue in which we begin to address some of the issues that have emerged from this study.

Recommendations for Practice

Recommendations for Psychological Therapists

- Develop a working definition of how the client derives benefit from the therapeutic encounter and regularly review both planned and emergent benefit.
- Regularly evaluate the benefit of the therapeutic work for the client.
- Jointly agree with the supervisor on how to address client benefit in supervision, including comparing supervisor and supervisee working definitions of client benefit.

Recommendations for Supervisors of Psychological Therapists

- Develop a joint working definition with each supervisee of how the supervisee's clients derive value from the therapeutic work.
- Develop systematic structures for the implementation of the following levels of evaluation:
  - Supervisee evaluation of supervision
  - Supervisor's evaluation of the supervisee
  - Evaluating supervisor competences
  - Evaluating the efficacy of supervision in defined areas of impact (supervisee professional practice, client safety, client outcome/benefit)
- Consider how the issue of non-disclosure is collaboratively managed in supervision.
- Consider how the competing demands of the normative and restorative functions of supervision are collaboratively managed in supervision.
- Develop a working definition of supervision that includes a clear understanding of who supervision serves.

Recommendations for Supervisor Trainers

By the end of supervisor training newly qualified psychotherapy supervisors will be able to:

- Develop a working definition of supervision that includes a clear understanding of who supervision serves.
- Differentiate between psychotherapy models and supervision models as influences on supervision practice
- Think critically about supervision practice, understand the empirical base for supervision and apply it in practice
- Have a clear understanding of supervisor responsibility including ethical and legal implications

- Develop a working definition of how the client derives benefit from therapy and understand the importance of considering this with supervisees as a basis for good supervision practice
- Effectively implement evaluation of supervision in four key areas:
  - Supervisee evaluation of supervision
  - Supervisor's evaluation of the supervisee
  - Evaluating supervisor competences
  - Evaluating the efficacy of supervision in defined areas of impact (supervisee professional practice, client safety, client outcome)
- Describe how standards of supervision practice will be maintained beyond training.

Recommendations for Professional Bodies

- Develop supervisor training accreditation schemes.
- Incorporate a greater emphasis on client outcome in guidelines of ethical practice for therapists and supervisors.

Proposed Definition for Supervision

> A professional activity, contracted for between a supervisor and a supervisee, for the purpose of bringing benefit to the supervisee, their practice and the supervisee's clients. The nature of the benefits are jointly defined at the outset of the contract, regularly reviewed and evaluated and should include furthering the supervisee's professional development and ethical capacity as well as consistently adding to the value that the supervisee's clients derive from therapy.

Reflections on the Research Process

The research study began with a professional challenge to my own assumptions as a clinical supervisor and my aim - to attempt to explain how supervisors perceived the relationship between supervision and TOs - was based on my own need to understand my own supervision practice better. Being consistently reflexive was therefore a central plank in the research process, given my very close relationship with the research area.

As data collection progressed the absence of a systematic attention to TOs became a major and preoccupying concern, and yet, I was aware that it reflected my own experience of supervising and being supervised. I discussed my concerns widely - with research colleagues, with research supervisors and eventually presented early findings at a

supervision research conference. Keeping a reflective research journal was also a helpful and essential tool in trying to make sense of the research process.

In addition to my central concern about the absence of attention to TOs within the data, I had a second, more subtle, but more worrying and pervasive difficulty. As I discussed my early findings in various arenas, I began to sense some criticism directed towards participants. From in-depth interviews I believed that the participants were ethical professionals committed to good practice and I was aware that the study emerged from my own sense of an absence of attention to TOs in the supervision process. It was important that I neither colluded with my participants nor be pulled into a collective critical conformity.

Using my reflective diary and research supervision, these concerns eventually led to a turning point in the research process. Instead of focusing on what was absent, I made the decision to focus on what was present. If supervisors were not attending to TOs, what were they attending to and what did they prioritise? This reframing enabled me to develop a fuller and more realistic theory of the relationship between supervision and TO.

Throughout the study, I felt a strong collegial and professional connection with participants as they struggled to make sense of the relationship between supervision and TOs through a close scrutiny of their own supervision practice. It is a struggle I closely identified with as my own struggle formed the genesis of this research and I am profoundly grateful to my participants for their willingness to share this process of discovery with me. Without their personal and professional courage in challenging their own assumptions, this research study would not have been possible.

Developing the theory of the relationship has therefore been challenging on an emotional as well as an academic level. Given the parallels between my experience and that of the participants, the emergent theory feels very much a co-construction, reflecting a sense of congruence between my professional identity as a supervisor and the constructivist-interpretivist epistemological stance of the study. The recursive cycle of constant comparison, a cornerstone of grounded theory method, has been instrumental in keeping the emergent theory grounded within the data and close to the participants' voices.

This constant interaction is a reminder that multiple realities co-exist within the research process and that this is 'an inquiry process that creates knowledge through interpreted constructions' (Annells, 1996, p.385). Working with participants from a range of therapeutic orientations has been a salutary personal reminder that there are many ways of delivering supervision, many ways of delivering benefit to supervisees and clients alike, and multiple versions of 'therapeutic outcome'.

On a more practical level, learning how to work with grounded theory was a challenge but, once grasped, the method itself framed the process, moving the research from stage to stage. Memo-writing is a practical device for developing interpretations, theoretical sampling is an effective strategy for developing the emerging theory and constant comparison keeps the researcher in contact with the data. Working with large amounts of data was an overwhelming though exciting element of the research process and I had to actively keep myself anchored in the 'problem area' to avoid making the research area too far-reaching and unwieldy, thereby losing impact and meaning.

A key stage in the research process was beginning the literature search. I had some concerns about my decision to delay this until the analysis was well advanced but it proved to be the right decision for this research project. I avoided the temptation to skew the findings to fit the literature and once accessed, the points of contact between the literature and the findings, served to illuminate the study's findings in two directions. In some cases the literature supported the findings, whilst in other cases the findings contributed new insights to the existing literature, both discursive and empirical.

Concluding Reflections

The research process has been transformative on many levels. Before undertaking this study, my identity was very much as a practitioner counselling psychologist but this experience has transformed my sense of professional identity, from being relatively one dimensional to a fuller, more rounded identity as practitioner-researcher counselling psychologist.

Completing this research project has developed my research skills, honed my critical capacity and increased my professional confidence. This has equipped me with the necessary tools for engaging in a more critical and meaningful dialogue with the empirical base of professional psychology and its professional discourse, in a way that would not have been possible before undertaking the research.

The benefits of this will extend to all areas of my counselling psychology practice, including therapy, supervision, training, writing and future research projects. More specifically, in terms of my knowledge and understanding of supervision, its processes and issues, there have been quantum leaps in my understanding and knowledge base. What I previously thought of as 'good enough' knowledge at the start of the process was indeed not good enough. The discussions with participants and an intense interaction with the data have been gifts in terms of professional development and have brought about permanent changes in attitude and perspective. Very specifically, I have acquired a broader and more complex

understanding of a ‘therapeutic outcome’, an understanding that I hope will benefit my clients and supervisees alike. What I have learned above all else, is to acknowledge my assumptive stance, consistently challenge it and refuse to collude with a ‘face value’ approach.

I believe there is value in the findings from this research and, what was important in a practitioner doctorate in counselling psychology, I believe the findings have pragmatic value for counselling psychology practice. Above all, the research has a personal value for me. I feel a profound sense of satisfaction in being a producer as well as consumer of research and having the privilege of contributing to the research base of counselling psychology.

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APPENDICES

APPENDIX 1

TABLE 1 OUTCOME STUDIES				
Study	**Sample and Focus**	**Design and Measures**	**Findings**	**Previous Reviews**
Dodenhoff (1981)	59 master's level trainee supervisees, 12 supervisors, client numbers not specified. Purpose to examine supervision as a social process, proposing that supervisee attraction to the supervisor would give the supervisor greater influence with the supervisee leading to improved client outcomes. Supervisory style (direct or indirect) also measured.	2 X 2 completely crossed quasi-experimental design with three measures of the dependent variable, trainee effectiveness. Using Counselor Evaluation Rating Scale, Rating Scale for Outcome and Counselor Rating Form	Positive interpersonal attraction related to improved client outcome as rated by the supervisor and a direct supervisory style related to improved trainee effectiveness.	Freitas (2002): criticised methodology. Watkins (2011b): dismissed as failing to assess patient outcome Wheeler & Richards (2007b) : average rating
Steinhelber, Patterson, Cliffe & Legoullon, (1984)	237 psychiatric outpatients, trainee psychotherapists from range of disciplines including clinical psychology, supervisors from psychology, psychiatry, and social work backgrounds. . Purpose to investigate if the amount of supervision and congruence of theoretical orientation between the supervisor, trainee and therapy would correlate to improved client outcome	Client outcome was rated using the Global Assessment Scale (GAS) at the beginning of therapy and at the time of the study. The principal hypotheses were tested by analyses of covariance, with current GAS score as the dependent variable, either amount or congruence of supervision as the independent variable, and initial GAS score as the covariate.	No statistical difference between GAS scores and amount of supervision but congruence of therapeutic approach related positively only on the low amount of supervision condition	Freitas (2002): major methodological flaws. Watkins (2011b): problems with rating scale (GAS), focus on therapist self perception, lack of focus on supervision. Wheeler & Richards (2007b) : poor rating
Couchon & Bernard (1984):	55 supervisor-supervisee-client triads. Purpose to investigate the effects of timing of supervision.	Three time conditions. Analysis was done using ANOVA regression analysis and analysed using chi-square tests	No significant difference between conditions for client or counsellor satisfaction with treatment. Follow through from supervision to counselling was greatest on the shortest time condition.	Freitas (2002): Watkins (2011b): serious methodological difficulties Wheeler & Richards (2007b) : average rating
Sandell (1985)	20 psychiatric outpatients. Purpose to explore the relationship between client ego level, therapist competence, supervision and therapy outcome.	Used Mann's time limited psychotherapy model and data analysed by means of path analysis.	Found that client ego level had positive correlation with outcome but supervision appeared to have a negative effect on outcome.	Freitas (2002): major methodological flaws in execution and presentation Watkins (2011b): not a patient-supervisor outcome study.
Friedlander,	Triad of client-trainee counsellor-	Case study design applying multiple	Results point to the similar aspects	Freitas (2002): excluded from

Siegel & Brenock (1989)	supervisor. Purpose to examine the theoretical model of parallel process.	indexes of the process and outcome, using self report and verbal communication data.	of the two relationships, possible indicators of parallel process, and an identification of the behavioural features of the supervisor's style but do not provide any client-supervisor outcome link.	review on grounds of 'limited external validity' Watkins (2011b): not a patient-supervisor outcome study.
Alpher (1991)	Single triad of patient-therapist-supervisor. Purpose to examine parallel process in therapy and supervision.	Case study method and using Structural Analysis of Social Behavior ratings to track perceptions of interpersonal process by patient, therapist and supervisor through a 25 session treatment.	Effects of supervision on client outcome not evaluated	Freitas (2002): excluded on grounds of 'limited external validity' Watkins (2011b): not a patient-supervisor outcome study.
Kivlighan, Angelone & Swafford (1991)	48 undergraduate volunteer 'clients', 48 trainee counsellors and 17 supervisors. Purpose to compare the effects of video and live supervision in individual psychotherapy	A quasi-experimental design used to compare a cohort of therapists who received live supervision *(N* = 23) with a cohort who received videotaped supervision *(N* = 25) over 4 sessions. Trainee therapists recorded their intentions for each of their interventions and clients completed the Working Alliance Inventory and Session Evaluation Questionnaire after each session	Therapists in the live supervision condition used more relationship and support intentions, and their clients reported stronger working alliances and more challenging sessions suggesting that live supervision enhanced the learning of an interpersonal-dynamic approach to therapy.	Freitas (2002): well designed study with some limitations Watkins (2011b): does not have a supervisor-client outcome focus.
Milne, Pilkington, Gracie & James (2003)	One triad of supervisor-trainee therapist-client. Purpose to assess the effectiveness of cognitive behaviour therapy supervision in terms of impact on supervisee and client.	*N*=1 design utilizing a qualitative and quantitative content analysis methodology, based on the intensive coding of a series of 10 longitudinal, video-recorded supervision sessions, linked to the subsequent 10 therapy sessions.	14 supervisory themes extracted. Change methods employed in the supervision transferred to the therapy session indicating that the supervision was effective. The study provides limited evidence that CBT supervision can be effective.	Watkins (2011b): study does not show the effects of supervision on the patient. Wheeler & Richards (2007b) : average rating
Vallance (2005)	19 participants. Purpose to explore counsellors' perceptions of the impact of counselling supervision on their clients.	Data collection combined open-ended questionnaires (*N* =13) and semi-structured interviews (*N* =6) analysed using a phenomenological approach.	Supervision directly and indirectly impacts client work in a range of ways both helpful and unhelpful.	Watkins (2011b): acknowledges the value of the study but prefers more specific observations of supervision Wheeler & Richards (2007b) : average rating
Bambling, King, Raue,	127 patients, 127 therapists and 40 supervisors. Purpose to evaluate the	Quantitative study using a nested design with multiple intervals of measurement.	The results showed a significant effect for both supervision	Watkins (2011b): 'truly stellar model study' p.249.

Schweitzer & Lambert (2006)	impact of supervision on therapeutic alliance and client symptom reduction.	The experimental variable was supervision; levels were process-focus condition (*N* =34) skill-focus condition (*N*=31) and no supervision condition (*N*=38). Dependent variables were client-rated working alliance in therapy (measurement points at Sessions 1, 3, and 8), client symptom scores (measurement at intake assessment and Sessions 1 and 8). Patients randomly assigned to one of the three conditions.	conditions on working alliance, symptom reduction, treatment retention and evaluation but no effect differences between supervision conditions.	Wheeler & Richards (2007a) : excellent rating
Tracey, Bludworth and Glidden-Tracey (2012)	17 supervisor-trainee counsellor-client triads (3 supervisors, 7 therapists and 17 clients). Purpose to investigate for occurrence of parallel process and if the presence of parallel process was related to client outcome.	The relation between parallel processes over the course of treatment and client outcome was examined using hierarchical Bayesian modeling.	Significant results for each dyad indicating the presence of bidirectional parallel processes in each supervision triad. Results also indicate that a positive client outcome was associated with increasing similarity of therapist and supervisor behaviour .	Not reviewed

APPENDIX 2

INCLUSION CRITERIA FOR PARTICIPANTS

Psychological Research Study

Working Title of the Study
Clinical Supervisors' perceptions of the relationship between Supervision and Therapeutic Outcomes.

Background to the Study
This research is part of my course at City University, which is a Post Qualifying Practitioner Doctorate in Psychology (DPsych in Counselling Psychology). Although the role of clinical supervision is widely accepted to be an integral element in the effective and ethical delivery of the psychological therapies, it remains an under-researched area. The aim of this study is to explore clinical supervisors' perceptions of clinical supervision generally and any relationship with therapeutic outcomes.

The Research Project
This is a qualitative study using Grounded Theory Method. The primary data collection methods being utilised are semi structured interviews and focus groups. All data is recorded, transcribed and analysed according to Grounded Theory Method and will be kept securely and confidentially.

Inclusion Criteria

1. Is accredited with a national professional body as a counsellor, psychotherapist, CBT practitioner, counselling psychologist, clinical psychologist [e.g. with BPS, BACP, UKCP, BABCP, HCPC]
2. Has been practising as a supervisor for a minimum of one year
3. Has experience of providing psychotherapy supervision in a minimum of two different contexts

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Thank you for supplying this information. Should you have any questions I can be contacted at elizabeth@talkmatters.com and my supervisor is Professor Carla Willig at C.willig@city.ac.uk

APPENDIX 3

PARTICIPANT INFORMATION SHEET

Psychological Research Study

Clinical Supervisors' perceptions of the relationship between Supervision and Therapeutic Outcomes

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You are invited to take part in a qualitative research study focusing on clinical supervision in the psychological therapies. This research is part of my Post Qualifying Practitioner Doctorate in Psychology (DPsych in Counselling Psychology) at City University. Before you decide whether to take part in the study, it is important for you to understand why the research is being done and what it will involve for you. Please take time to read the following information carefully. After that, you will then have an opportunity to discuss the study and your role in it with me before making any decision about your participation.

Background to the Study

Although the role of clinical supervision is widely accepted to be an integral element in the effective and ethical delivery of the psychological therapies, it remains an under-researched area. The aim of this study is to explore clinical supervisors' perceptions of clinical supervision and any relationship it might have with therapeutic outcomes.

The research project

This is a qualitative study using semi structured interviews and focus group interviews to gather data for a Grounded Theory research design.

Your participation in the study

This is a semi structured interview (either individually or in a focus group) from your perspective as a clinical supervisor. You will also be asked about your views from your perspective and experience as a supervisee and therapist. The interviews are recorded and last for up to one and a half hours. The interview will be at a location and time convenient to you.

Confidentiality

Interviews will be recorded and transcribed for subsequent analysis. All your data will be kept anonymously and your identity safeguarded. All information which is collected during the course of the research will be kept confidential and will conform to the Data Protection Act of 1998 with respect to data collection, storage and destruction. In addition, data storage and handling will conform to the guidelines of the British Psychological Society and City University. Any references to supervisees, clients or organisations, during the interview, should be made using identifiers only in order to safeguard contingent identities and contexts. You have the right to withdraw at any time and you will not be contacted again after completion of the interview unless you have given your written permission to be available for a follow up interview should that be relevant to the study. All material will be used anonymously in my thesis and direct quotes will only be used if

a. You have given your permission in writing on the Consent Form.

b. You, your supervisees, your clients or any work setting cannot be identified, in any way, by the publication of the quotation or quotations.

Benefits in taking part in the research

It is anticipated that taking part in the study will offer an opportunity to reflect on your own supervision practice and to consider aspects of supervision which have so far been under-researched. Depending on the criteria of your regulating professional body you may be able to count participation as CPD.

Disadvantages to taking part in the research

It is unlikely that there will significant disadvantages to taking part in the study apart from the time commitment. If any issues arise as a result of taking part in this study, the researcher will discuss these with you and consider what course of action could be taken. If you feel disturbed in any way by the issues which arise in the course of the interview, I can be contacted at the email address below should you wish to discuss anything further. Alternatively, you may want to take any issues to your own supervisor or to your professional body. In addition, there are practitioner directories on the BPS (British Psychological Society), BABCP (British Association for Behavioural and Cognitive Psychotherapies) and BACP (British Association for Counselling and Psychotherapy) websites, should you feel you would like further support.

If you have concerns about the research

As this research is part of my course at City University, if you feel you have grounds for complaint regarding this study or the way in which it is being conducted I refer you to my supervisor Professor Carla Willig, School of Health and Social Sciences[1], Northampton Square, London EC1V 0HB. Email: C.willig@city.ac.uk.

The Next Step

I look forward to your contacting me with any questions regarding the study and interview. I will also follow up this email and contact you again shortly. If you agree to take part then we will then arrange a time to meet for the interview at which point I will ask you to sign the consent form (also attached for your information) and answer any further questions prior to the interview taking place. Thank you for your time.

Elizabeth Dartnall
Email elizabeth@talkmatters.com

[1] Please note that this was an error on the Information Sheet. At the time of contacting participants it should have read ‘School of Social Sciences’ and not ‘School of Health and Social Sciences’.

APPENDIX 4

PARTICIPANT CONSENT FORM

Psychological Research Study

Clinical Supervisors' perceptions of the relationship between Supervision and Therapeutic Outcomes

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Please read through the following questions carefully before you complete or sign this form as it is important that I have your fully informed consent before we proceed. The interview will be recorded and later transcribed. The data will be coded and contribute to the findings of this study which will be reported in a doctoral thesis and will include anonymised quotes. No identifiable personal data will be disclosed or published. There will be an opportunity to discuss the implications of all the points and I will answer any questions you may have before you give your consent to the interview.

Please circle as appropriate:

1. I have read and understood the information sheet and have had the nature and purpose of the study explained to me. Yes No
2. I agree to take part in this study. Yes No
3. I understand that I am free to withdraw from the study at any time without having to give any reason. Yes No
4. I am willing to take part in an audio recorded interview which will be transcribed and the data used in the research study. Yes No
5. I am willing to be contacted for a follow up interview. Yes No
   (If you have circled *yes* please complete contact details in the space below)
6. I am willing to allow you to use quotations from the interview in the final writing up of the study on the condition that all quotations are anonymised. Yes No
7. I understand that if any ethical practice issues emerge during the interview that these will be addressed in accordance with the ethical guidelines and codes of practice of my professional body. Yes No

Your Signature …….....…..**.....** Date …….....……

Your Name …….....…….....

Your Contact Details (if you have circled Yes in Question 5)

Email address .....

Telephone (Mobile and/or Landline) .....

Researcher: Elizabeth Dartnall

Signature of Researcher ..... Date.....

Thank you for completing this Consent Form. Please keep a copy of this form and the accompanying information sheet for your records

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Thank you for supplying this information. Should you have any questions I can be contacted at elizabeth@talkmatters.com and my supervisor is Professor Carla Willig at C.willig@city.ac.uk

APPENDIX 5

PARTICIPANT DEMOGRAPHICS QUESTIONNAIRE

Psychological Research Study

Supervisors' perceptions of the relationship between supervision and Therapeutic Outcomes

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Thank you for agreeing to participate in this study. It would be very helpful to be able to refer to the following background information in the research findings. This information will be kept anonymously and any reference to it in the study will protect all participants' identities.

Please delete as appropriate

Gender Male Female

Age 25-35 36-45 46-55 56-65 65 – 75 75+

Therapeutic Orientation

.....

Membership of Professional Bodies: please state all which apply

.....

.....

Accreditation with a professional body as a counsellor/psychotherapist/applied psychologist: please state all which apply

.....

Accreditation with a professional body as a supervisor: please state all which apply

.....

Year you began practising as a supervisor

.....

Number of contexts in which you have practised supervision and please specify

.....

.....

Have you undertaken any supervisor training? If so please state if it was Certified or non-certified training.

.....

Are you currently practising as a supervisor? Yes No

Thank you for supplying this information. Should you have any questions I can be contacted at elizabeth@talkmatters.com and my supervisor is Professor Carla Willig at C.willig@city.ac.uk

APPENDIX 6

INTERVIEW SCHEDULE FROM PURPOSIVE SAMPLING

1. ***Will you give me a brief description of your current supervision practice?***

PROMPTS: what contexts have you worked in; does the context make a difference to your practice;; do you keep notes of supervision sessions; if so, for what purpose; do you have supervision of supervision; have you had supervisor training; can you tell me about it; does it influence your supervisor practice

2. ***Please tell me about a typical supervision session of yours***

PROMPTS: does your training influence this; how is the session decided; what do you mainly focus on in supervision sessions; do sessions generally follow the same format or change; if so, why and how

3. ***What are your views about therapeutic outcomes?***

PROMPTS: what are your thoughts about monitoring outcomes; should outcomes be monitored; if so, by whom; if not, what are your reasons; does supervision play a part

4. ***In your view, how is a supervisee's practice - therapeutic outcomes - generally monitored?***

PROMPTS: who might do it; how might it be done; might the supervisor be involved

5. ***What are your views about the relationship between supervision and therapeutic outcomes in general?***

PROMPTS: what is your own experience; where do your views come from;

6. ***Do you think your own supervision practice influences the therapeutic outcomes of your own supervisees' practice?***

PROMPTS: how does it do this; can you identify the ways it does influence outcomes; how do you know that; what do you think your supervisee thinks;

7. ***How responsible do you feel for therapeutic outcomes?***

PROMPTS: how do you arrive at that;

8. ***Is there anything else you would like to add before we end?***

APPENDIX 7

INTERVIEW SCHEDULE FROM THEORETICAL SAMPLING

1. ***Will you outline what you see as your main responsibilities as a supervisor?***

2. ***To what degree to you leave it to the supervisee to decide on how the session is used?***

3. ***To what degree do supervisees bring their difficulties, stuckness or not knowing to supervision?***

PROMPTS: are there times when a supervisee might avoid issues; have you ever experienced this; what did/would you do

4. ***How much of a 'full picture' do you have of your supervisees' practices?***

   PROMPTS: what does it mean to you whether you have the 'full picture' or not; is it practical to have the 'full picture'; what would you do with the 'full picture'

5. ***Are there times when you take the lead yourself in supervision?***

   PROMPTS: when would that be; how would that happen; what is the consequence; does it change the dynamic of the relationship and if so, how

6. ***It's often said that supervision is a 'safe space' for supervisees. What do you make of that?***

   PROMPTS: what is its purpose;

7. ***It's sometimes said that a supervisor has a 'gatekeeping' function. What do you make of that?***

   PROMPTS: what does it mean; have you acted as 'gatekeeper'; what happened; have you experienced any tension in this role or tension in the supervisory relationship; what are your experiences of 'evaluating' supervisees; what are your experiences of handling unethical breaches of behaviour

8. ***Have you ever experienced any conflict or tension in managing these two elements of supervision?***

9. ***How important is it that the supervisor's and supervisee's therapeutic approaches are similar?***

10. ***What does the term 'therapeutic outcome' mean to you?***

11. ***Where does the responsibility for 'therapeutic outcome' lie?***

12. ***Do you see any relationship between supervision and 'therapeutic outcomes'?***

PROMPTS: what relationship does the supervisor have with the supervisee's clients; how does this work out in practice

13. ***Is there anything else you would like to add before we end?***

APPENDIX 8

Sample of initial and focused coding

TRANSCRIPT	INITIAL CODING	FOCUSED CODING
R: So it's recognising that there is a tension, where you've got a supervisee from a different therapeutic model? P5: Yes, so even though ostensibly you might both be practising in the same way, underneath there are a whole load of other assumptions that are going on about therapeutic process and, yeah, about therapeutic process and about how best to use the supervisory relationship.	Appearing to be practising from the same approach Different assumptions underneath Having assumptions about therapeutic process Having assumptions about how to use the supervisory relationship	Working with different therapeutic approaches in supervision
R: Yes, so what are your thoughts on supervision models that are 'atheoretical'? P5: Well, I suppose the one I was first introduced to and the one I'm most wedded to is Inskipp and Proctor's normative, supportive, formative so in terms of my formula this tends to be – again it's a formulation based approach, and so I identify with specific factors. And, as in therapy, I think there are generic and specific competences and I suppose it's identifying which bits of those, and which bits we're doing now, are primarily supportive and which bits are primarily normative; and, you know this is the right and this is the wrong way to do and which bits are formative in the sense of teaching and the specific development role, and sort of try to bear that in mind and thinking what does this person need right now. *R: And so would you say this informs your work?* P5: Yes, implicitly informs my work and I think the other thing that informs my work came from my IAPT training and I can't remember the full title of it now – it's the Declarative ....[*Declarative, Procedural, Reflective – DPR Model]* Bennett Levy, isn't it, and again that comes to mind often when people are coming and asking a question and I'm telling them something they don't know so declarative knowledge. Ok, so you haven't come across this before and I have so and umm I think again that DPR is implicit as well, the way it tends to inform the work is it pops up with automatic thoughts when I'm very much in it	Being introduced to first model Being most attached to Inskipp and Proctor's functional model Being a formulation based approach Identifying with specific factors Being like therapy in terms of competences Identifying with some bits Identifying what he's using in the moment Being supportive bits Being normative bits Thinking about what's the right and wrong way Being formative bits Being a teaching and developmental role Bearing in mind what the supervisee needs in the moment Model implicitly informing supervision work Supervision training informing his work Trying to remember the model Supervisees asking for information Giving supervisees information Model implicitly informing supervision work	Having theoretical models of supervision

R: So it's very much there in terms of your framework of reference Yes, yes, that's right and taken together, I think those two together are the kind of probably the entire substance of my theoretical knowledge on supervision *R: Yes, because you said earlier, it's primarily about your therapeutic model, isn't it?* P5: Mmm.	Popping up with automatic thoughts Being what he knows about supervision theory	 Primarily being informed by therapy model
R: So can you tell me about a typical supervision session of yours. What would it look like? P5: A typical supervision session? [pauses to think]. I suppose probably some factors that will always be present and some factors that will sometimes be present and the factors that will always be present will be some kind of agenda, and - what does a typical one look like? Identification of – agenda, identification of the main topics we'll be covering, and if possible to formulate that as the supervision question, "what is it you're wanting to address, to hear and why is that important to you?" So that would always be kind of typical. Then case presentation from people and then working with – and so there'll be a phase of exploration, information gathering and exploration, hypothesis generating and then a plan for how to take that back out into the work. So, that would be what it typically would look like. Having said that, there may also be quite a lot of general supportive listening if there are any difficulties coming up in their personal life and their academic study as well.	Some factors always being present Some factors being present sometimes Setting an agenda always being present Identifying main topics for supervision session Trying to formulate as supervision question Asking what the supervisee wants to address Being typical Supervisees doing case presentation Working with case presentation Exploring Generating hypotheses Planning how to take it back to work with client What a typical session looks like Being a lot of supportive listening Supportive listening when difficulties for supervisee Supervisee difficulties in personal life or in training	Having a typical session structure Asking what supervisee wants Supervisee presenting cases Being supportive to supervisee

APPENDIX 9

Table 2. Comparison of versions of Grounded Theory analysis

	FIRST LEVEL ANALYSIS	**SECOND LEVEL ANALYSIS**	**THIRD LEVEL ANALYSIS**	**Version Features**
Glaser and Strauss (1967)	Coding and Constant Comparison	Identifying the core category; integrating properties	Delimiting and generating theory	'The Glaser and Strauss version offers little practical guidance on coding procedures' (Birks and Mills, 2011, p.95)
Glaser (1978)	Substantive or Open Coding	Selective coding: identifying the core variable; selective coding for the core variable only; delimiting the coding to codes relating to the core variable	Theoretical coding (conceptualising how the substantive codes relate to each other). Using coding families; Glaser uses theoretical coding to define relationships between codes in a similar way to axial coding.	Glaser (1992) suggests there are two types of codes (substantive and theoretical) although three coding processes. The core variable emerges and is selectively coded for, delimiting the coding to only those codes relevant to the core variable. Other variables are 'demoted' to a role 'subservient' (1978, p. 61) to the core variable.
Strauss and Corbin (1990; 1998)	Open Coding	Axial Coding using a Coding Paradigm	Selective Coding for the core category and generating the story line.	The coding paradigm is the key feature used in second level analysis with axial coding to determine relationships between categories and explicate dimensions and properties
Charmaz (2006)	Initial Coding	Focused Coding	Theoretical Coding for integration of categories and raising level of abstraction	Charmaz puts less emphasis on identifying a core category and more on integrating categories and sub categories.

APPENDIX 10: Diagrammatic Development of Theoretical Integration Version 1

Trying to work it through in supervision - balancing trust and negotiating expectations

ASSUMPTIVE LENS

Believing in my model
- Implicit Trusting
- Personal and professional values
- Shaping supervision practice
- Matching with supervision practice - training - models
- Applying it to supervision practice
- Working with other therapeutic approaches in supervision
- Assuming the role - becoming a supervisor

Trusting in supervision
- Learning from being supervised
- Believing in professional discourse
- Thinking it through / needing to think it through in the interview
- Some tautological reasoning
- Negative cases

BEING PROFESSIONAL

Making choices and resolving dilemmas
- Leaving it to the supervisee [to decide what to bring, use the space]
- Taking the lead
- Trust dimension
- Time dimension
- Context dimension
- Dealing with ethical dilemmas
- Being the 'stalking person' – negotiating the policing - gatekeeping role

Meeting/fulfilling - trying to fulfil Expectations
- Professional pride and personal values - model
- Tasks of supervision [note taking, contracting]
- Dealing with ethical dilemmas and ethical decision making
- Being ethical and keeping boundaries
- Balancing supervisee, context and wider expectations

Stepping up and being accountable - responsible - checks and balances
- Am I getting it right - who checks on me
- Evaluating practice
- Using supervision
- Avoiding litigation

PUTTING THE SUPERVISEE AT THE CENTRE

Holding the supervisee in a flexible space
- A safe space
- A reflective space
- A personal space
- A work space

The supervisory relationship
- Creating a two way trusting relationship
- As a vehicle for supervisory practice

Enabling the supervisees
- To look after their clients – the nursing triad
- Teaching and learning
- Developing practice
- Building confidence
- Restoring
- Encouraging
- Developing practice
- Being directive/not being directive

THE CLIENT AT THE END OF IT ALL - there's a client in there as well

In the supervisee's shadow
- Bringing the client into the supervisee's space
- Seeing the client through the supervisee's lens
- Effects of seeing the client one step removed
- The Supervisee's Story
- The Client's Voice [report, audio, video, live, parallel process, other]

The invisible clients
- Not having the 'full picture'

Supervisee – Client Pull
- Slips of the tongue
- Torn Loyalties
- In the supervisee's shadow

INTERPRETING THE OUTCOME - interpretations of outcome - how it ends for the client

Unpacking meanings
- Outcome of what, for whom, when and how?

Identifying moment
- Thinking it through
- Trying to make it add up - referring back to other categories and properties
- Looking for solutions
- Thinking about responsibility

APPENDIX 10: Development of theoretical integration Version 2

PROBLEM AREA – Supervisors' Perspectives of the relationship between Supervision and Therapeutic Outcomes

FINDING A NARRATIVE EXPLAINING CONNECTIONS AND GAPS IN THE RELATIONSHIP BETWEEN SUPERVISION AND TOs

ASSUMPTIVE LENS - finding a baseline [trusting what I know, unexplored, unexamined connections]

Trusting the therapeutic approach
- Implicit trusting
- Personal and professional values
- Applying the therapeutic approach to supervision practice
- Working with other therapeutic approaches in supervision
- Assuming the role - becoming a supervisor

Trusting in supervision
- Learning from being supervised
- Believing in professional discourse
- Thinking it through in the interview
- Tautological reasoning and identifying moment
- Negative cases

BEING PROFESSIONAL Quality Control

Making choices and resolving dilemmas
- Leaving it to the supervisee
- Taking the lead
- Trust dimension
- Following up and time / context dimensions
- Dealing with ethical dilemmas and ethical decision making
- Being the 'stalking person' – negotiating the policing role

Meeting expectations
- Professional pride and personal values
- Tasks of supervision [note taking, contracting]
- Being ethical and keeping Boundaries
- Balancing expectations

Being accountable
- Evaluating practice
- Checks and Balances
- Using Supervision
- Avoiding Litigation

LOOKING AFTER THE SUPERVISEE - restorative element and educative element

Holding the supervisee in a flexible space
- A safe space
- A reflective space
- A personal space
- A work space

The supervisory relationship
- Creating a two way trusting relationship
- Vehicle for supervisory practice

Enabling the supervisees to look after their clients – the nursing triad
- Teaching and Learning
- Developing practice
- Restoring
- Encouraging
- Being directive / not being directive

THE CLIENT AT THE END OF IT ALL

How the client emerges in supervision
- The Supervisee's Story / shadow / lens
- The Client's Voice [report, audio, video, live, parallel process, other]
- Effects of seeing the client one step removed

The invisible clients
- Having / not having the 'full picture'
- Implications - meaning of not having 'full picture'

Supervisee – Client Pull
- Slips of the tongue
- Torn Loyalties

OUTCOMES AND RESPONSIBILITY

Finding the right language
- Viewed according to therapeutic approach
- Just not a part of what supervision is

Identifying moment
- Thinking it through
- Trying to make it add up
- Looking for solutions
- Thinking about responsibility

APPENDIX 10: Development of theoretical integration Version 3

PROBLEM AREA – Supervisors' Perspectives of the relationship between Supervision and Therapeutic Outcomes

NEGOTIATING AN AMBIVALENT PATHWAY WITH PROBLEMATIC LINKAGES AND IMPLICATIONS

FINDING A THEORETICAL BASE FOR SUPERVISORY PRACTICE [becoming a supervisor, a baseline , trusting what I know, unexplored, unexamined connections]

Trusting the therapeutic approach [what is influencing supervision practice]

- Implicit Trust
- Personal and Professional Values
- Applying the Therapeutic Approach to Supervision
- Working with Other Therapeutic Approaches in Supervision

Trusting in Supervision

- Learning from being supervised
- Believing in professional discourse
- Unexplored Connections - thinking it through in the interview - identifying moments
- Negative cases

MAKING DECISIONS AS A PROFESSIONAL- quality control

Making Choices and Resolving Dilemmas

- The trust contradiction
- Role conflict [using supervisory relationship]
- Leaving it to the supervisee or taking the lead [directive issue]
- Time and context properties

Meeting Expectations

- Professional pride and personal values
- Tasks of supervision
- Being ethical and keeping boundaried
- Balancing competing expectations

Being Accountable

- Evaluating practice
- Checks and Balances
- Using Supervision
- Avoiding Litigation

LOOKING AFTER THE SUPERVISEE - restorative element and educative element

Holding the Supervisee in a flexible space

- A safe space
- A reflective space
- A personal space
- A work space

The supervisory relationship

- Creating a two way trusting relationship

Enabling the Supervisees to look after their clients – the nursing triad

- Teaching and Learning
- Developing practice
- Restoring
- Encouraging

THE CLIENT AT THE END OF IT ALL

How the client emerges in supervision

- The Supervisee's Story / shadow / lens
- The Client's Voice [report, audio, video, live, parallel process, other]
- Effects of seeing the client one step removed

The invisible clients

- Having / not having the 'full picture'
- Implications - meaning of not having 'full picture'

Supervisee – Client Pull

- Slips of the tongue
- Torn Loyalties

LOCATING OUTCOMES IN THE SUPERVISION SPACE Outcomes and Responsibility

Finding the right language

- Viewed according to therapeutic approach
- Just not a part of what supervision is

Responsibility

- Thinking it through
- Trying to make it add up
- Identifying moment
- Finding a solution
- The Responsibility Axis

APPENDIX 10: Development of theoretical integration Version 4

PROBLEM AREA – Supervisors' Perspectives of the relationship between Supervision and Therapeutic Outcomes

NEGOTIATING AN AMBIVALENT RELATIONSHIP WITH PROBLEMATIC LINKAGES AND IMPLICATIONS

INFLUENCES AND ASSUMPTIONS [becoming a supervisor, baseline, trusting what I know, shaping supervisory practice, implicit connections]

Influence of Therapeutic Approach

- Conceptualising own therapeutic approach
- Personal and professional values [personal philosophy and professional practice]
- Applying the approach in Supervision [comparing with supervision models] supervision models
- Working with other therapeutic approaches

Beliefs about supervision

- Learning from being supervised
- Learning from supervisor Training
- Learning from a wider / professional discourse

Intentionality and Awareness

- In relation to TOs

Being a Professional Quality Control

Making Choices and Resolving Dilemmas

- The trust contradiction
- Leaving to supervisee or taking the lead [add Time and Context]

Meeting Demands

- Staying congruent [professional pride and values]
- Balancing competing demands / expectations - supervisee 'paying customer, organisations, profession

Being Accountable

- Evaluating practice
- Tasks of supervision Checks and Balances [including using supervision, avoiding litigation]
- Being ethical [and keeping boundaried]

LOOKING AFTER THE SUPERVISEE - restorative element and educative element

Holding the Supervisee in a flexible space

- A safe space
- A reflective space
- A personal space
- A work space

Forging a Trusting Relationship

- Creating a two way trusting relationship
- Role Conflict [using the supervisory relationship]

Enabling the Supervisees to look after their clients – the nursing triad

- Teaching and Learning
- Developing practice
- Restoring
- Encouraging

THE CLIENT AT THE END OF IT ALL

Bringing the Client into Supervision

- The Supervisee's Story / shadow / lens
- The Client's Voice [report, audio, video, live, parallel process, other]
- Effects of seeing the client one step removed

The invisible clients

- Having / not having the 'full picture'
- Implications - meaning of not having 'full picture'

Supervisee – Client Pull

- Slips of the tongue?
- Torn Loyalties ?

LOCATING OUTCOMES IN THE SUPERVISION SPACE Outcomes and Responsibility

Finding the right language

- Viewed according to therapeutic approach?
- Just not a part of what supervision is?

- ***Monitoring Outcomes***

Intentionality and Awareness

- In relation to TOs

An Axis of Responsibility

- Thinking it through?
- Trying to make it add up?
- Identifying moment?
- Finding a solution?
- The Responsibility Axis?

APPENDIX: 10 Development of theoretical integration Version 5

Indirect relationship characterised by contradiction, ambiguity, ambivalence and vagueness and lacking intentionality - uneasy and indistinct relationship. JUST NOT A PART OF WHAT SUPERVISION IS. Where is intention in impact on supervisee development and client outcomes?

INFLUENCES AND ASSUMPTIONS [becoming a supervisor, baseline, trusting what I know, what preconceptions, where did they come from, how do they influence perceptions of the relationship with TOs?]

Theoretical and Philosophical Foundations*[establishing theoretical base for supervision practice]*

- *Trusting the therapeutic approach and philosophical base/values*
- *Working with other approaches*
- *Learning from supervisor training*
- *Using models of supervision*
- *Other influences - wider discourse*
- *Intentionality and awareness*

Learning from Practice – Skills?

- *Learning from being supervised*
- *Other influences – teaching supervision, giving supervision*

Beliefs about supervision

- *Making assumptions about supervision*
- *Believing in supervision [and negative cases]*
- *Considering the value of supervision*

BEING PROFESSIONAL
Normative element

Making Choices and Resolving Dilemmas

- *The trust contradiction*
- *Leaving it to the supervisee or taking the lead [including time and context]*

Meeting Professional Demands

- *Meeting demands of professional role – tasks of supervision*
- *Balancing competing demands - supervisee, organisation, profession*
- *Dual roles*
- *Being accountable [i.e. evaluating practice]*
- *Being ethical [getting support, using supervision, avoiding litigation]*

LOOKING AFTER THE SUPERVISEE [to look after the client - nursing triad - restorative and formative elements

The Supervisee's Space

- *A safe space*
- *A reflective space*
- *A personal space*
- *A work space*

Creating the Supervisory Relationship

- *A Collaborative Relationship*
- *Two Way Trusting Relationship*
- *A Deeper Bond*
- *Role Conflict*

Enabling the Supervisee *- to look after their clients – the nursing triad*

- *Teaching and Learning*
- *Developing Practice*
- *Encouraging and Confidence Building*

THE CLIENT AT THE END OF IT ALL

Bringing the Client into Supervision

- *Supervisor's relationship with the client*
- *The Supervisee's Story / shadow / lens*
- *The Client's Voice [report, audio, video, live, parallel process, other]*
- *Effects of seeing the client one step removed*

The invisible clients

- *Having the full picture of the supervisee's case load - supervisee's practice*

Supervisee – Client Pull

- *Slips of the tongue?*
- *Torn Loyalties ?*

THERAPEUTIC OUTCOMES – tussling with new connections, playing with new connections, thinking it all through

Finding the right language

- *Viewed according to therapeutic approach?*
- *Just not a part of what supervision is?*
- *Measuring and monitoring and Therapeutic Outcomes*

Making it fit, making sense of the relationship between supervision and TOs

- *Thinking it all through*
- *Identifying the nature of the connections between supervision and TOs*
  - *Intentionality and Awareness in relation to TOs*

Working out Responsibility

- *The Responsibility Axis*

APPENDIX 10: Development of theoretical integration Version 6

BEING AMBIVALENT ABOUT AN INDIRECT AND INDISTINCT RELATIONSHIP. Overall it's an indirect relationship characterised by contradictions and vagueness and the root of it is that there is no intentionality on the part of supervisors to influence the TO directly. The intention is to look after the supervisee and to develop the supervisee's practice in diverse ways - no measurement of effects of supervision on supervisee's development - intention - frame of reference

BEING A PROFESSIONAL
Normative element

Influences and Assumptions
- *Theoretical and philosophical foundations [therapy model, supervisor training, supervision model]*
- *Learning from practice [learning from having supervision, learning from giving and teaching supervision]*
- *Finding the value in supervision and negative cases*

Being Accountable
- *Evaluating supervisory practice*
- *A wider accountability [public, law]*

Finding Support
- *Staying ethical as a supervisor*

MAKING CHOICES AND RESOLVING DILEMMAS

Meeting Professional Demands
- *Tasks of the professional role - contracting, notetaking*
- *Balancing competing demands - dual roles, contexts of supervision*

Leaving it to the supervisee or taking the lead
- *Leaving it to the supervisee*
- *Following up and checking out*
- *Keeping the supervisee ethical*
- *Negotiating the space [time and context demands]*

Trust Contradiction
- *Trusting and assuming*
- *Not trusting*
- *Knowing both things- holding the tension*
- *Managing the contradiction*

PUTTING THE SUPERVISEE AT THE CENTRE - restorative and Formative elements

Creating the Supervisory Relationship
- *A Collaborative Relationship*
- *Two Way Trusting Relationship*
- *A Deeper Bond*

Role Conflict
- *Being 'stalking person' and 'good parent'*
- *Negotiating conflictual positions*

The supervisee's space
- *A Safe Space*
- *A Personal Space*
- *A Work Space [and reflective space]*
- *Enabling the supervisee*

THE CLIENT AT THE END OF IT ALL

Bringing the client into the supervision space
- *Supervisor's relationship with the client - the fantasy relationship*
- *Effects of seeing the client one step removed*
- *The Supervisee's Story / shadow / lens*
- *The Client's Voice [report, audio, video, live, parallel process, other]*

The Invisible Clients
- *Different versions of the full picture [case load, outcome]*
- *Missing piece - not following through on supervisor interventions?*

Supervisee-client pull
- *Slips of the Tongue*
- *Torn Loyalties? Linking to supervisory relationship?*

FINDING THE CONNECTIONS AND MISSING LINKS

Finding the Right Language
- *Tussling with notions of TOs*
- *Viewed according to therapeutic approach?*
- *Just not a part of what supervision is?*
- *Intentionality and TOs*

Assessing - Evaluating TOs
- *Measuring TOs*
- *Monitoring TOs*

Working out Responsibilities
- *Supervisor Responsibilities*
- *Supervisee Responsibilities*
- *Client Responsibilities*
- *A Responsibility Axis*

Playing with Connections or Trying to Connect the Pieces
- *Direct connections*
- *Through a step*
- *Thinking it all through*
- *Supervisory purpose*

APPENDIX 10: Development of theoretical integration Version 7

BEING AMBIVALENT ABOUT AN INDIRECT AND INDISTINCT RELATIONSHIP. Overall it's an indirect relationship characterised by contradictions and vagueness and the root of it is that there is no intentionality on the part of supervisors to influence the TO directly. The intention is to look after the supervisee and to develop the supervisee's practice in diverse ways. - no measurement of effects of supervision on supervisee's development - intention - frame of reference

BEING A PROFESSIONAL

Influences and Assumptions
- *Faith in the Therapeutic Approach and its application in supervision*
- *Professional and personal philosophy*
- *Learning from supervising and being Supervised*
- *Finding the value in supervision*

***Meeting Professional Demands** – how I conceive and manage the role*
- *Tasks of the professional role*
- *Managing Multiple Roles, contexts, demands*

Being Accountable
- *Accountable to whom for what [law, public, context, supervisees]*
- *Evaluating supervisory practice*
- *Being supported and staying ethical*

MAKING CHOICES AND RESOLVING DILEMMAS

Leaving it to the supervisee or taking the lead
- *Leaving it to the Supervisee*
- *Keeping the supervisee ethical*
- *Wanting to follow up and check out*
- *Limited by time and context*
- *Negotiating the space with the Supervisee*

The trust contradiction
- *How do supervisees choose what to bring?*
- *Trusting and assuming*
- *Knowing the Dark Side*
- *Holding the tension and Managing the contradiction*

PUTTING THE SUPERVISEE AT THE CENTRE [normative, formative, restorative]

The supervisee's space
- *Defining the space*
- *The safe space illusion*

Enabling the supervisee
- *The nursing triad*
- *Teaching and Learning*
- *Supporting and Restoring*

Creating the supervisory relationship
- *A Collaborative Relationship*
- *Two Way Trusting Relationship*
- *A Deeper Bond[supervisee-client pull]*
- *Conflicted relationship [being 'stalking person' and 'good parent']*

THE CLIENT AT THE END OF IT ALL

The client's space
- *A Dynamic Contention*
- *Supervisor's relationship with the client - the fantasy relationship*
- *Effects of seeing the client one step removed*
- *The Supervisee's Story / shadow / lens*
- *The Client's Voice [report, audio, video, live, parallel process, other*

The invisible clients
- *Different versions of the full picture [case load, outcome]*
- *Missing piece - not following through on supervisor interventions?*

FINDING THE CONNECTIONS AND MISSING LINKS

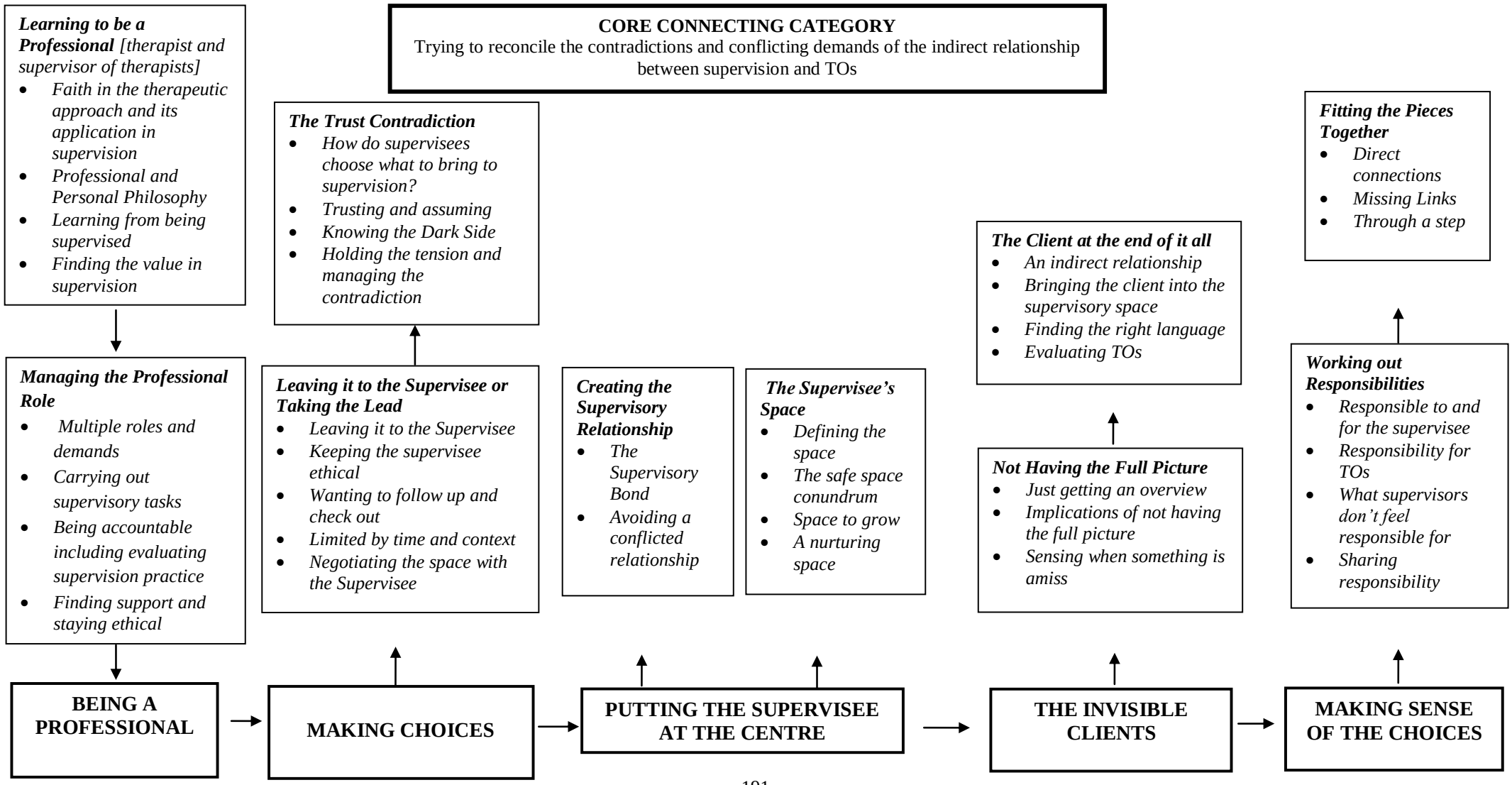
Finding the right language
- *Meanings and interpretations*
- *Tussling with notions of TOs according to therapeutic approach*
- *Just not a part of what supervision is?*
- *Intentionality and TOs*

Evaluating TOs
- *Following through on supervisor interventions*
- *Measuring TOs*
- *Monitoring TOs*

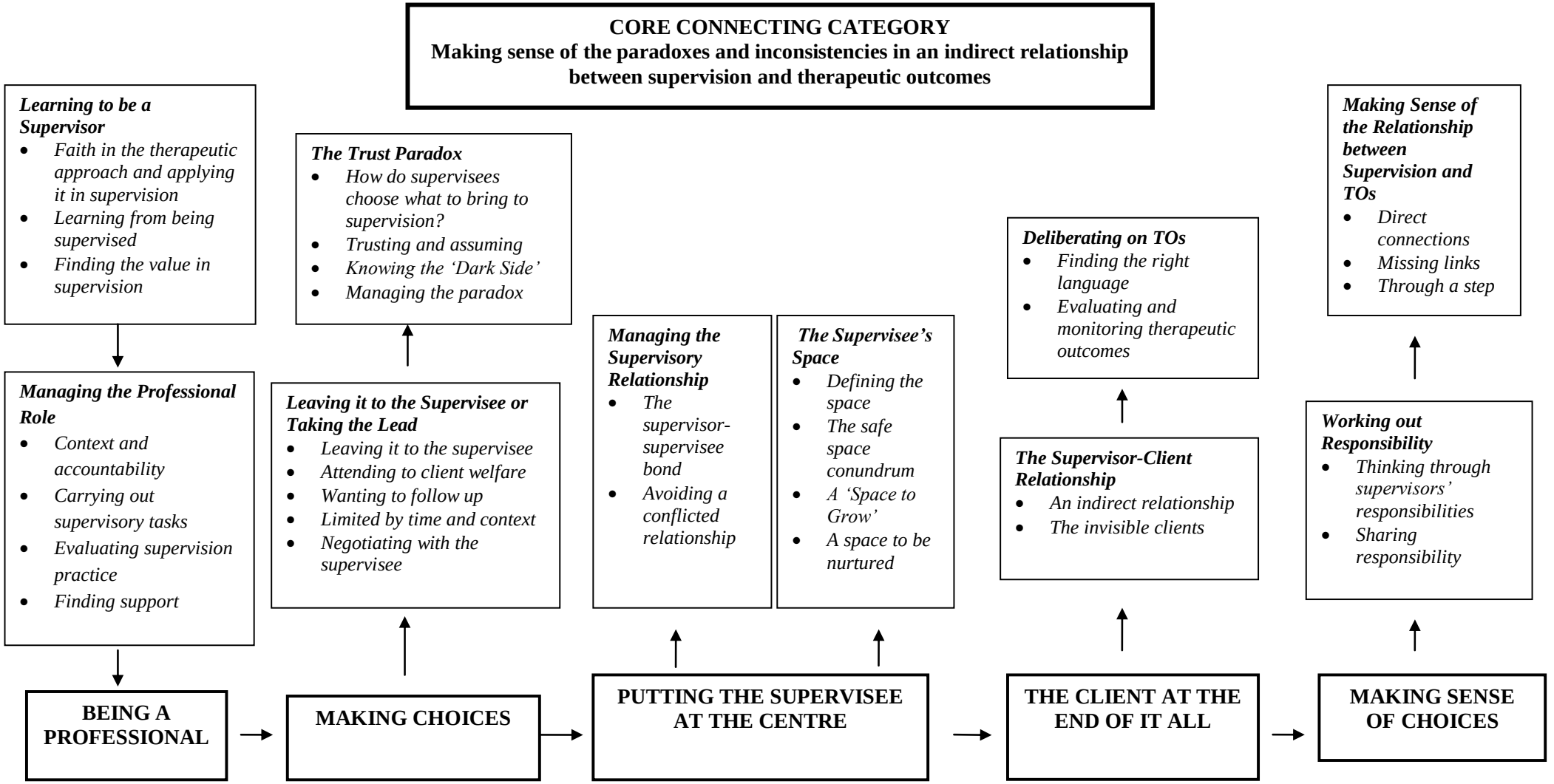
Working out responsibilites
- *Responsible to and for the supervisee*
- *Overall Supervisor Responsibility*
- *What supervisors don't feel responsible for*
- *Sharing responsibility*

Fitting the pieces together - perceptions of how supervision contributes to TOs]
- *Direct connections*
- *Through a step*
- *Thinking it through - coda*

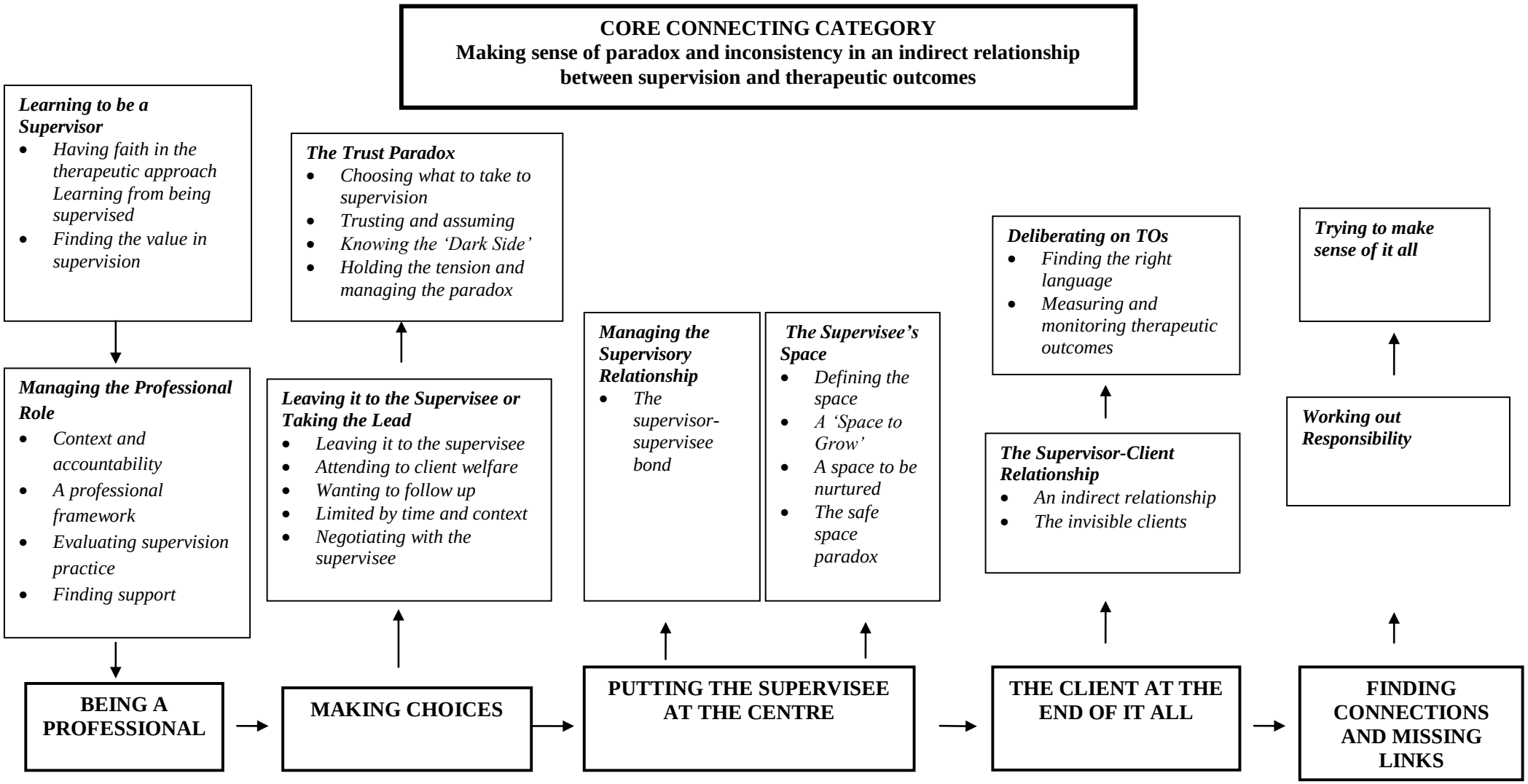
APPENDIX 10: Development of theoretical integration Version 8



APPENDIX 10: Development of theoretical integration Version 9



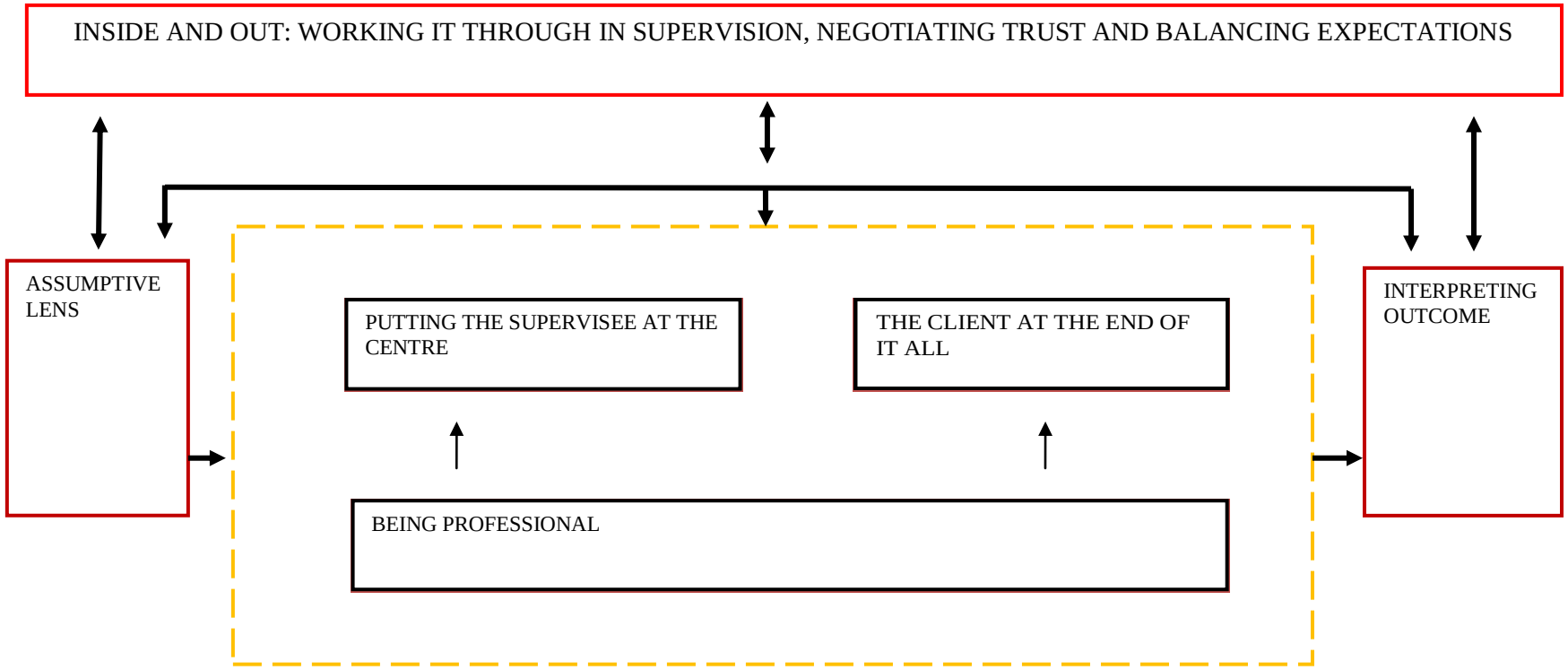
APPENDIX 10: Development of theoretical integration Version 10



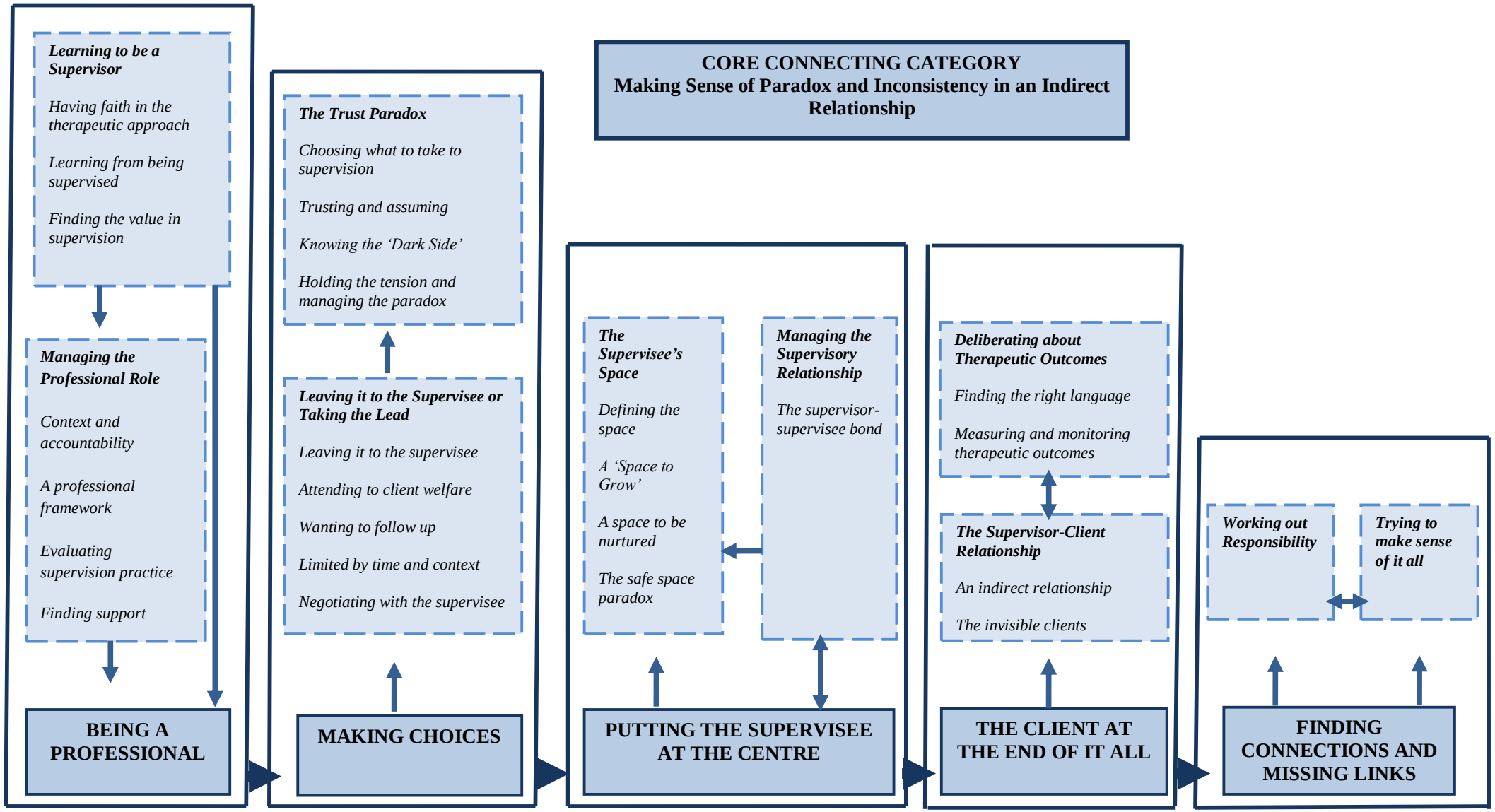
APPENDIX 11: Development of Explanatory Model Version 1

DIAGRAMMATIC THEORETICAL INTEGRATION

Supervisor Perspective of the Relationship between Supervision and Client Outcomes



APPENDIX 11: Development of Explanatory Model Version 2



APPENDIX 12

MEMBER CHECKING FEEDBACK

The findings do resonate with my experience ... the notion of a supervisor following up on particular clients struck me as a core issue (P1).

It fits with my impression that most supervisors do not consider therapeutic outcomes, which is worrying ... I think the link to personal philosophy is interesting and a topic that needs more discussion in the field ... reading this made me think more about the disclosure issue (P2).

I have found much of it fascinating. You have drawn out common themes and it makes for accessible reading (P4).

On the whole all the themes resonate ... after the interview I did give my practice a lot more thought and questioned my interventions more closely' (P6).

I've read through [the extracts of the findings] a couple of times and ... I'm sure you have it right (P8).

the findings give me greater clarity on the issues involved in the research & it was very useful to have taken part in the interview ... I was particularly interested in the dynamic for supervisees working with a different orientation to the supervisor and how 'one size' may not fit all. I do not feel the need to challenge any of the connections you have made (P10).

I am not sure that ambivalent is the right expression here, I think clarification is needed re what it means in this context ... I think that we choose the approach that fits with our personality ... I think as a result of this I may start asking people – when we evaluate – what it is they are not bringing! (P11/FG).

Has made me think more carefully about the impact and effect on 'outcomes' and of 'meaning' of the therapy for the client that myself as supervisor might have / contribute ... further consideration of what may NOT be brought to supervision and how to facilitate this appropriately ... so much more to think about than I had appreciated previously (P12/FG).

I'm not comfortable with the word "ambivalent" as a characterisation of my perception of the relationship between supervision and therapeutic outcomes.

"Ambivalence" refers to something that's not thought through, or where someone is in two minds about something. That's not an accurate characterisation of where I stand as I think I do have a consistent position on the subject of supervision.

When discussing supervision and therapeutic outcomes I think it's easy to end up talking at cross purposes because we have in mind different notions of what we're talking about.

It's important to distinguish between clinical supervision and training supervision.

The relationship between supervision and therapeutic outcome can be understood either in managerial or non-managerial terms, but it is all too easy to slip from the one framework into the other. I think this slippage is apparent in a number of places in the draft summary.

'Therapeutic outcome' can be defined in many different ways ...

The supervision I do seems to work best when supervisees feel safe.

I'd put my responsibility for therapeutic outcomes like this. I go back to my legal responsibility and build on that. My responsibility is to my supervisee and I think it's confusing if I focus on anything else.

Is this shared responsibility? I don't think that's the best way of putting it. I want to encourage my supervisees to be grown up and take on full responsibility for their work, whilst knowing that I'm 100% behind them as far as I can be, but as a support or as an assistant in helping them do the very best they can. (P13/FG). *

*P13/FG gave very detailed feedback which developed the discussion of the points raised in the focus group interview and developed the points in the Findings excerpts, which engaged him on a profound level. The feedback, while including some insightful comments, is too lengthy to include in full so extracts have been included which I think have specific relevance to this study.

APPENDIX 13

Excerpts from Reflective Journal

01.05.2011

I'm feeling very confused about the direction of the research as all kinds of avenues are emerging and it's like seeing a field of rabbits running in all different directions! Which ones do I chase? After 4 interviews there is so much data it's tempting to want to follow them all up and I know this would lead to trying to do several research studies at the same time. So many thoughts and so many directions. I'm trying to keep focused on my original research area but it's hard to keep focusing on it with so many seemingly different directions. I'm reading Glaser's Theoretical Sensitivity at the moment and this is what I need right now. I need to go back and look at the focused coding and think more about patterns and inter-relationships.

I know this is how to keep focused on my research area but I think the underlying anxiety is that there is a worrying gap in the data about TOs. I think this is another reason why chasing other rabbits is tempting as it seems so much easier than to keep searching for the rabbit with 'Therapeutic Outcome' on his waistcoat! It just feels like I can make so much more out of other avenues but at the same time I know that the gap in itself is significant. It feels so much harder to focus on a gap! I need to memo now about the 'gap' and see where it takes me.

21.09.2011

I've been thinking about the role of language – taking meaning for granted, not finding out, using a shared language as counsellors, as supervisors, as counselling psychologists and taking for granted that we know what each other means. I remember my surprise during the first interview when the participant began to reflect on the meaning of TO. I had just taken it for granted that this would be part of the universal language and that the focus would be on the part supervision plays/doesn't play. I'm a little concerned now about my own preconceptions and implicit assumptions. It has been salutary - but helpful, to experience this. Having moved around approaches from humanistic, to psychodynamic to CBT, I had thought I had a wider perspective. Having just interviewed a psychoanalytic participant has taken me back to my psychodynamic roots and I realise I need to be vigilant about reflecting on my own preconceptions and assumptions.

25.02.2012

I've just had a really useful meeting with a colleague/friend about my research and he seems really excited about what's emerging. He loves GT and so it was very helpful to have someone to 'brainstorm' with about coding and possible categories. There are so many interesting issues and I can see a real shape materialising from the data mountain. He also tells me that on the basis of what's emerging he is reviewing his own supervision practice, which feels very affirming.

So this is all good - but I'm feeling anxious. As I think back it's that so much of what is emerging - the not knowing, the identifying moments, the contradictions, inconsistencies - are fascinating but it's still feeling as though there is a gap, that the relationship between supervision and outcome is elusive. On the other hand, the moment of being confounded and temporarily confused in the interviews parallels my own thinking in the workshop that began this process. Perhaps the 'gap' is the point of it all.

06.01.2013

I've just agreed to take on a new supervisee - the first new supervisee since I started my research so I have an opportunity for using the research in practice. I'm still working through theoretical integration so it's still embryonic, but I know for sure that I will be more focused about contracting and have a much wider understanding of the issues. I wonder how it will be for her? She is experienced herself and so it may be a surprise when I broach issues like client outcome and 'full picture' and all the other issues buzzing around in my head. It would be good to be doing this when I have fuller findings but maybe the experience in itself will shift my own understanding when I experience some of this in practice.

It's set me thinking about how my perspective of supervision has changed since I started out. I think after the workshop (that started it all!) I was pretty much thinking that we should, as supervisors, monitor outcomes in some shape or form. At this point,, I can see that it is so much more complex than that and that supervision fulfils so many roles and perhaps too many roles. But - it still seems to me that accountability is missing somewhere and I suppose I see this as a moral issue not just a methodological one. I think being clearer about this is an 'outcome' of sorts in terms of transferring learning from the research back to practice. This still needs thinking through but perhaps a discussion with a new supervisee is a good place to start.

PART C: PROFESSIONAL PRACTICE

A Case Study of

Context Driven Group Supervision

Foreword

This case study was the first completed piece of work in the thesis portfolio and returning to it again in the final stage of editing and proof reading of the portfolio has been a valuable learning experience. Reviewing this work has reminded me of some of the implicit assumptions I shared with my participants, prior to carrying out the research and reinforces my sense of having co-constructed new perspectives with them, throughout the research process. I have revised and updated parts of the case study (for example, website references) but have left these items intact to demonstrate the transformative effects of the research on my own understanding of supervision practice. They are identified by superscript notations and critiqued at the end of the case study.

Introduction

The group supervision presented in this case study took place within a university setting over one academic year. The three supervisees were trainees employed as High Intensity trainee psychological therapists under the Government scheme Improving Access to Psychological Therapy (IAPT) (IAPT, 2013) and attended the university training course in Cognitive Behavioural Therapy (CBT) for High Intensity trainees for two days a week for one academic year.

The case study begins by describing the context of the work and the issues involved. It then presents an overview of the theoretical underpinnings for the work, describing how they informed and supported it. There is an account of the supervision with the three supervisees and the study concludes with an evaluation of the work and the learning I derived from it.

Rationale for choosing this work

The circumstances of this supervision presented a complex range of contextual demands, which impacted on the supervision work and challenged my skills as a supervisor. It raised my awareness of the impact of context on the supervision work (e.g. Carroll, 1996; Hawkins & Shohet, 2012; Towler, 2005, 2008) and developed my learning significantly. There was a complicated grouping of organisations involved in the supervisees' training programme and clinical practice and, in addition, my supervisor role was complicated by having additional roles. The elements involved are described below.

The Organisational Context

As the supervision was an element of a university training course, university examination assessment procedures were a constant presence. In addition, the training course had to be

structured and implemented to conform to IAPT national curriculum guidelines (National Curriculum for High Intensity Courses, 2011) and to satisfy the criteria for course accreditation with the professional body for the cognitive behavioural therapies, the British Association for Behavioural and Cognitive Psychotherapies (BABCP) (BABCP, 2013a). A further complication was that the course had to provide the trainees with eligibility for individual accreditation criteria with BABCP (BABCP, 2013b). Finally, the supervisees' workplaces had their own policies and procedures and the course serviced five different employing organisations.

The Supervisees' Context

The trainees spent two days a week at the university and the remaining three days in clinical practice in their respective IAPT workplaces. The course curriculum was 'intense' as the course title implies and they began working with clients from the first days in their employment, which began shortly before the academic training. The supervisees received weekly group supervision at the university in groups of three for 1.5 hours a week as mandated by IAPT guidelines; in addition, they were expected to receive weekly individual supervision in their IAPT service but this was variable according to the resources within the different services. However, it meant that the supervisees worked with two different supervisors throughout the year, adding to boundary issues and the potential for confusion. All supervision, whether university or workplace based, had to meet IAPT and BABCP criteria and compliance was demonstrated in a completed portfolio at the end of the course.

The Supervisor's Context

There were three aspects to my role: supervisor, tutor and programme director. As tutor I was responsible for assessing the trainees' work throughout the year. As programme director I was responsible for the overall management of the programme but what was more relevant for the trainees was that this entailed liaising with workplace managers, with BABCP (in managing the course accreditation) and liaising with national IAPT co-ordinators. In effect, it entailed being in regular communication with those involved in the supervisees' overall assessment[1].

Issues involved and Aims for Supervision

The complexity of interfaces framing the context of the work was significant and boundary issues were a central concern. Maintaining the boundaries of my supervisor role was a primary issue; maintaining the boundaries of the supervision space was a further issue, in that supervision needed to be protected from organisational demands as well as serving

them[1]. The issue of the supervisees working with two clinical supervisors needed to be addressed in order for it to be a benefit and not a hindrance to the work and their development[1].

In terms of my role boundaries, I wanted to balance the normative, educative and restorative functions (Proctor, 1988) appropriately and not become inappropriately didactic by slipping into tutor role, or become overly administrative by slipping into programme director role. A further aim was to maintain a spirit of transparency and openness in the supervision. There were problematic areas that realistically would impact on the work and on our relationships within the group. By promoting a climate of openness, I hoped that we would be able to address and learn from difficulties that might emerge.

Theoretical Background

Delivering supervision in a group format is a complex process (e.g. Lockett, 2001) and although it is widely practised (Prieto, 1996) the research base remains sparse (Mastoras & Andrews, 2011; Werstlein & Borders, 1997) although there are indications of increasing interest (Fleming, Glass, Fujisaki, & Toner, 2010; Smith, Riva & Erickson Cornish, 2012). For a theoretical base to frame and inform the work in this case study I drew on two primary sources: a CBT model of supervision[2] (Liese & Beck, 1997; Padesky, 1996) and Proctor's participative group supervision style (Proctor, 2000, 2008).

The CBT model of supervision mirrors the structure of a CBT therapy session. Supervision begins by linking back to issues from the previous session, then collaboratively setting an agenda for the session and using specific CBT features such as Socratic dialogue, guided discovery and collaborative empiricism (Beck, 1989) to provide supervisees with an experiential understanding of the approach. Sessions end with supervisees summarising their learning from the session and describing how it will inform the clinical work, and this is followed by both supervisor and supervisee offering feedback on the session. The supervisor and supervisee might agree on work for the supervisee to do between supervision sessions such as reading or developing techniques. Personal development work may be part of the out of session work, and although it is important that the boundary between therapy and supervision is explicit (e.g. Feltham & Dryden, 1994) where a belief or cognitive bias is hindering the work, this can be useful experiential learning for the supervisee. All three supervisees in this case study worked on elements of their personal belief systems during the work.

Based on my own early experiences of supervision[3], I have been drawn to a participative supervision style, one of Proctor's four types of supervision (2000, 2008). Although trainees are often initially reluctant to fully 'participate', encouraging participation facilitates self belief in clinical judgement and competence. Full participation by supervisor and supervisees gives the group its power, offering more opportunities for learning (Gonsalez-Doupe, 2008; Werstlein & Borders, 1997) and, 'at its best, a group is a great deal more than the sum of its parts. Potentially, the group *is* [author's italics] the supervisor' (Proctor, 2000, p.17). Hawkins and Shohet (2012) propose a quadrant model, similar to Proctor's four types model. However, they recommend that the supervisor should be flexible, moving between 'quadrants' (2012, pp.180-181) in order to avoid negative aspects of each of the styles such as collusion or dependency.

Although a power imbalance seems inevitable (e.g. Page & Wosket, 2001; Scaife, 2009), it is exacerbated in training supervision (Woolfe & Thostrup, 2010) by the fact that 'the supervisee is regularly exposing his shortcomings and difficulties in a way that is not the case for the supervisor' (Page & Wosket, 2001, p.12). Research has shown that power imbalance in the supervisory relationship is a major cause of trainee dissatisfaction with supervisors (Nelson & Friedlander, 2001). I tried to equalise the relationship with the supervisees by sharing some of my own difficult clinical experiences and this has been found to help supervisees be more forthcoming about their own problems (Knox, Burkard, Edwards, Smith & Schlosser, 2008). Creating a safe[4] enough supervisory environment for supervisees 'not to know' and maintain a non-shaming, valuing and respectful stance are aims that are present throughout my practice. A further way that I sought to address the power imbalance was to find and actively work with areas of 'expertise' that each supervisee brought to the group.

Responding appropriately to the supervisees' developing competences and experience (e.g. Stoltenberg & Delworth, 1987) was of primary importance and is especially important in training supervision where the formative function (Proctor, 1988) of supervision is a dominant feature (e.g. Holloway & Neufeldt, 1995; Wolfe & Tholstrupp, 2010). I drew on models of learning theory (James, Milne, Blackburn & Armstrong, 2006), and primarily the Kolb Learning Cycle (Kolb, 1984). The IAPT curriculum (IAPT, 2013) tended to dominate the sessions, especially as supervision has a central role in the training process (Roth & Pilling, 2008a, 2008b; Wheeler & Turpin, 2011). I often struggled to avoid becoming overly didactic, but an overriding pressure, for all of us, was that their jobs were in jeopardy if they failed the course, as the role of High Intensity CBT practitioner is dependent on the qualification, which bestows eligibility for accreditation with BABCP.

The Supervision Competences Framework (Roth & Pilling, 2008a; Supervision Competences Framework, 2013) for group supervision offered an outline for attending to group process, stating that supervisors should: promote good relationships between group members, between supervisor and supervisees, be alert to developing problems in relationships and be aware of issues of cultural difference and power issues.

The challenging impact of context on supervision practice is emphasised by Towler (2005, 2008), which can affect the process of supervision (Ungar & Costanzo, 2007) and Copeland (1998) emphasises the need for clear contracting. She also found (Copeland, 2002) that supervisors working with diverse organisational contexts experienced dilemmas relating to responsibility, confidentiality, boundaries and relationships amongst other difficulties. Holding role boundaries in this work was continually challenging and is a common difficulty where a supervisor performs dual roles (e.g.Tromski-Klingshirn, 2007; Tromski-Klingshirn, & Day, 2007).

The tutor-supervisor duality was a demanding one although Hawkins and Shohet (2012) point out that the assessment role exists for many supervisors who act as supervisor-referees for supervisees applying or re-applying for accreditation. They too advise that this is addressed at the contracting stage and that any difficulties are dealt with as soon as they arise, although supervisors tend to delay in addressing difficult issues (Smith, Riva and Erickson Cornish, 2012). The Division of Counselling Psychology (2005) advises that the supervisor is responsible for maintaining boundaries and should make trainees and supervisees aware of complaints procedures.

The Supervision Work

The Supervisees

The supervisees in this case study came from different workplaces so it was less likely they would have knowledge of each other's clients or their clients' family members, helping to prevent patient confidentiality issues arising within the group (Smith et al., 2012). They had not met before the start of the course, when the trainees had a full week in the university. The first supervision session took place at the end of this first week. All names and identifying material have been changed to protect the identities of the supervisees, their clients and their workplaces, though every attempt has been made to maintain the authenticity of the case study.

Richard had previous training and experience in counselling settings, and had worked with a variety of client groups. As the only male in the group, he said he was used to this from

previous training where females predominate. He had several colleague trainees in his workplace (also attending the course) and although the service was new, he felt well supported throughout the course.

Alice was a qualified and experienced health professional and had some familiarity with CBT techniques from this work but no previous counselling training or experience, which caused her anxiety from the outset. She was the youngest member of the group, the most enthusiastic and the most anxious. She was part of a small group of IAPT trainees in her workplace (also attending the course), her workplace service was well organised and she felt well supported.

Louise had psychology training, had worked with several specific client groups in a helping capacity but had had no counselling training. She was the oldest member of the group, and the least assertive and she also had the most personal commitments and responsibilities of the three outside the course. She had difficulties in her workplace from the start as she was placed in an isolated setting and her service was new and still being restructured.

The case study charts our journey together through an intensely pressurised year. The presentation of the case study is structured to parallel the three taught modules (and terms) of the course - Fundamentals of CBT, CBT for Anxiety Disorders and CBT for Depression. We met for a total of 27 sessions throughout the year.

Professional Framework

Although clear contracting at the outset of a supervision relationship is always important (Sills, 1997) the particularly complex circumstances of the context of supervision created more areas for clarification and discussion than is usually the case. The supervision contracts were devised by the course team and the dual involvement of course and workplace in the supervisee's training was addressed, together with procedures for resolving problems (Appendix 1).

Session notes were kept on a password secure computer, as were the audio recordings (recorded on a digital recorder and uploaded to a computer). Supervision for the work consisted of monthly peer supervision with the course team and private external supervision.

Beginnings

The First Session

In the centre of this complicated relationship matrix was the relationship between myself and the supervisees and theirs with each other and I believed that the challenges we were likely

to face would be resolved more positively if we were able to build a trusting relationship[5] (Bernard, 2005). We set an agenda collaboratively as far as we could but the supervisees were too apprehensive to offer very much at this stage. I knew from my own experience that beginning a new course can be very deskilling and it is easy to forget that one knows anything at all. With this in mind, I asked each supervisee about their work experience up to this point so that we had a foundation of 'good knowing' to counteract the deskilling process, and each one began to establish their own areas of expertise in the group. Richard began, followed by Alice and then Louise, which was to become a pattern that was addressed later in the year. The level of experience was impressive and we were all able to acknowledge this, and we then ended with my own background summary.

We each reflected on what we wanted from the supervision. Alice found this very difficult as this was her first experience of supervision and, I quickly found out in this session that she liked to know the 'rules'. Richard found it more straightforward to answer as he had previous experience of supervision but basically they were both looking 'to be told what to do' with their first patients, due to be seen the following week. Louise was experiencing the first of many problems. She was feeling isolated, had not been allocated a patient although she was experiencing some pressure to take on complex patients from a very long waiting list. This provided an opportunity for discussions between the three supervisees as Alice and Richard offered support and advice based on their new, and more positive, experiences.

I opened up the issue of my different roles, voicing my thoughts about the possible impact of the dual roles on how we might all experience our supervision together. The response at this point was muted but I intended that this would be a live issue for us and I knew there would be many opportunities to return to it through the course of the year. This led to examining and discussing the supervision contract. Again, there was little response so I asked them to reflect on it until the following week and we would return to it, though in the event nothing further emerged.

At the end of the first session I felt we had made a good beginning with a sense of mutual respect and good will, some humour and expressions of hopes as well as fears. I considered the collective plea of 'tell us what to do'. Shaw points out 'the technical acquisition of CB interventions is rapid, whereas judgments about when to apply these interventions develop slowly' (1984, p.179). I felt that supervision should offer a reflective space rather than more didactic input, if they were to accomplish this and I wondered to what degree they might resist.

First Clients

The supervisees were expected to be working with patients from the outset and Alice came the following week with a caseload of three patients, reporting that her workplace supervision had supported her in her first sessions with them. I took this opportunity to open up the discussion about their having two supervisors, suggesting that they could take this as an opportunity to develop their own clinical judgement by appraising supervisory input in the light of their own learning and experience rather than accepting. There was a welcoming response to the idea and we agreed to hold it in our collective awareness.

It was some weeks before Louise saw her first patients and despite encouragement from the group she was reluctant to speak up in her workplace. This was the first occasion I felt supervisor-programme director role conflict. To complete the course they had to complete a minimum of 200 clinical hours and so Louise's position could quickly become precarious. As a group we explored her options, including my intervention with her workplace and Louise challenging herself as to what prevented her from voicing her needs. Alice and Richard were sensitive and supportive and there was a sense of sharing responsibility.

Supervisees' Development

CBT training involves using audio recordings of client sessions in supervision in order to support the supervisee's development as a cognitive behavioural therapist by giving feedback on their performance[6]. They were all reluctant to bring recordings but eventually Alice was the first to bring one and then Richard. They both agreed that they had learned a lot about themselves and the experience was less daunting than they feared. Nevertheless, it was still a struggle to get them to bring recordings to supervision and we discussed the problem in peer group supervision.

By the middle of the first module, Louise had resolved the issue of patient referrals herself but though she had four patients they refused to give their consent to have sessions recorded. Again, I felt the conflict of my dual role but trusted that discussion and support would help Louise resolve this problem, as recordings were essential for inclusion in the final portfolio.

During this module, the supervisees' self confidence was low as they struggled to assimilate and apply large amounts of theory. The theme in supervision continued to be 'tell me what to do' and I had failed to resist this on a number of occasions. In an effort to moderate their self critical attitudes, around the mid way point of the module, I shared some of my early experiences as a therapist and while they enjoyed the stories I could not be sure of their effect.

Alice in particular struggled with self criticism and set herself very high standards, while Richard had a more relaxed attitude. They both took advantage of sharing personal process in the group and gained support from the group by doing this but Louise found opening up more difficult. She was more reserved about herself though exceptionally sensitive and empathic with Richard and Alice and engaged warmly with their process. Her reserve concerned me insofar as I knew of her workplace difficulties and her tendency to hold on to problems.

First review

As agreed at the outset, we reviewed our supervision at the end of the first module, when they were just over two months into the course. The process was informal and consisted of asking the supervisees for verbal feedback on their experience of the supervision and the degree to which it was meeting their needs. However, I made the mistake of not adequately preparing the supervisees and they struggled with feedback, especially Alice. She had no experience to fall back on and was still wary of not knowing the 'rules'. Alice said that she found the emotional support of the group helpful, Richard named the didactic input, which I found disconcerting as I had tried to resist the tutor role.

However, it provided a forum for Louise to reveal the extent of her difficulties in her workplace, where she felt she lacked adequate support. Again, Alice and Richard encouraged her to voice her feelings but I was very concerned about the lack of improvement in the work situation . Eventually Louise suggested that she would like to try to resolve the difficulties herself and we would review the situation after the break. I had decided by that point that an intervention may well be necessary with the workplace.

Middle Stages

Beginning to record sessions

At the end of the first module, our peer supervision group had agreed that we would like to record our supervision sessions so that we could offer each other feedback on our supervision practice, and one group member had designed an evaluation sheet for the purpose. Our major concern was the response of the supervisees so we decided to broach the idea with them at the beginning of the next module.

To my surprise, all three supervisees supported the idea and given the response, I also broached the notion of my using our group supervision as a case study for my thesis portfolio. Again, they were supportive and I gained their written consent for both (Appendix 2 & 3). They explained that they liked the fact that the course supervisors were prepared to

'expose' themselves (Page & Wosket, 2001) in the same way as they had to. With regard to the case study, they felt a sense of identification with me in that we were all still studying for further qualifications. This shifted the power dynamic in our supervision somewhat; they were more at ease with bringing their own recordings and they seemed to become more forthcoming and confident in their participation in supervision.

Working through dilemmas

Both course and clinical workloads were increasing at this point and anxiety levels in supervision were high. I was also preoccupied with my own anxieties about course accreditation and meeting ever increasing IAPT criteria and I wondered how much my anxiety fuelled theirs.

The supervisees' predominant struggle was trying to connect theory to practice, which is a usual challenge for trainees (e.g. Shaw, 1984), but the process was greatly exacerbated for these supervisees given the short time frame in which they were expected to assimilate and implement a great deal of theory. Reflecting their feelings, I struggled with feelings of helplessness and frustration with the system that structured learning in this way.

At this point a number of issues emerged that resulted in an unsettling merging of my supervisor-tutor-programme director roles. To meet course criteria the trainees had to deliver 'protocol correct' therapy, which involved 'in vivo' work (e.g. Bennett- Levy et al., 2004) and 'reliving' sessions for treating Post Traumatic Stress Disorder (Ehlers & Clark, 2000; Foa & Rothbaum, 1998). In order to achieve this, lengthier therapy sessions had to be scheduled into their working days. Alice and Richard, again, were supported in their workplaces to do this but Louise appeared to be having problem. What emerged was that the workplace supervisor was reluctant to allow trainees to work with some anxiety disorders until they had attended all the taught modules. This was the only occasion during the supervision when a difference of opinion between course and workplace supervision impacted on the supervisee's clinical work. However, there was no difficulty in waiting and allowing Louise to implement the protocols at a later date with no adverse impact.

An additional problem was that by responding to long waiting lists, all three supervisees were now working with cases that were too complex for their stage of training, and they regularly brought this dilemma to supervision. I thought this was likely to be more widespread than just this supervision group, but to take it further would have meant breaking group confidentiality. The solution we found was to use the next cohort meeting for a discussion, initiated by Alice. It emerged as a common problem, and was addressed at the

next course-workplace meeting. It was a relief to have found a relatively easy solution, through collaboration and negotiation.

Insights

By the half way point of this middle term, I noticed that Louise had taken the last 'turn' in the group for the last five sessions and I was taken aback to realise that her lack of assertiveness had gone unnoticed for some time, and especially since she was still having problems getting support in the workplace. Going last usually meant that this person had less time, and since we had agreed at the contracting stage that I would take responsibility for time-keeping, I was doubly disturbed. This was addressed by organising 'turn-taking' differently, and I attended to time-keeping better. However, at this point I think it would have been better to discuss sharing responsibility in recognition of their maturing as practitioners.

Shortly after this, my sense of their increased confidence in their clinical judgement was confirmed in what felt like a key session. Louise had presented a particularly difficult case and I could see that both Alice and Richard were eager to respond. They no longer needed prompting or encouragement from me and they both offered insightful and well informed responses. I realised at this point that that they had moved past wanting me 'to tell them what to do' and to have suggested sharing responsibility for timing would have been a better option. This was a good session for all of us and felt very much like a turning point in their confidence and competence.

Second review

In our second review, Louise was absent but Richard and Alice gave feedback on two points: their experience of the sessions being recorded and to what degree supervision was meeting their needs[6]. Their feedback was thoughtful, demonstrating the extent of their professional development in a relatively short time and led to an exploration of their needs, my supervision style and the supervision space itself.

They continued to feel positive about recording the sessions and speculated about changes in my behaviour. In an ironic comment on timing, Alice thought I had been *'more hot on timing and structure since recording'* and Richard said that he was *'aware of you being aware'[of the recording]*.

Alice commented on how useful it was that I asked them to summarise what they had learnt from the supervision session, and although she said she disliked *'being put on the spot'*, it helped her to focus and concretise her learning. She wondered if I had always done this or if

she had now just reached the stage where she could hear it, which was interesting to note since I do this routinely but had not been aware of a change in Alice's response. Richard said that he also found this helpful and compared the process to the Kolb Learning Cycle (Kolb, 1984).

Richard commented on the lack of reflective time on the course (which echoed my concern with the course) and he welcomed the review as an opportunity for reflection. He described his difficulty with the pace of the course '*these opportunities for shift and change, they're not snatched away but you can't hold on to them so well – that's what if feels like sometimes'.* On the other hand, he was pleased when he could *'blend this supervision with site supervision – they gel quite nicely sometimes'.*

Alice expressed some of her confusions about the appropriateness of bringing her own process issues, which she had done several times and this led to an exploration of the purpose of supervision. She thought that the lack of information was *'a gap in the course'*, which indicates that more explicit attention should be paid to this for trainees. However, for her supervision felt like '*a safe space to bring your ideas and check them out ... and I feel like I use that and that I've exposed myself on a couple of occasions, bringing my own struggles'*.

Endings

Negotiating solutions

When the supervisees returned after the final break, they were rather subdued and flat. I was aware that they accessed my 'tutor' role again more as they struggled to put together their final portfolios but now I felt able to share this with them and encouraged them to take responsibility for what they needed. However, another dilemma arose at this time because of the criteria for the portfolio. They were complicated criteria requiring that each supervisee had presented each of eight patients in supervision for a minimum of 5 hours for each patient. This meant they sometimes had a choice of presenting a patient in supervision simply to get the required hours or risk failing by not getting the hours if they presented the patient they needed to discuss. This presented us with a major ethical dilemma and one that we discussed in depth and negotiated our way to a solution. The supervisees suggested that in their view the meaning of this criterion was that they should be using their work with their eight key patients to further their learning and learn in depth aspects of theory and how to apply to practice. They chose, with my agreement, that they would present the case and choose an aspect of the case that would have a more universal application in their practice so that they maximised their learning. It was a helpful process and one that demonstrated their

maturing ethical thinking. I found the whole process valuable for them and for myself and was aware that I had behaved differently and had allowed them the space to find the answer rather than supplying it.

Ending and final review

The quality of the ending is important (Chambers & Cutliffe, 2001; Proctor, 2000) and we planned our ending carefully with a double session to give us time to draw our work to a close and share our experiences of working with each other. Richard commented on the *'supportive, equal quality'* of the group space and how he had felt enabled to ask for help. Despite his initial reservations about a group format, which he had not experienced before, he said his first experience of group supervision had been a good one.

Alice said that she had never felt judged or criticised when she had been emotional and exposed and had felt '*really good vibes from each other'*. Regarding my constant concerns about my dual roles, she concluded by saying, '*I think you've juggled those two roles really well*'.

Louise summed up her sense of the supervision by noting that I had been *'able to put a structure around it and yet still have flexibility'*. I truly valued her next comment about the power dynamic, '*you as a person not bringing the power relationship here and it's a special quality to allow that barrier to come down but still be a on a professional level and still hold on to that human quality and reach out to us and be supportive'.*

I shared my appreciation of them and their contributions: Richard's willingness to contribute and not stand back; his courage and good humour; Louise's steadfastness and quiet determination despite the difficulties she had faced along the way and Alice's curiosity and rigour, always questioning and curious.

The ending reinforced the sense of a year of collaborative working, and negotiating our way through external pressures.

Evaluation

The supervisees completed a Supervision Evaluation questionnaire, which I devised for the purpose of the case study and the Supervisory Relationship Questionnaire (SRQ), a psychometrically validated questionnaire (Palomo, Beinart & Cooper, 2008). Feedback from both sets of data suggest that all three supervisees had a positive supervision experience. The SRQ overall score from six sub scales showed a high overall satisfaction rate of 92.6%, with the lowest sub scale being 'reflective education' at 89% and the highest

being ‘role model’ at 96% (Appendix 4: SRQs; Appendix 5: Supervision Evaluation questionnaires).

However, they have only limited credibility as they were not returned anonymously for practical reasons, both were self report, and the Supervision Evaluation questionnaire was designed for the study and not psychometrically tested.

I found working with the boundaries of role and context challenging and at times felt as though the process simply unfolded rather than my actively influencing it. Despite this, I was able to hold an awareness of the processes for most of the time. One major area that I would like to develop for the future is more flexibility in my supervisory style and I look forward to experimenting more with Hawkins and Shohet’s (2012, pp.180-181) ‘quadrants’ in future practice.

I believe I succeeded in fostering good interpersonal relationships within the group, which contributed to establishing an environment in which they enjoyed a positive learning experience, as well as facilitating the negotiating of numerous collective pressures.

Retrospective Reflections

Although I benefited from my learning from the case study, revisiting it two years later has greatly increased my understanding of my supervisory practice. I believe I demonstrated reasonable supervision work in this case study but in the light of the research project I am now able to question the issues more critically and with a greater awareness of their implications. The following are brief comments on the notations in the script above.

[1] I notice that I fall into the same patterns as my participants and miss opportunities for acknowledging the centrality of the client.

[2] In parallel with the findings, I worked primarily with a psychotherapy-based model, albeit a formal model on an explicit level.

[3] The experience of being supervised is powerful, especially experiences at the beginning of training. The important point is to be able to critically evaluate them and determine the degree to which they can usefully inform future practice.

[4] There is an unquestioning emphasis on the ‘safe’ space without adequate exploration of the implications.

[5] The quality of the relationship is an important feature in this case study and contributed to managing difficult situations collaboratively, as in the research findings. In future I

will work with greater openness of the underlying paradoxes in the supervision context, such as non-disclosure and the reality of 'safe' place.

[6] In line with the research findings, my focus was on supervisee practice rather than client outcome when listening to audio recordings, whereas in future I shall use recordings to facilitate a more equal focus on supervisee and client.

Having this unplanned opportunity to review the case study in retrospect has had reciprocal benefits for both pieces of work. In terms of the research study, I think it has emerged as an additional piece of data; in terms of the case study, it has allowed me evaluate my practice form a more mature viewpoint and reflect on the degree to which the research study has advanced my understanding of supervision practice.

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APPENDICES

APPENDIX 1

Supervision Contract

This Supervision Contract is between	
Supervisor.....	Supervisee.....
	Supervisee.....
	Supervisee.....

ARRANGEMENTS

The group will meet weekly during the Course Timetable for a period of $1^{1}/_{2}$ hours per week and group members will remain the same unless there is a need to make changes resulting from changes within the programme. If this happens the group will be notified as soon as possible.

CANCELLATION

If the supervisor has to cancel for any reason the group will be given as much as notice as possible and where possible alternative arrangements will be made. If a group member is unable to come to a supervision session, it is important to give the supervisor as much notice as possible.

CONTENT OF SUPERVISION – BASED ON BABCP AND IAPT GUIDELINES

- The content of supervision will focus on the acquisition of knowledge, formulation and clinical skills within a cognitive behavioural model.
- The therapeutic relationship, engaging with the client and engaging the client in therapy
- The process of therapy, treatment plans, models and protocols
- Associated issues will also be discussed when it is relevant to do so e.g. the use of medication, hospitalisation, case management, risk issues ethical issues.
- Identification (and collaborative change of this is appropriate) of supervisee thoughts, attitudes, beliefs and values and the impact of these on the therapeutic work and/or professional behaviour.
- Discussion and working through relationship and process aspects of supervision within the group as necessary and/or appropriate.

CONFIDENTIALITY and ETHICAL PRACTICE

All professional, clinical and personal issues discussed are confidential within the session. Patient confidentiality is paramount at all times. The exceptions to this are:

- Where the supervisor takes issues to consultative supervision, which is itself bound by codes of confidentiality
- Where there is a risk of physical or psychological harm to the supervisee, patient or other person or persons
- Audio Recordings: informed written consent needs to be obtained from the patient before the recordings are brought to supervision
- Information regarding the supervisee's development will be shared with your workplace supervisor in order to provide a coherent training trajectory for the supervisee. This means that any areas for development will be covered before they become problematic
- Where the supervisor has reason for concern regarding the supervisee's practice or competence or any other concern regarding the supervisee, the following steps will be taken
    - The concerns will be addressed in supervision with the supervisee
    - If this does not resolve the concern the supervisor will discuss it with the supervisee in confidence
    - If this fails to resolve the concern the supervisor will discuss the matter with the Programme Leader and the Course Team
    - If the matter is still unresolved then it will be taken to the supervisee's workplace clinical lead, supervisor or manager whichever is appropriate.

SUPERVISION METHODS - BASED ON BABCP AND IAPT GUIDELINES:

- Discussion
- Rehearsal of therapeutic techniques e.g. simulation, role-play
- Case Presentations
- Homework (e.g. applying methods to self to develop understanding)
- Review of audio recordings
- Review of clinical guidelines/manuals/models and protocols
- Review of psychoeducational material
- Experiential exercises
- Other strategies as agreed

COLLABORATIVE SUPERVISION, REVIEWS AND FEEDBACK

It is important that supervisees' needs and feedback are taken into account. If the supervisee has an issue with the supervisor or the supervision that is being delivered, which cannot be resolved with the supervisor, then this should be taken to the Programme Leader. If the supervisor is also the Programme Leader, then the matter can be taken to the supervisee's Personal Tutor.

The first supervision session will include a discussion of the needs of the supervisees and how these needs will be met in the sessions.

Reviews of the supervision will be held at the end of each Module when feedback from supervisees will be sought. If matters arise that need addressing then an action plan will be devised and reviewed again at the next Review.

I have read, understand and agree with the above supervision contract. Supervisor's signature…… Date …… Supervisee's signature…… Date …….. Supervisee's signature…… Date …….. Supervisee's signature…… Date ……..

APPENDIX 2

Supervisee Consent to Record Course Supervision Sessions

As part of our professional practice as clinical supervisors, it is a requirement that we attend regular supervision for our supervision practice. BABCP routinely requires 'live' supervision of therapeutic practice and this is now also a requirement for clinical supervisors. In addition, as part of our professional development as clinical supervisors, we believe it would be useful to reflect on audio recordings of our supervision practice in our own supervision.

The recordings of sessions are used solely for the purpose of training, professional development and reflection on my supervisory practice and the recordings may be used in discussions of practice with a supervisor or in a peer supervision group. All supervisors (including those in peer groups) are members of BABCP (and other professional organisations) and are bound by the ethical standards of their registering organisation to safeguard your confidentiality and that of your patients.

Audio recordings are strictly confidential and are kept in a secure place at all times. They will be erased as soon as they are no longer required for training and evaluation purposes.

I would be grateful if you would allow our sessions to be recorded. If you give permission to record our sessions you have the right to withdraw your permission at any time, and your recordings will then be erased. If you do not wish to allow recording of the sessions, this will have no effect on our arrangements for your supervision, which will continue as usual.

I give my permission for my supervision sessions to be recorded. I understand that recordings may be used as part of training or for quality assessment assurance purposes.

Supervisee's Signature: *'Louise'*

Supervisee's Signature *'Richard'*

Supervisee's Signature *'Alice'*

APPENDIX 3

Supervisee Consent to use the supervision work in a Case Study

As part of my professional development I am engaged in completing a DPsych in Counselling Psychology at City University. Part of my thesis will consist of a piece of work on an element of Professional Practice and I would like to do a case study of our supervision group. I am seeking your consent to use material from our work together in the case study. All work will be anonymised and your identities and the identities of others (including patients, sites, other supervisors) safeguarded. In addition the case study will focus on issues and process rather than individual factors.

I am also seeking your consent to using quotes from the recordings of the sessions to demonstrate my case study but would only do so if it did not identify you personally or your site or anyone connected to you including any of your patients. If you are willing to consent to these requests, please sign below and add contact details if you would like to be contacted when the case study is completed. Thank you very much for your co-operation.

I give my permission for the supervision work to be written up as a case study as an element of your doctoral thesis. I give my consent for the recordings to be used to illustrate the case study.

Supervisee's Signature: *'Louise'*

Supervisee's Signature *'Richard'*

Supervisee's Signature *'Alice'*

Thank you for completing this Consent Form. Please keep a copy of this form and the accompanying information sheet for your records

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Should you have any questions I can be contacted at elizabeth@talkmatters.com and my supervisor is Professor Carla Willig at C.willig@city.ac.uk

APPENDIX 4 - Supervisory Relationship Questionnaires

['Louise']

THE SUPERVISORY RELATIONSHIP QUESTIONNAIRE (SRQ)

Developed by Marina Palomo (supervised by Helen Beinart)

The following statements describe some of the ways a person may feel about his/her supervisor. To what extent do you agree or disagree with each of the following statements about your relationship with your supervisor? Please tick the column which matches your opinion most closely.

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
SAFE BASE SUBSCALE							
1. My supervisor was respectful of my views and ideas	1	2	3	4	5	6	7
2. My supervisor and I were equal partners in supervision	1	2	3	4	5	6	7
3. My supervisor had a collaborative approach in supervision	1	2	3	4	5	6	7
4. I felt safe in my supervision sessions	1	2	3	4	5	6	7
5. My supervisor was non-judgemental in supervision	1	2	3	4	5	6	7
6. My supervisor treated me with respect	1	2	3	4	5	6	7
7. My supervisor was open-minded in supervision	1	2	3	4	5	6	7
8. Feedback on my performance from my supervisor felt like criticism	7	6	5	4	3	2	1
9.The advice I received from my supervisor was prescriptive rather than collaborative	7	6	5	4	3	2	1
10. I felt able to discuss my concerns with my supervisor openly	1	2	3	4	5	6	7
11. Supervision felt like an exchange of ideas	1	2	3	4	5	6	7
12. My supervisor gave feedback in a way that felt safe	1	2	3	4	5	6	7
13. My supervisor treated me like an adult	1	2	3	4	5	6	7
14. I was able to be open with my supervisor	1	2	3	4	5	6	7
15. I felt if I discussed my feelings openly with my supervisor I would be negatively evaluated	7	6	5	4	3	2	1
Total Safe Base Subscale =	14				5		77
STRUCTURE SUBSCALE							
16. My supervision sessions took place regularly	1	2	3	4	5	6	7
17. Supervision sessions were structured	1	2	3	4	5	6	7
	1	2	3	4	5	6	7

18. My supervisor made sure that our supervision sessions were kept free from interruptions							
19. Supervision sessions were regularly cut short by my supervisor	7	6	5	4	3	2	1
20. Supervision sessions were focused	1	2	3	4	5	6	7
21. My supervision sessions were disorganised	7	6	5	4	3	2	1
22. My supervision sessions were arranged in advance	1	2	3	4	5	6	7
23. My supervisor and I both drew up an agenda for supervision together	1	2	3	4	5	6	7
Total Structure Subscale =	14					12	28
COMMITMENT SUBSCALE							
24. My supervisor was enthusiastic about supervising me	1	2	3	4	5	6	7
25. My supervisor appeared interested in supervising me	1	2	3	4	5	6	7
26. My supervisor appeared uninterested in me	7	6	5	4	3	2	1
27. My supervisor appeared interested in me as a person	1	2	3	4	5	6	7
28. My supervisor appeared to like supervising	1	2	3	4	5	6	7
29. I felt like a burden to my supervisor	7	6	5	4	3	2	1
30. My supervisor was approachable	1	2	3	4	5	6	7
31. My supervisor was available to me	1	2	3	4	5	6	7
32. My supervisor paid attention to my spoken feelings and anxieties	1	2	3	4	5	6	7
33. My supervisor appeared interested in my development as a professional	1	2	3	4	5	6	7
Total Commitment Subscale =	14					12	35
REFLECTIVE EDUCATION SUBSCALE							
34. My supervisor drew from a number of theoretical models	1	2	3	4	5	6	7
35. My supervisor drew from a number of theoretical models flexibly	1	2	3	4	5	6	7
36. My supervisor gave me the opportunity to learn about a range of models and primarily my own theoretical model	1	2	3	4	5	6	7
37. My supervisor encouraged me to reflect on my practice	1	2	3	4	5	6	7
38. My supervisor I linked theory and clinical practice well	1	2	3	4	5	6	7
39. My supervisor paid close attention to the process of supervision	1	2	3	4	5	6	7
40. My supervisor acknowledged the power differential between supervisor and supervisee	1	2	3	4	5	6	7
41. My relationship with my supervisor allowed me to learn by experimenting with different therapeutic techniques	1	2	3	4	5	6	7
42. My supervisor paid attention to my unspoken feelings and anxieties	1	2	3	4	5	6	7
43. My supervisor facilitated interesting and informative discussions in supervision	1	2	3	4	5	6	7
44. I learnt a great deal from observing my supervisor	1	2	3	4	5	6	7
Total Reflective Education Subscale =					5	42	21

ROLE MODEL SUBSCALE							
45. My supervisor was knowledgeable	1	2	3	4	5	6	7
46. My supervisor was an experienced clinician	1	2	3	4	5	6	7
47. I respected my supervisor's skills	1	2	3	4	5	6	7
48. My supervisor was knowledgeable about the organisational system in which they worked	1	2	3	4	5	6	7
49. Colleagues appear to respect my supervisor's views	1	2	3	4	5	6	7
50. I respected my supervisor as a professional	1	2	3	4	5	6	7
51. My supervisor gave me practical support	1	2	3	4	5	6	7
52. I respected my supervisor as a clinician	1	2	3	4	5	6	7
53. My supervisor was respectful of clients	1	2	3	4	5	6	7
54. I respected my supervisor as a person	1	2	3	4	5	6	7
55. My supervisor appeared uninterested in his/her clients	7	6	5	4	3	2	1
56. My supervisor treated his/her colleagues with respect	1	2	3	4	5	6	7
Total Role Model Subscale =	7					12	63
FORMATIVE FEEDBACK SUBSCALE							
57. My supervisor gave me helpful negative feedback on my performance	1	2	3	4	5	6	7
58. My supervisor was able to balance negative feedback on my performance with praise	1	2	3	4	5	6	7
59. My supervisor gave me positive feedback on my performance	1	2	3	4	5	6	7
60. My supervisor's feedback on my performance was constructive	1	2	3	4	5	6	7
61. My supervisor paid attention to my level of competence	1	2	3	4	5	6	7
62. My supervisor helped me identify my own learning needs	1	2	3	4	5	6	7
63. My supervisor did not consider the impact of my previous skills and experience on my learning needs	7	6	5	4	3	2	1
64. My supervisor thought about my training needs	1	2	3	4	5	6	7
65. My supervisor gave me regular feedback on my performance	1	2	3	4	5	6	7
66. As my skills and confidence grew, my supervisor adapted supervision to take this into account	1	2	3	4	5	6	7
67. My supervisor tailored supervision to my level of competence	1	2	3	4	5	6	7
Total Formative Feedback Subscale =	7					24	42

THANK YOU VERY MUCH FOR COMPLETING THIS MEASURE.

APPENDIX 4 - Supervisory Relationship Questionnaires

['Alice']

THE SUPERVISORY RELATIONSHIP QUESTIONNAIRE (SRQ)

Developed by Marina Palomo (supervised by Helen Beinart)

The following statements describe some of the ways a person may feel about his/her supervisor. To what extent do you agree or disagree with each of the following statements about your relationship with your supervisor? Please tick the column which matches your opinion most closely.

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
SAFE BASE SUBSCALE							
1. My supervisor was respectful of my views and ideas							**7**
2. My supervisor and I were equal partners in supervision						**6**	
3. My supervisor had a collaborative approach in supervision							**7**
4. I felt safe in my supervision sessions							**7**
5. My supervisor was non-judgemental in supervision							**7**
6. My supervisor treated me with respect							**7**
7. My supervisor was open-minded in supervision						**6**	
8. Feedback on my performance from my supervisor felt like criticism	**7**						
9.The advice I received from my supervisor was prescriptive rather than collaborative	**7**						
10. I felt able to discuss my concerns with my supervisor openly						**6**	
11. Supervision felt like an exchange of ideas							**7**
12. My supervisor gave feedback in a way that felt safe							**7**
13. My supervisor treated me like an adult							**7**
14. I was able to be open with my supervisor						**6**	
15. I felt if I discussed my feelings openly with my supervisor I would be negatively evaluated	**7**						
Total Safe Base Subscale =	**21**					**24**	**56**
STRUCTURE SUBSCALE							
16. My supervision sessions took place regularly							**7**
17. Supervision sessions were structured					**5**		

18. My supervisor made sure that our supervision sessions were kept free from interruptions						**6**	
19. Supervision sessions were regularly cut short by my supervisor	**7**						
20. Supervision sessions were focused						**6**	
21. My supervision sessions were disorganised	**7**						
22. My supervision sessions were arranged in advance							**7**
23. My supervisor and I both drew up an agenda for supervision together					**5**		
Total Structure Subscale =	**14**				**10**	**12**	**14**
COMMITMENT SUBSCALE							
24. My supervisor was enthusiastic about supervising me							**7**
25. My supervisor appeared interested in supervising me							**7**
26. My supervisor appeared uninterested in me	**7**						
27. My supervisor appeared interested in me as a person						**6**	
28. My supervisor appeared to like supervising						**6**	
29. I felt like a burden to my supervisor	**7**						
30. My supervisor was approachable							**7**
31. My supervisor was available to me						**6**	
32. My supervisor paid attention to my spoken feelings and anxieties							**7**
33. My supervisor appeared interested in my development as a professional						**6**	
Total Commitment Subscale =	**14**					**24**	**28**
REFLECTIVE EDUCATION SUBSCALE							
34. My supervisor drew from a number of theoretical models							**7**
35. My supervisor drew from a number of theoretical models flexibly						**6**	
36. My supervisor gave me the opportunity to learn about a range of models and primarily my own theoretical model						**6**	
37. My supervisor encouraged me to reflect on my practice							**7**
38. My supervisor I linked theory and clinical practice well						**6**	
39. My supervisor paid close attention to the process of supervision						**6**	
40. My supervisor acknowledged the power differential between supervisor and supervisee						**6**	
41. My relationship with my supervisor allowed me to learn by experimenting with different therapeutic						**6**	

techniques							
42. My supervisor paid attention to my unspoken feelings and anxieties						**6**	
43. My supervisor facilitated interesting and informative discussions in supervision							**7**
44. I learnt a great deal from observing my supervisor						**6**	
Total Reflective Education Subscale =						**48**	**21**
ROLE MODEL SUBSCALE							
45. My supervisor was knowledgeable							**7**
46. My supervisor was an experienced clinician							**7**
47. I respected my supervisor's skills							**7**
48. My supervisor was knowledgeable about the organisational system in which they worked							**7**
49. Colleagues appear to respect my supervisor's views							**7**
50. I respected my supervisor as a professional							**7**
51. My supervisor gave me practical support					**5**		
52. I respected my supervisor as a clinician							**7**
53. My supervisor was respectful of clients							**7**
54. I respected my supervisor as a person							**7**
55. My supervisor appeared uninterested in his/her clients	**7**						
56. My supervisor treated his/her colleagues with respect							**7**
Total Role Model Subscale =	**7**				**5**		**70**
FORMATIVE FEEDBACK SUBSCALE							
57. My supervisor gave me helpful negative feedback on my performance					**5**		
58. My supervisor was able to balance negative feedback on my performance with praise					**5**		
59. My supervisor gave me positive feedback on my performance						**6**	
60. My supervisor's feedback on my performance was constructive						**6**	
61. My supervisor paid attention to my level of competence						**6**	
62. My supervisor helped me identify my own learning needs						**6**	
63. My supervisor did not consider the impact of my previous skills and experience on my learning needs		**6**					
64. My supervisor thought about my training needs							**7**
65. My supervisor gave me regular feedback on my					**5**		

performance							
66. As my skills and confidence grew, my supervisor adapted supervision to take this into account						**6**	
67. My supervisor tailored supervision to my level of competence							**7**
Total Formative Feedback Subscale =		**6**			**15**	**30**	**14**

THANK YOU VERY MUCH FOR COMPLETING THIS MEASURE.

APPENDIX 4 - Supervisory Relationship Questionnaires

['Richard']

THE SUPERVISORY RELATIONSHIP QUESTIONNAIRE (SRQ)

Developed by Marina Palomo (supervised by Helen Beinart)

The following statements describe some of the ways a person may feel about his/her supervisor. To what extent do you agree or disagree with each of the following statements about your relationship with your supervisor? Please tick the column which matches your opinion most closely.

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
SAFE BASE SUBSCALE							
1. My supervisor was respectful of my views and ideas	1	2	3	4	5	6	**7**
2. My supervisor and I were equal partners in supervision	1	2	3	4	5	**6**	7
3. My supervisor had a collaborative approach in supervision	1	2	3	4	5	**6**	7
4. I felt safe in my supervision sessions	1	2	3	4	5	**6**	7
5. My supervisor was non-judgemental in supervision	1	2	3	4	5	6	**7**
6. My supervisor treated me with respect	1	2	3	4	5	6	**7**
7. My supervisor was open-minded in supervision	1	2	3	4	5	6	**7**
8. Feedback on my performance from my supervisor felt like criticism	7	**6**	5	4	3	2	1
9.The advice I received from my supervisor was prescriptive rather than collaborative	**7**	6	5	4	3	2	1
10. I felt able to discuss my concerns with my supervisor openly	1	2	3	4	5	6	**7**
11. Supervision felt like an exchange of ideas	1	2	3	4	5	6	**7**
12. My supervisor gave feedback in a way that felt safe	1	2	3	4	5	6	**7**
13. My supervisor treated me like an adult	1	2	3	4	5	6	**7**
14. I was able to be open with my supervisor	1	2	3	4	5	**6**	7
15. I felt if I discussed my feelings openly with my supervisor I would be negatively evaluated	**7**	6	5	4	3	2	1
Total Safe Base Subscale =	14	6				42	35
STRUCTURE SUBSCALE							
16. My supervision sessions took place regularly	1	2	3	4	5	6	**7**
17. Supervision sessions were structured	1	2	3	4	**5**	6	7

18. My supervisor made sure that our supervision sessions were kept free from interruptions	1	2	3	4	5	6	**7**
19. Supervision sessions were regularly cut short by my supervisor	**7**	6	5	4	3	2	1
20. Supervision sessions were focused	1	2	3	4	5	**6**	7
21. My supervision sessions were disorganised	**7**	6	5	4	3	2	1
22. My supervision sessions were arranged in advance	1	2	3	4	5	6	**7**
23. My supervisor and I both drew up an agenda for supervision together	1	2	3	4	5	6	**7**
Total Structure Subscale =	14				5	6	28
COMMITMENT SUBSCALE							
24. My supervisor was enthusiastic about supervising me	1	2	3	4	5	6	**7**
25. My supervisor appeared interested in supervising me	1	2	3	4	5	6	**7**
26. My supervisor appeared uninterested in me	**7**	6	5	4	3	2	1
27. My supervisor appeared interested in me as a person	1	2	3	4	**5**	6	7
28. My supervisor appeared to like supervising	1	2	3	4	5	6	**7**
29. I felt like a burden to my supervisor	**7**	6	5	4	3	2	1
30. My supervisor was approachable	1	2	3	4	5	6	**7**
31. My supervisor was available to me	1	2	3	4	5	6	**7**
32. My supervisor paid attention to my spoken feelings and anxieties	1	2	3	4	5	**6**	7
33. My supervisor appeared interested in my development as a professional	1	2	3	4	5	6	**7**
Total Commitment Subscale =	14				5	6	42
REFLECTIVE EDUCATION SUBSCALE							
34. My supervisor drew from a number of theoretical models	1	2	3	4	**5**	6	7
35. My supervisor drew from a number of theoretical models flexibly	1	2	3	4	5	**6**	7
36. My supervisor gave me the opportunity to learn about a range of models and primarily my own theoretical model	1	2	3	4	5	6	**7**
37. My supervisor encouraged me to reflect on my practice	1	2	3	4	5	6	**7**
38. My supervisor I linked theory and clinical practice well	1	2	3	4	5	6	**7**
39. My supervisor paid close attention to the process of supervision	1	2	3	4	5	6	**7**
40. My supervisor acknowledged the power differential between supervisor and supervisee	1	2	3	4	5	6	**7**
41. My relationship with my supervisor allowed me to learn by experimenting with different therapeutic	1	2	3	4	5	**6**	7

techniques							
42. My supervisor paid attention to my unspoken feelings and anxieties	1	2	3	4	**5**	6	7
43. My supervisor facilitated interesting and informative discussions in supervision	1	2	3	4	5	6	**7**
44. I learnt a great deal from observing my supervisor	1	2	3	4	**5**	6	7
Total Reflective Education Subscale =					15	12	42
ROLE MODEL SUBSCALE							
45. My supervisor was knowledgeable	1	2	3	4	5	6	**7**
46. My supervisor was an experienced clinician	1	2	3	4	5	6	**7**
47. I respected my supervisor's skills	1	2	3	4	5	6	**7**
48. My supervisor was knowledgeable about the organisational system in which they worked	1	2	3	4	5	6	**7**
49. Colleagues appear to respect my supervisor's views	1	2	3	4	5	**6**	7
50. I respected my supervisor as a professional	1	2	3	4	5	6	**7**
51. My supervisor gave me practical support	1	2	3	4	**5**	6	7
52. I respected my supervisor as a clinician	1	2	3	4	5	6	**7**
53. My supervisor was respectful of clients	1	2	3	4	5	6	**7**
54. I respected my supervisor as a person	1	2	3	4	5	**6**	7
55. My supervisor appeared uninterested in his/her clients	**7**	6	5	4	3	2	1
56. My supervisor treated his/her colleagues with respect	1	2	3	4	5	6	**7**
Total Role Model Subscale =	7				5	12	56
FORMATIVE FEEDBACK SUBSCALE							
57. My supervisor gave me helpful negative feedback on my performance	1	2	3	4	5	**6**	7
58. My supervisor was able to balance negative feedback on my performance with praise	1	2	3	4	**5**	6	7
59. My supervisor gave me positive feedback on my performance	1	2	3	4	5	**6**	7
60. My supervisor's feedback on my performance was constructive	1	2	3	4	5	6	**7**
61. My supervisor paid attention to my level of competence	1	2	3	4	5	6	**7**
62. My supervisor helped me identify my own learning needs	1	2	3	4	5	**6**	7
63. My supervisor did not consider the impact of my previous skills and experience on my learning needs	7	**6**	5	4	3	2	1
64. My supervisor thought about my training needs	1	2	3	4	5	6	**7**
65. My supervisor gave me regular feedback on my	1	2	3	4	5	**6**	7

performance							
66. As my skills and confidence grew, my supervisor adapted supervision to take this into account	1	2	3	4	5	6	**7**
67. My supervisor tailored supervision to my level of competence	1	2	3	4	5	6	**7**
Total Formative Feedback Subscale =		**6**			**5**	**24**	**35**

THANK YOU VERY MUCH FOR COMPLETING THIS MEASURE.

APPENDIX 5 - Supervisory Relationship Questionnaires

SRQ ANALYSIS OF SCORING

Sub Scale	'Louise'	'Alice'	'Richard'	Sub Scale Mean Score	Sub Scale Mean Score %age	Sub Scale maximum score
Safe Base	96	101	97	98	93.3%	105
Structure	54	50	53	52.3	93.3%	56
Commitment	61	66	67	64.6	92.2%	70
Reflective Education	68	69	69	68.6	89%	77
Role Model	82	82	80	81.3	96%	84
Formative Feedback	73	65	70	69.3	90%	77
TOTAL SCORES	434 - 92.5%	433 - 92.3%	436 - 92.9%	434.3	92.6%	469

APPENDIX 6 - Supervision Evaluation Questionnaires

['Louise']

END OF SUPERVISION QUESTIONNAIRE

Will you answer each question on a scale of 1 – 5 where 1 is the least and 5 is the most. All questions apply only to your supervision on the course. Any comments you would like to make in addition to the scores are welcome.

	COMMENTS AND SCORING 1 – 5
FORMATIVE ASPECTS OF SUPERVISION - Educative process - developing skills and understanding	
1. How far did supervision develop your knowledge and understanding of CBT	4 Group supervision was invaluable in developing my understanding and skills. It provided a forum for exploration and development of ideas and seeking expert advice/knowledge.
2. How far did supervision develop your knowledge and understanding of disorder specific models and protocols	4 This opportunity provided the most important resource for me in gaining an understanding of models and protocols and it was useful to hear others' experiences. Supervision was very supportive and enabled me to deal with difficult situations.
3. How far did supervision challenge your understanding and lead to new insights	3 I feel that supervision did challenge my understanding and highlight areas for further study but did not always lead to new insight, particularly if there was not an opportunity for further discussion.
RESTORATIVE ASPECTS OF SUPERVISION - Support and self development	
4. To what extent did you feel supported in your supervision by your supervisor	5 I felt very supported and often I was experiencing significant difficulties around my job role. Supervision enabled me to continue in a more positive frame of mind.
5. Did the group feel a safe place to explore personal development and/or professional development issues	4 The group did feel a safe place and very supportive, especially when I felt isolated at work. In terms of gaining confidence, the group encouraged me to appreciate my positive personal qualities and not to focus on the negative experiences I was trying to cope with.

6. To what degree did supervision contribute to your personal development throughout the course	3 I feel this course has been extremely challenging on a personal level and I felt less confident at the end of the course, which is sad. Whilst I have to take some responsibility for my own studying, I feel there have been other factors that have detracted from my ability to do this.
NORMATIVE ASPECTS OF SUPERVISION - The administrative or quality control aspects	
7. To what extent was the supervision generally seem well organised and well run including contracting and reviewing	4 Supervision was well organised and any advice or resources that we needed outside of supervision was usually provided promptly. We had time to reflect on our experience in supervision, although limited, this was very supportive.
8. To what degree were the sessions well structured and time keeping adhered to	5 The sessions were well structured, but not excessively, so that we were able to respond to situation or issues that arose. The sessions felt comfortable and relaxed.
9. To what degree were the methods used in supervision helpful and is there anything else that you would have liked	4 I feel that I should have brought more recordings to the session which I avoided. This is my responsibility but maybe a firmer hand would have encouraged me to do this.

Please add any other comments regarding any aspect of the course supervision.

Thank you for your time in completing this questionnaire

APPENDIX 6 - Supervision Evaluation Questionnaires

[Alice]

END OF SUPERVISION QUESTIONNAIRE

Will you answer each question on a scale of 1 – 5 where 1 is the least and 5 is the most. All questions apply only to your supervision on the course. Any comments you would like to make in addition to the scores are welcome.

	COMMENTS AND SCORING 1 – 5
FORMATIVE ASPECTS OF SUPERVISION - Educative process - developing skills and understanding	
1. How far did supervision develop your knowledge and understanding of CBT	5 Being able to share and develop my knowledge of CBT through group supervision was invaluable – learning from each other, and from the expertise, knowledge and guidance of our supervisor (Elizabeth)
2. How far did supervision develop your knowledge and understanding of disorder specific models and protocols	4 It was a really good space to be able to check out our understanding and rationale gained from lectures, and to discuss and problem solve challenges of applying theory to practice. Elizabeth was great at pointing us in the right direction – in a Socratic way, also giving positive feedback to consolidate correct understanding
3. How far did supervision challenge your understanding and lead to new insights	4 We were able to challenge each other's understanding safely in the group and Elizabeth was very effective in enabling us to gain new insights, through her inquisitive and supportive style – both in terms of CBT and personally as therapists.
RESTORATIVE ASPECTS OF SUPERVISION - Support and self development	
4. To what extent did you feel supported in your supervision by your supervisor	5 Extremely – Elizabeth was consistently supportive and created a very safe space. I felt able to open up and never felt judged or criticised, always held and supported. It always felt like Elizabeth was 'on our side', she managed her two hats of course leader and supervisor very well.

5. Did the group feel a safe place to explore personal development and/or professional development issues	5 As above. As the group became more established I felt able to bring personal and professional struggles around boundaries and the therapeutic relationship – even shedding a tear or two. It also felt a safe space to bring recordings – which although at times felt exposing, often lead to positive or constructive feedback.
6. To what degree did supervision contribute to your personal development throughout the course	5 Supervision was helpful for personal development – often helping me to lower the expectations and pressures I put on myself, look at issues of responsibility around endings, and Elizabeth was good at guiding us towards using CBT tools ourselves for personal development – such as using my own blue print, coping cards and positive data log.
NORMATIVE ASPECTS OF SUPERVISION - The administrative or quality control aspects	
7. To what extent was the supervision generally seem well organised and well run including contracting and reviewing	4 A supervision contract was signed at the beginning of the course, and we had supervision reviews at the end of each module. Supervision was generally well run and organised.
8. To what degree were the sessions well structured and time keeping adhered to	4 Generally structure and time-keeping was good – with only occasional inconsistencies, only to be expected when managing three people's needs in a room, but this never felt unequal or unproductive as I always learnt from what my peers were bringing.
9. To what degree were the methods used in supervision helpful and is there anything else that you would have liked	5 Elizabeth was persistent in asking us to bring formulations, measures and audio recordings to the sessions, which was very useful. We mostly used audio recordings and case discussions, with the occasional role play and Elizabeth often shared knowledge and experiences from her own practice, which was helpful in normalising challenges we were encountering.

Please add any other comments regarding any aspect of the course supervision.

Overall the experience was very safe and supportive – I felt listened to, valued and an equal throughout. To her credit Elizabeth managed to create a both a nurturing and challenging learning environment. The sessions were extremely useful and will be missed.

Thank you for your time in completing this questionnaire

APPENDIX 6 - Supervision Evaluation Questionnaires

['Richard']

END OF SUPERVISION QUESTIONNAIRE

Will you answer each question on a scale of 1 – 5 where 1 is the least and 5 is the most. All questions apply only to your supervision on the course. Any comments you would like to make in addition to the scores are welcome.

	COMMENTS AND SCORING 1 – 5
FORMATIVE ASPECTS OF SUPERVISION - Educative process - developing skills and understanding	
1. How far did supervision develop your knowledge and understanding of CBT	(4) I found supervision a very useful forum for discussing the links between theory and practice; and importantly how to work with theoretical knowledge and techniques in real world situations with clients'.
2. How far did supervision develop your knowledge and understanding of disorder specific models and protocols	(3) This became relevant towards the end of last year/start of this year - i.e. just after having teaching on the models and having clients to treat using the models. However, discussing models in supervision became a common feature.
3. How far did supervision challenge your understanding and lead to new insights	(4) This was a cornerstone of supervision for me, as supervision led me to make significant connections in supervision.
RESTORATIVE ASPECTS OF SUPERVISION - Support and self development	
4. To what extent did you feel supported in your supervision by your supervisor	(5) Very supported.
5. Did the group feel a safe place to explore personal development and/or professional development	(5) Absolutely.

issues	
6. To what degree did supervision contribute to your personal development throughout the course	4.
NORMATIVE ASPECTS OF SUPERVISION - The administrative or quality control aspects	
7. To what extent was the supervision generally seem well organised and well run including contracting and reviewing	(4) Overall, supervision was well organised and run well.
8. To what degree were the sessions well structured and time keeping adhered to	(4) sessions were well structured as was time keeping.
9. To what degree were the methods used in supervision helpful and is there anything else that you would have liked	(3) Overall, supervision methods were useful and appropriate, perhaps we could have done a bit more role play or modelling CBT techniques.

Please add any other comments regarding any aspect of the course supervision.

Thank you for your time in completing this questionnaire

PART D: CRITICAL REVIEW OF LITERATURE

Review of Supervisor Training in the Psychological Therapies in the UK: Influences, Issues and Challenges

Introduction

Supervisors perform key functions as gatekeepers of ethical practice (e.g. Holloway, 1995, 1997; Milne, 2009) and educators of practitioners (e.g. Milne & James, 2002) within the delivery of clinical practice in professional psychology. Supervisory training is one of the primary methods for preparing supervisors for their role. Milne and James (2002) note a lack of interest in developing systematic supervisor training, a view which is supported by many in the supervision field (e.g. Robiner, Salzman, Hoberman & Schirvar, 1997; Russell & Petrie, 1994). Watkins puzzled over the paradox of the importance placed on supervision and the lack of importance placed on training supervisors, declaring 'something does not compute' (Watkins, 1997, p.604).

Hoffman raised an ethical question in her review of the 'barren scape' of supervisor training and conveyed her sense that this state of affairs was the profession's 'dirty little secret' (1994, p.25). Practising within the limits of professional competence is a cornerstone of ethical clinical practice and professional psychology (British Psychological Society, 2009). Concerns continue to be expressed that no training, or minimal training, leads to supervisors practising outside their competence (e.g. Comier & Bernard, 1982; Falender & Shafranske, 2004; Robiner et al., 1997; Stoltenberg & Delworth, 1987; Taub, Porter & Frisch, 1988; Watkins, 1991; Whitman, Ryan & Rubenstein, 2001). Falender et al. (2004, p.774) state 'the ethical principles of psychologists ... require that psychologists who serve as supervisors have an ethical responsibility to acquire competence in supervision' and yet Falender and Shafranske (2004) claim that the majority of supervisors do not have formal training for the role.

Aims of the Review

This paper poses a number of key questions in reviewing the literature on supervisor training, beginning with questioning whether supervisors need training at all. The elements of training programmes and the impact of training on the effectiveness of supervisory practice are key issues. A further central issue is the supervisor's developmental process and how the transition from novice supervisee to supervisor is managed. Integral to this process are the supervisor competences required to enable the supervisor to deliver 'good enough' supervision (Hawkins & Shohet, 2012, p.4). Professional bodies such as the British Psychological Society (BPS), British Association for Counselling and Psychotherapy (BACP), British Association for Behavioural and Cognitive Psychotherapies (BABCP) and United Kingdom Council for Psychotherapy (UKCP), play an important role in developing,

maintaining and monitoring minimum standards for supervision practice, and their contribution is examined in this review.

The aim of this paper is to review the literature, both discursive and empirical, to answer these questions and to identify current issues and challenges. Key literature is reviewed and empirical data evaluated with conclusions and recommendations for future research.

Review Parameters and Criteria

The inclusion criteria for the review are: literature focusing on supervisor training in the psychological therapies (clinical and counselling psychology, counselling and psychotherapy) with a specific interest in post qualifying training in psychotherapy supervision in the 'talking therapies'. The family therapy supervision literature is excluded from this review on the basis that it is very specific to the practice of family therapy and requires a specific subset of skills (Whitman et al., 2001). The same applies to group supervision, where a knowledge of groups dynamics and group facilitation are necessary skill subsets (Ogren, Boethius & Sundin, 2008; Wheeler, 2004), although the lack of empirical data has made this a self de-selecting criterion. In addition, individual supervision is the most widely practised and 'the cornerstone of professional development' (Bernard & Goodyear, 2009, p.218).

The relevant literature was searched using PsycINFO, EMBASE, PsycArticles and Psychology and Behavioral Sciences Collection from 1990 to 2013. The key construct was supervisor training and various search terms were used to capture as wide a literature base as possible: clinical supervisor/consultant/supervision, development/training/education, workshops/training, curriculum/programme, competences, development models, professional psychology (clinical, counselling), counselling, psychotherapy, psychological therapy. References were reviewed and followed up from studies, articles and books which emerged in order to identify and explore the diverse themes within the literature.

As a supervisor and trainer I acknowledge my own biases in reviewing the literature. I have been supervising psychological therapists and other health professionals for fifteen years. As an academic in a university I have been programme director for a professional doctorate in counselling psychology and have also been involved in establishing, developing and leading a High Intensity CBT training programme as part of the Improving Access to Psychological Therapies (IAPT) initiative.

Do supervisors need training?

An early assumption was that good supervisors evolved through experience and seniority, drawing on their own experience of being supervised and relying on their therapeutic approach for a theoretical base (e.g. Baranchok & Kunkel, 1990; Bernard, 1981; Bernard & Goodyear, 2009; Drapela, 1985; Hawkins & Shohet, 2012; Hess, 1987; Loganbill & Hardy, 1983). Hess (1987) points out that psychologists have tended to take supervision for granted but various factors contributed to shifting attitudes. Novice supervisors became more vocal about expressing difficulties in assuming the role of supervisor (McColley & Baker, 1982; Watkins, 1994, 1999) and the supervisee literature raised awareness of novice supervisors' difficulties (e.g. Blair & Peake, 1995; Hess, 1987; Watkins, 1990).

Worthington (1987, p.206) suggested that lack of training may mean that supervisors 'perpetuate the mistakes of their own supervisors', leading Watkins (1995) to insist that both experience and training are necessary for supervisor development and that longevity as a supervisor does not guarantee development. Rodolfa et al. (1999) conducted a survey on supervisory style and practice and concluded that training, not experience, was the crucial factor.

The publication of The Clinical Supervisor in 1983, a journal devoted entirely to supervision providing a forum for discussion and research (Munson, 1983) contributed to the recognition of psychotherapy supervision as a profession in its own right, distinct and separate from the profession of psychotherapy (McMahon & Simons, 2004). In 2004 Falender et al. declared that supervision is now a 'distinctive professional competency' (2004, p.775). Hawkins and Shohet (2012, p.152) assert that supervision 'requires an additional knowledge base, competencies, capabilities and capacities'. This all added weight to the argument for distinct and separate training (e.g. Borders et al.,1991; Dye & Borders, 1990; Holloway & Carroll, 1999; McMahon & Simons, 2004; Wheeler, 2004).

Despite the wider acceptance of the need for supervisor training, claimed by Gonsalvez and Milne (2010, p.234) to be 'unanimous', the literature suggests that supervisors do not routinely access training (Milne & James 2002; Russell & Petrie, 1994). Watkins (1991, p.146) refers to the 'persistent paradox' where demands for training are not followed up with action, a concern reiterated two decades later (Watkins, 2012a). In 2000 Scott, Ingam, Vitanza and Smith, in a survey of current practices in America, found that the majority of supervisors had not received formal training. In the UK, Townend, Ianetta and Freeston (2002, p.497) surveyed practitioners accredited with BABCP, reporting that over a third of supervisors had not received any training and that at least half of supervisees 'did not know

if their supervisor had received any training in supervision'. Milne (2010) suggests that many supervisors continue to receive little or no supervisor training and the training on offer may well not be evidence based (Falender, Burnes & Ellis, 2013). However, Owen-Pugh and Symons (2012), in their survey of 342 practising supervisors in the UK, found that 83% had participated in some form of supervision training, ranging from certified courses to one day workshops.

Neilson, Jacobsen and Mathiesen (2012) investigated whether new clinical psychology supervisors were sufficiently trained to deal with complicated tasks. They concluded that they were not trained to carry out the complex tasks they were required to undertake and found that 82.7% of new supervisors had received no training in supervision (although they subsequently went on to access training). Lack of information detracted from the study, such as not defining 'formal training', nor how the participants were recruited or their level of training at the time of the study. The self administered instrument (the Development of Psychotherapists Common Core Questionnaire) needed to be supplemented for the study, weakening the psychometric properties as well as leaving scope for self report bias.

Counselling and applied psychology graduate and internship programmes in America increasingly include supervisor training in their curricula. In the UK the Health Care Professions Council (HCPC) requires that professional psychology doctorate programmes include supervisor training in their programmes. The call for post qualifying supervisor training for psychological therapists is largely absent in the literature. Although there are indications that the availability and uptake of supervision training is increasing, there remains a lack of provision (Spence, Wilson, Kavanagh, Strong & Worrall, 2001; Townend et al., 2002) making it difficult for supervisors to access training.

Supervisor Training

Despite over two decades of inquiry, the evidence base for supervisor training remains scant (Falender et al., 2013; Milne, Sheikh, Pattison & Wilkinson, 2011; Watkins, 2012a, 2012b). A number of reviews of the literature have been presented (e.g. Barker & Hunsley, 2012; Borders, 2006; Gonsalvez & Mcleod, 2008; Gonvsalvez & Milne, 2010; Milne et al., 2011; Spence et al., 2001; Watkins, 2012a, 2012b) yet the lack of empirical data in the psychotherapy supervisor training literature means that reviews are often drawn from allied health disciplines such as speech therapy or social work, rather than focusing on supervision in the psychological therapies (e.g. Milne et al., 2011; Watkins, 2012b).

Content of Supervision Training

Many training programmes, curricula and workshop formats have been presented over the last 25 years (e.g. Bernard, 1981; Borders et al., 1991; Britton, Goodman & Rak, 2002; Culloty, Milne & Sheikh, 2010; Dimino & Risler, 2012; Dye & Borders, 1990; Getz & Agnew, 1999; Loganbill & Hardy, 1983; McMahon & Symons, 2004; Milne, 2010; Neufeldt, 1994; Pegeron, 2008; Reiss & Hermann, 2008; Schindler & Talen, 1996; Taub et al., 1988). This collective endeavour over several decades has led to a good measure of agreement on the content of supervision training programmes and the methods of teaching supervision (Milne et al., 2011).

The didactic experiential model, based on psychotherapeutic training, is widely acknowledged as an appropriate framework (e.g. Borders, 2010; Bradley & Whiting, 1989; Britton et al., 2002; Falender et al., 2004; Hawkins & Shohet, 2012; Loganbill & Hardy, 1983; O'Donovan, Slattery, Kavanagh & Dooley, 2008; Russell & Petrie, 1994; Watkins, 2012b).

The didactic component is delivered in a classroom situation in the form of workshops, lectures and seminars. Typical theoretical content includes models of supervision, ethical and legal issues, supervision alliance, role acquisition, function and responsibility, contracting, assessment and evaluation and supervisor competences (e.g. Bernard & Goodyear, 2009; Hawkins & Shohet, 2012; Page & Wosket, 2001; Roth & Pilling, 2008; Watkins, 2012a, 2012b).

Effective application of theoretical knowledge requires a well structured experiential component comprising both skills practice and supervised in vivo supervision practice. Occasionally, training may be linked to a psychotherapy approach (e.g. Milne & James, 2002; Perris, 1994; Watkins, 2010), or to a specific client group (Culbreth, 2001; Mason, 2005; Kavanagh, Spence, Wilson & Crow, 2002).

Green and Dye (2002) used the Delphi method to investigate appropriate content for supervisor training. Using a panel of 50 experts consisting of directors (N=10) and tutors (N=10) of clinical psychology programmes; managers responsible for CPD (N=10); experienced supervisors (N=10); and novice supervisors (N=10), they constructed a questionnaire and ran two rounds of questions. There was a strong consensus on both rounds, with the novice supervisors differing most strongly. Primary issues clustered around ethical and gate-keeping issues, managing placements and concerns about managing failing supervisees/trainees. The findings reflect the context of the study, which was primarily aimed at supervisor training on clinical psychology doctorate programmes in the UK.

Milne, Scaife and Cliffe (2009) continued the theme with a consensus building exercise, using the Nominal Group Technique. Participants were 36 supervisors from clinical psychology doctorate programmes, attending a CPD workshop. They generated 16 primary factors perceived to be core to experiential training, which the authors compared with the competences consensus frameworks developed by Falender et al., (2004) and Kaslow et al., (2004). They found that themes of safe space, reflective space and teaching were similar to those of their American counterparts but the UK group did not attribute any great importance to supervisor development models or evidence based practice. Milne et al. put this down, in part, to the interpretative nature of their methodology (NGT) but it may well reflect a deeper difference in the supervision cultures in the UK and America. The literature shows that most of the work on supervisor development models has been done in America where the educative component is more prominent, whereas in the UK, with the culture of lifelong supervision, restorative elements may well have greater significance.

An Australian survey attempted to identify a generic supervision framework for each of the nine colleges (equivalent to BPS Divisions - clinical, community, counselling, educational, forensic, health, neuropsychology, organisational, sport) of the Australian Psychological Society (O'Donovan et al., 2008). Participants were the Queensland State chairs of the nine colleges. Data was collected using semi structured interviews and analysed using content analysis. Although the small sample size limits generalisability, the findings indicated a good level of commonality between the specialisms.

A noticeable gap in the empirical literature is the area of ethical practice in supervisor training, although it is addressed in the wider literature (Bernard & Goodyear, 2009; Hawkins & Shohet, 2012).

Evaluating the effectiveness of supervisor training

McMahon and Simons (2004) evaluated the effects of a supervision training programme for counsellors, using a pre-test/post-test experimental design. Participants were counsellors (*N*=79), members of professional counselling organisations, 63% with post-graduate qualifications and with a modal range of counselling experience 5 – 10 years. The majority of participants (*N*=43) had received less than one week of supervision training at the point of the study, but no information is supplied regarding the remaining 36 participants, which raises questions as to how this might have impacted the overall findings. Participants were divided into the experimental group (*N*=16) and the control group (*N*=63), with a small attrition rate in both groups.

Drawing on the curriculum guidelines of Borders et al., (1991), they provided a four day didactic-experiential training programme. The experiential components included personal reflection, small group work, case discussion, role play and practice supervision sessions but omitted supervision of in vivo supervision practice.

The authors constructed the self administered Clinical Supervision Questionnaire (CSQ) for the purpose of the study and report that 'experts' judged it to have content and face validity and internal consistency reliability. However, the psychometric data for the measure is weak and the findings were potentially further confounded by self report bias. The CSQ was administered three times to the experimental group – the beginning and end of the training programme and at a 6 month follow up, and twice with the control group at the beginning of the study and at the 6 month follow up.

The data was analysed using one way and repeated measures ANOVA. Although the small sample size was a disadvantage, the authors note there was a large effect size over the three time periods. They found a significant difference in the change of the supervision scores for the experimental group across the three time periods, whereas a paired samples *t*-test found no statistical difference in the supervision scores for the control group, thereby concluding that the training intervention increased the supervision scores for the experimental group. This study provides good evidence of the beneficial effects of supervisor training though with some limitations. One issue is that not all the participants were practising supervisors, meaning that the learning may have been theoretical rather than applied.

Bambling, King, Raue, Schweitzer and Lambert (2006) demonstrated the efficacy of supervisor training rather as a by product of their primary research purpose. Watkins (2012b) and Milne et al. (2011) include this study in their reviews of supervisor training despite the fact that the purpose of the study was to examine the impact of supervision on psychotherapy practice, by way of measuring client working alliance and client symptom reduction in the brief treatment of major depression. Although the study was methodologically robust, its contribution to understanding supervisor training is therefore limited.

Participants were 127 clients with a diagnosis of major depression, 127 therapists and 40 supervisors. Inclusion criteria for supervisors were minimum qualifications of a graduate qualification in a recognised mental health discipline and two years of experience providing supervision. No information about prior supervision training is provided but the authors state that a rating of competency was part of the selection criteria. In return for participating, they received free supervision training designed for the study consisting of a one day workshop and were assessed in the use of the study's supervision manual using role play.

Clients received eight sessions of treatment with either a supervised or unsupervised therapist.

The study used a repeated measures ANOVA with multiple measurement intervals. The conditions were a process-focus condition (*N*=34), a skill-focus condition (*N*=31) and a no supervision condition (*N*=38). Measurements of client rated working alliance were taken at sessions 1, 3 and 8 and client symptom scores taken at intake, sessions 1 and 8. Multiple measures were used to assess client progress and supervisor adherence (Supervision Focus Adherence Scale). Findings showed that clients in both of the supervised groups had reduced symptoms and rated the working alliance higher than the unsupervised group and that there was no significant difference between the two supervised groups.

Kavanagh et al. (2008) investigated the effects of supervisor training in a randomised controlled trial with 46 supervisor-supervisee dyads participants (*N*=92) divided into three conditions: Immediate condition where both supervisors and supervisees received training together; Delayed condition to produce a wait condition control group; Split condition where the supervisor was trained first and then the supervisee after a delay of several months. Their hypothesis was that the Immediate condition would receive the most benefit from the training compared with the Delayed condition, and the Split condition would be somewhere in between. Participants from both the Immediate and Split conditions attended a 2 day manualised training, with a specific focus on supervision agreements, supervision strategies, supervisor self efficacy and frequency of supervision problems.

Data were collected with a self report questionnaire which the authors had used in a previous study (Kavanagh et al., 2003) and analysed using repeated measures ANOVA/ANCOVA. Results were reported in each of the four foci of the study in each of the conditions. The Immediate condition showed better results in the supervision agreement and supervision problems foci but apart from this the findings showed limited impact of supervisor training.

There are a number of issues with this study. The authors admit that 'making significant improvements in supervision practice may be more challenging than were initially anticipated' (Kavanagh et al., 2008, p.104) perhaps underestimating the complexity of supervisor training. They relied on an instrument from a previous study (Kavanagh et al., 2003) which appears to have insufficient psychometric data. There was no formal fidelity check on workshop delivery or comparability of workshop content and the authors report issues of timing which led to participants from different conditions being trained together risking contamination effects. Finally, there were issues with the training itself. The content of the training appeared to be ambitious for the time frame despite the very specific training foci and complicated by encompassing both supervisor and supervisee perspectives. There

was some experiential content on day two but this was limited and no supervised in vivo practice was included. The shortcomings in the training may have had much to do with the limited findings.

In contrast to this, Sundin, Ogren and Boethius (2008) conducted a naturalistic, longitudinal study to evaluate the success of a two year part time training programme for psychotherapy supervisors. The dual purpose of the study was to measure the participants' attainment of knowledge and skills as well as the factors contributing to this. The participants were 21 supervisor trainees, all qualified psychotherapists with a minimum of three years post qualifying experience. The 6 participant course supervisors, were experienced clinical psychologists who had completed a two year supervisor training programme themselves. All participants worked from a psychodynamic perspective. The course comprised didactic content, group supervision of supervision and instruction on group supervision.

Limited psychometric data was presented for the measure used. Ratings were gathered at 6, 12 and 18 month intervals; attainment of knowledge and skills was analysed using a general linear model repeated measures procedure. Factors contributing to the attainment of knowledge and skills were analysed using simple regression analysis with backward elimination.

Results indicated significant change in level of knowledge and skills acquisition with a number of contributory factors. The authors found some of the findings unexpected. For example, although the relationship between trainees was a positive factor, the relationship between supervisors and trainees was not a significant factor, nor was the supervisory style of the supervisors. The small sample size was a limitation but a more serious limitation was the lack of a control group and for this reason Milne et al. (2011) failed to include it in their systematic review.

In a bid to address the lack of rigour in evaluating supervisory training Culloty et al., (2010) applied the fidelity framework in an evaluation of supervisor training programme. This is a conceptual framework which measures the degree to which an intervention (in this case a two day supervisor training workshop) adheres to delivery intentions (Carroll et al., 2007). The participants were 17 students on an MSc in CBT. The results indicated that the authors had been successful in operationalising the fidelity framework in all five levels. They recommended that it be applied to further supervisor training, although admitting practical difficulties in its application.

Supervision of supervision

A primary function of supervision is educative (e.g. Alonso, 1985; Watkins, 2012b) and consequently supervision of in vivo supervision during training is viewed as desirable (Bernard & Goodyear, 2009; Ellis & Douce, 1994; Dimino & Risler, 2012; Hawkins & Shohet, 2012; Schindler & Talen, 1996; Watkins, 2010). Watkins suggests that it has only been cursorily addressed and recommends it as a key factor in supporting novice supervisors, citing an example of organisational failure to 'hold' the novice supervisor (1999, p.70). Hawkins and Shohet agree, 'as supervisors we need the same organisational holding as our supervisees' (2012, p.135) and assert that 'supervision on your supervision is a critical ingredient' (2012, p.171).

Getz and Agnew (1999) made this a focal element of their training programme which consisted of brief didactic classroom training followed by highly structured supervision of supervision groups. The programme was evaluated using focus group interviews and the Semantic Differential Scale (SDS) to test the reliability of interview responses. The authors concluded that the programme positively impacted participants' practice, personal and professional development and knowledge base. The absence of a control group and participant information were limitations of the study.

A survey conducted by Wheeler and King (2000) found that supervisors expressed great satisfaction (mean score of 70%) with their supervision of supervision arrangements, suggesting that this element should be developed. However, despite support for supervision of supervision as being both educative and supportive for the novice supervisor, there is a lack of empirical data.

Supervisor training – when is it enough?

There is wide variation in supervisor training (Fleming, 2004; Milne et al., 2011; Wheeler, 2004). Currently supervisor training in the UK ranges from Master's level courses through Diploma and Certificate level courses, to short workshops. The HCPC requirement to include supervision training in doctoral level courses does not specify length, breadth or depth of supervisor training. The IAPT initiative makes regular supervision for trainees a key aim and a central learning tool and the supervision training provided consists of short (usually four day) supervisor training workshops. Hawkins and Shohet (2012) argue that effective training is modular and delivered over a period of time, enabling the novice supervisor time to reflect on and to implement didactic components in their workplaces. Furthermore, they insist that supervision of supervision is needed to enable the trainee supervisor to integrate theory with practice and develop their own supervisory style.

Although this model is used in a range of training courses in the UK, research studies tend to focus on the short workshop model.

Factors including length, depth and breadth of training are absent in the research literature and have not been the focus of studies.

Supervisor Development

How the supervisor negotiates developmental stages and makes the transition from therapist to supervisor (Schindler & Talen, 1996; Whitman et al., 2001) is fundamental in the development of systematic supervisor training and a number of supervisor development models have been proposed (Alonso, 1983; 1985; Bernard, 1979; Heid, 1998; Hess & Hess, 1983; Marovic & Snyders, 2010; Rodenhauser, 1994; Stoltenberg & Delworth, 1987; Watkins, 1990, 1993) together with several reviews (e.g. Borders & Fong, 1994).

Bernard and Goodyear (2009) point out that there has been little work on supervisor development models since the Ellis and Ladany review (1997) and Falender et al., (2013) agree that supervisor development remains under researched. Barker and Hunsley conclude that the 'dearth of empirical studies on supervisor development' is a challenge for supervisory training (2012, p.7). In their systematic review of theoretical models in psychology supervisor development research, they found the most often cited model was Watkins' Supervisor Complexity Model (SCM) (Watkins, 1990; 1993) and dubbed it 'the only game in town' (2012, p.7). Blair and Peake (1995) conclude that the SCM is the most comprehensive of the development models. Watkins developed the Psychotherapy Supervisor Development Scale (PSDS) to evaluate the SCM (Watkins, Shneider, Haynes & Nieberding, 1995) and in 2002 Baker, Exum and Tyler's study with doctoral student participants, found that the scale was congruent with the theory.

Supervisor role acquisition

A crucial element in supervisor development is the ability to assume the role of supervisor (Baker et al., 2002; Mordock, 1990). Borders (1993) emphasises the need to create an optimal learning environment for the supervisee by transitioning from being client centred to supervisee centred.

The theme of supervisor style (Hess, 1987; Watkins, 1993) was investigated by Stevens, Goodyear and Robertson (1998) in a study with 60 supervisors focusing on changes in supervisor self efficacy and supervisory stance. Their findings indicated that both training and experience increased supervisors' sense of self efficacy but that training was needed to enable the novice supervisor to become more supportive and less critical of the supervisee.

Ogren et al. (2008) produced similar findings in a qualitative study investigating supervisor trainee perceptions of the 'super-supervisor' as a role model. The participants were six trainees in three different supervision groups, all accredited psychotherapists with at least ten years experience as practitioners, and three supervisors of the groups, all experienced psychotherapy supervisors on a part time supervisor training course (the same course as that used in the study by Sundin et al., 2008).

Data was collected using semi structured interviews by one of the authors and analysed using grounded theory method. To avoid duality of role, none of the researchers worked with the study participants. Responses were categorised according to the two research questions and supervisor and supervisee responses presented separately. Primary themes of the super-supervisor as role model reflected the findings of Stevens et al. (1998) and Borders (1993). Over the course of the training programme the novice supervisors were able to adopt a supervisory stance similar to that described by Borders. They were able to model their own supervisory style on the super-supervisors' tolerant attitudes and ability to provide a 'non-authoritarian' reflective space in supervision (Ogren et al., 2008, p. 14).

Ybrandt and Armelius (2009) conducted an empirical investigation into the changes in self image of novice supervisors using the Structural Analysis of Social Behaviour (SASB). Participants were six female and three male psychotherapists (SVT group) enrolled on a three semester postgraduate supervisor training programme. The mean age was 48 and the mean length of practice time as psychotherapist was four years. The aim of the training programme was to enable the trainees to develop an identity as a supervisor within a didactic-experiential framework. Each trainee worked with three supervisees and received course supervision of their supervision practice. The trainers/supervisors were qualified and experienced clinical psychologist supervisors who had themselves completed a two year psychotherapy supervision training (SV group).

Data was collected using the Swedish SASB long form, for which there is good data for reliability and validity - Chronbach's alpha for the Swedish version is 0.80 (2009, p.117). The SV group completed the measure once, which was mailed to them and returned anonymously. The SVT group completed the measure at three points: before training and after training when they completed the measure on the premises and then at a four month follow up, when the questionnaire was mailed out to them.

The data were analysed using the SASB model and compared on two levels of aggregation for affiliation and autonomy with paired sample *t*-tests. There was only one significant finding which showed that trainee self image became more autonomous after training,

demonstrating the same level as the experienced supervisors. However, trends showed that after training the trainees tended to become more positive in their self image. The main limitation to this study is the small sample size which possibly led to inconclusive findings. Watkins (2012a) criticises the self report measure as a limitation but since the aim of the study was to investigate self image, the instrument used seems appropriate in this case.

Supervisor Competences

Well defined competences are an essential component of systematic supervisor training. Dye and Borders (1990) developed standards for counselling supervisors to meet the requirement for supervision training to be included in doctoral programmes accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP) in America, emphasising that implementation is dependent on professional bodies. Following the Competences Conference in America in 2002, Falender et al. (2004, p.774) developed a competencies framework, identifying 'core components of competence in Supervision'. Mirroring the focus on evidence based psychotherapy practice, there has been an increasing interest in competency based supervisory practice over the last decade, both in the UK and internationally (Falender et al., 2004; Falender et al., 2013; Falender & Shafranske, 2004; Farber & Kaslow, 2010; Kaslow et al., 2004) including an emphasis on cultural competency (Falender et al., 2013; Foo Kune & Rodolfa, 2013; Grus, 2013; Westfield & Rasmusson, 2013). Falender et al. (2013, p.13) note that 'clarity is lacking regarding the extent, breadth, and depth of supervisors' competence' although they acknowledge that recent work provides a foundation for the future.

In the UK, significant work on supervisor competences has emerged from the IAPT initiative. Roth and Pilling (2008) developed a Competence Framework for the Supervision of the Psychological Therapies, with four domains: generic, specific, applications to specific models and metacompetences. Owen-Pugh and Symons (2012) surveyed 342 practising supervisors to investigate its applicability and generalisability to current supervisory practice in the UK. They contacted participants through on line directories of professional organisations (BACP, BABCP, BPS, UKCP) and used an on line survey followed up with two email surveys. The data was analysed using descriptive statistics and *t*-tests to analyse for significance of difference. They found that supervisors identified strongly with the majority of competences although there was less acceptance of the lower order competences and some indications that CBT supervisors might have a stronger identification with some of the competences. However the authors remain tentative owing to the small sample size and self report data and recommend further observation studies.

Milne and James (2002) used Teachers' PETS (Milne, James, Keegan & Dudley, 2002; Milne et al., 2008) to evaluate the impact of supervision on supervisor competency, using a quasi experimental longitudinal design with four phases: baseline; routine consultancy; consultancy with feedback; maintenance. The authors' prediction that the consultancy with feedback intervention would lead to significant improvement in competency was not borne out although they noted a marked improvement overall from baseline to maintenance and speculated that there may be a time lag effect in assimilating learning. Given the field setting (in the NHS), variables could not be fully controlled but in addition, the strict focus on the teaching function of supervision may have precluded inclusion of other supervisory competences.

In 2010, Milne commented that there was still little understanding of how supervisors acquire competence and trialled a training manual in a national pilot study investigating its effectiveness in the delivery of supervisor training. Overall the trainers gave the manual an acceptability rating of 74%.

Professional Standards

Some professional bodies such as BACP and BABCP offer accreditation schemes for supervisors, which require prior training and the BPS currently offers a 'grandparenting' route to registration as a psychotherapy supervisor, due to end in 2013. Although the professional bodies provide clear guidelines and information about current regulations, there is wide variation in requirements regarding length of training, content of training, requirements for consultative supervision and CPD for supervisors. Despite steady progress over the last decade, significant gaps remain including the lack of accreditation schemes for supervisor training courses in the UK.

Conclusion and Recommendations

A review of the literature of supervisor training presents a mixed picture. On the one hand, Watkins (2012a, p.45) complains that 'despite a generation of inquiry, the psychotherapy supervisor still remains the largely unknown party in the supervision experience' and Milne et al. (2011, p.53) suggest that supervision training is 'still not given serious attention'. Frustration with the pace of development in supervisory training is a familiar theme (e.g. Borders, 2010; Milne, Leck & Choudhri, 2009). Watkins (2012b, p.282) concludes that 'recognition and acceptance does not translate into deliberate action'. The overall lack of empirical data in supervision hinders the development of empirically supported supervision training (Barker & Hunsley, 2012; Milne, 2010; Milne & James, 2002; Spence et al., 2001).

On the other hand, there have been over three decades of steady interest and research contributing to a small but increasing empirical base for a systematic approach to supervisor training. There have been significant developments such as much wider availability of supervisor training and the first BPS Conference on Supervision in the UK in 2013. There are grounds for optimism and the landscape is less 'barren', but there is often a counterpoint to each positive demonstrated in the following summaries.

The literature tells us that there is a general acceptance within professional psychology that training is desirable (Gonsalvez & Milne, 2010), yet the uptake of training is slow and supervisor training not widely available (Townend, et al., 2002).

Although the research base remains small, there are indications that training has beneficial effects on practice (Hawkins & Shohet, 2012). There are however, significant gaps. For example, as funding in mental health is increasingly stretched, more organisations, including the NHS, are turning to group supervision as a cost saving method of delivering supervision (Milne & Oliver, 2000). More empirical data is needed to inform us of the skill sets needed to deliver effective group supervision. Currently there is little in the literature, with only a few exceptions (e.g. Ellis & Douce, 1994; Proctor, 2000; Sundin et al., 2008).

The general acceptance of the didactic-experiential model masks numerous issues. Whilst empirical evidence is lacking to support this model, it is widely embraced in the advocacy literature (e.g. Hawkins & Shohet, 2012; Holloway, 1995). Research studies have tended to focus on a short workshop model of training leaving a gap between what is claimed to be good quality training and what is tested out. Short workshops are unable cover the range of theoretical material, have limited time for experiential activities and do not include supervision of in vivo supervision practice.

The HCPC requirement to include supervision training in doctoral level professional psychology programmes is a positive development but the absence of firm guidelines will invariably lead to wide variability across programmes. It is also questionable as to whether trainees are at an appropriate level of clinician development to benefit from supervision training (Townend et al., 2002). Whilst welcoming this development on doctoral programmes, it highlights the gap in provision of good quality post qualifying supervisor training and the dearth of empirical data focusing specifically on psychotherapy supervision training.

Whilst the notion of supervision of supervision is embraced in the wider literature, with Hawkins and Shohet (2012) integrating it into their model of training and Watkins (1999) arguing persuasively for it, it has little empirical support and more research is needed.

Given the gatekeeper function of supervisory practice and an increasingly litigious practice environment, the omission of research studies on the ethical and legal aspects of supervisor training is a concern and further research needs to be done.

The wide variety of training delivery (Fleming, 2004; Milne et al., 2011; Wheeler, 2004) suggests that little distinction is made between substantive training and Continuous Professional Development (CPD), with many studies failing to identify length of training as a factor when evaluating a training programme. Gonsalvez and Milne (2010) make no distinction in calling for resources to be made available and Watkins (2012b) likewise fails to differentiate when he endorses their suggestions. The contradiction between broad acceptance of the didactic experiential model and lack of rigour in implementation of its component parts clearly begs the question as to what is deemed to be good enough in terms of systematic training.

The work on supervisor development models seems to have lost momentum and is an area deserving of more attention, particularly in the UK, where the study by Milne, Scaife et al. (2009) demonstrated it was given a low ranking of importance by British clinical psychologists.

Interest in supervisor training is growing internationally with contributions from the UK, America, Australia, Canada, Denmark and Sweden (see Appendix 1 for Table of Research Studies) suggesting the need for increased attention to professional standards for supervisory training. Despite increasing evidence of the efficacy of supervisor training, there remains a sense that training as a supervisor is 'optional'. Professional bodies need to play a leading role in raising minimum standards for supervisory training, accreditation and practice if supervision is to retain its central role as an educative and ethical force within the psychological therapies. The implementation of an accreditation process for supervisor training programmes would be a major advancement in securing quality training and would also serve to address the ambiguity regarding what is substantive primary training and what is CPD.

The preponderance of advocacy literature over empirical data in the field of supervisory training is both a strength and a weakness. It provides a solid discursive base for the development of research projects but it is not enough in itself to support the implementation of systematic training. Supervision training comprises a complex matrix of factors and involves multiple stakeholders. A meaningful evidence base for effective supervisor training has to be more than a set of loose guidelines; it sits at the very heart of clinical supervision practice and the delivery of ethical and competent psychological therapy.

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APPENDIX 1

TABLE 1: EMPIRICAL STUDIES 1990 TO 2012 FOCUSING ON PSYCHOTHERAPY SUPERVISION WITH POST QUALIFYING PARTICIPANTS

Authors	Research focus	Sample	Design and Measures	Findings	Limitations
Bambling, King, Raue, Schweitzer & Lambert, 2006	Australian Investigation of the impact of clinical supervision on client working alliance and symptom reduction	Supervisors with a minimum qualification in a recognised mental health discipline and a minimum of two years of experience	A repeated measures ANOVA with multiple measurement intervals and three conditions - process-focus condition (*N*=34), a skill-focus condition (*N*=31) and a no supervision condition (*N*=38).	Clients in both the supervised groups had reduced symptoms and rated the working alliance higher than the unsupervised group; no significant difference between the supervised groups.	Measuring the effectiveness of supervisor training is by product of main focus of study
Culloty, Milne and Sheikh, 2010	UK study evaluating the delivery of supervisor training using the fidelity framework	17 trainees from a mental health nursing background attending an MSc in CBT	A quasi-experimental, longitudinal design using four measures (Training Acceptability Rating Scale, Semi structured interviews, Teachers' PETS, Marlow-Crowne Social Desirability Scale)	Results indicated that the fidelity framework has been successfully operationalised in all five levels. Recommended for application to future supervisor training.	Small sample size; self report data with no control conditions; practical limitations of applying fidelity framework for future studies
Getz and Agnew, 1999	American study evaluating a bespoke designed training programme for clinical supervisors in public agencies settings	Clinical supervisors in public agency settings	Training programme evaluated using focus group interviewing and self report Semantic Differential Scale.	Findings indicate that the training impacted positively on practice, personal and professional development and knowledge base.	Little information regarding participants' previous experience or training; limited information on analysis of data; no control group and self report data.
Kavanagh, Spence, Sturk, Strong, Wilson, Worrall, Crow and Skerrett,	Australian study examining the effects of supervision training with a sample of supervisor-supervisee dyads.	46 supervisor-supervisee dyads of supervisor-supervisees from mental health disciplines and 'majority' were psychologists	Randomised controlled trial with three conditions and data analysed using repeated measures ANOVA/ANCOVA. Survey questionnaire from earlier study	The Immediate condition resulted in statistically significant improvement but limited evidence of beneficial effects of the training course	Short (2 day) training course with over ambitious material which included dual focus on supervisors and supervisees; lack of psychometric data on measures used; little evidence of workshop delivery fidelity

2008					
McMahon and Simons, 2004	Australian study evaluating the effects of a supervision training programme	Qualified counsellors of whom the majority had received less than one week's training in supervision prior to the study.	Longitudinal pre test/post test experimental design using Clinical Supervision Questionnaire (CSQ). Analysed using paired samples t test, one way and repeated measures ANOVA	Significantly higher supervision scores on the CSQ in the experimental group and maintained at 6 month follow up.	Little psychometric data for self report measure (CSQ); limited information about level of participants' previous supervision experience/training; some participants not practising as supervisors; short course;
Milne, 2010	UK pilot study of an evidence based clinical supervision (EBCS) manual.	25 trainers and 256 qualified clinical psychologists all supervisors of trainee clinical psychologists and recruited from clinical psychology training programmes	Training only and training plus consultancy conditions with trainers rating the manual (MARS -Manual Acceptability Rating Scale) and novice supervisors rating the training (TARS-1 and TARS-2).	Overall self report novice supervisor satisfaction ratings high at 76% for the manual-only group, and 79% for the manual □□consultancy group. Trainers had some criticisms of the manual with the manual plus consultancy group giving it a higher rating (76% endorsement compared with 73% by the manual-only group).	Self report measures with limited psychometric data.
Milne and James, 2002	UK empirical study to evaluate the effects of consultancy and feedback on supervisor competence.	Clinical psychologist consultant and supervisor with 6 supervisees (4 CBT Diploma students and 2 mental health nurses)	Experimental longitudinal design using Teachers' PETS and Supervision Feedback Form with two intervention phases.	Limited improvement from feedback phase but overall improvement in competence when measured at maintenance phase suggesting a lag effect.	Lack of control over variables; involvement of supervisor in training observers in PETS measure
Milne, Scaife and Cliffe, 2009	UK consensus building exercise investigating primary elements of supervisor training	36 clinical psychology supervisors attending a short CPD workshop.	90 minute consensus building exercise analysed using Nominal Group Technique	Exercise generated 16 primary factors with key factors being providing a safe space, a reflective space and teaching	Small sample; interpretative nature of NGT
Nielsen , Haugaard Jacobsen & Mathiesen, 2012	Danish study investigating level of training prior to practice and the match between training and tasks	Clinical psychologist supervisors	Survey using the Development of Psychotherapists Common Core Questionnaire (DPCCQ); analysed using descriptive analysis	82.7% of supervisors received no training prior to practice and overall supervisors were not trained to deliver complex tasks See pp 185 - 7	Not clear how participants were selected, their level of training or when and how they accessed training. The DPCCQ needed to be adapted

	required				for the survey and no psychometrics offered.
O'Donovan, Slattery, Kavanagh & Dooley, 2008	Australian study investigating the common elements of supervisor training for a range of applied psychologies.	9 chairs of the Queensland Australian Psychological Society nine colleges (divisions).	Qualitative study using semi structured interviews and analysed by content analysis	Findings demonstrate a good level of commonality between the colleges and offers scope for designing professional psychology supervisor training.	Very small sample size limits generalisability; very little inter-rater information
Ögren, Boethius and Sundin, 2008	UK/Swedish study investigating supervisor and trainee supervisor perceptions of group supervision of supervision in a supervisor training programme with an emphasis on a shift of role from psychotherapist to supervisor.	6 trainees in 3 supervision groups, all accredited psychotherapists with minimum of 10 years experience and 3 experienced psychotherapy supervisors.	Data was collected using semi structured interviews and analysed using grounded theory method	Findings showed that the supervisors provided good role models for enabling the trainees to assume the supervisory role effectively	Very small sample size limits generalisability
Owen-Pugh and Symons, 2012	UK survey to determine the extent to which Roth and Pilling's competence framework reflects current supervisory practice in the UK.	342 supervisors of different therapeutic orientations were recruited via on line directories of professional organisations	On-line survey and two email surveys. Data analysed using descriptive statistics and *t*-tests to analyse for significance of difference.	Majority of participants felt able to identify with the competences although a minority disagreed. Researchers concluded that the framework is a helpful guide	Small sample size limits generalisability; self report data makes it difficult to confirm findings

Rodolfa, Haynes, Kaplan, Chamberlain, Goh, Marquis & McBride, 1999	American study investigating differences in supervisory style and practice between experienced and inexperienced supervisors	131 licensed psychologists divided into two time frame frames: licensed for at least 6 years (*N*=58) and licensed for less than 3 years (*N*=73) 131 licensed psychologists	Self report questionnaire adapted from the Supervisory Working Alliance Inventory. Between-group differences were calculated using via *t*-tests	No significant differences were obtained on the three measures of supervisory style or 21 measures of supervisory practice suggesting that experience alone does not positively impact on supervisory style or practice.	Small sample due to poor response rate; self report measures limit reliability of findings.
Stevens, Goodyear and Robertson, 1998	American study examining the relative influence of experience and training on supervisory stance, emphases and self efficacy.	60 mental health professionals with varying amounts of supervision experience. All but 3.3% (social workers) were psychological therapists	Experimental study where participants completed the Supervisory Emphasis Report Form–Revised before watching a video extract and a thought listing and self efficacy measure afterwards. Independent raters analysed results using factor analysis and z scores.	Findings show that both training and experience increase supervisors' sense of self efficacy; training alone shifts style to more supportive and less critical.	No psychometric data for the post video measures; scope for subjective interpreting of independent raters; use of video instead of live material
Sundin, Ogren and Boethius, 2008	UK/Swedish study Supervisor trainees and their supervisors' perceptions of attainment of knowledge and skills: An empirical Evaluation of a Psychotherapy supervisor training programme	Psychotherapy supervisors on two year part time supervisory training programme	Naturalistic longitudinal study Ratings gathered at 3 points over 2 years and data analysed with a) general linear model procedure and b) simple regression analysis with backward elimination	Significant findings regarding the positive effects of the training programme but mixed results on the factors contributing to positive knowledge acquisition of trainees.	No control group; self report so no independent verification; limited sample size; lack of psychometric data on instruments used
Townend, Ianetta and Freeston, 2002	UK survey to investigate supervision practices in a range of areas including supervisory training supervision practices of practitioners	Random sample (*N*=170) of CBT practitioners accredited with BABCP	Survey using questionnaire designed for the study, piloted with 10 participants and revised. Data entered into SPSS Version 10 and analysed with descriptive statistics,	Range of general findings including that over a third of current supervisors had not received any supervisor training.	Data not sufficiently detailed for formal analysis; limited psychometrics for questionnaire although piloted

	of CBT and accredited members of BABCP.		including cross tabulations.		
Ybrandt and Armelius, 2009	Swedish study investigating changes in self image during and following supervisor training.	6 female and 3 male psychotherapy supervisor trainees on a 3 semester post graduate programme	Empirical study comparing the effects of training on self image of trainee supervisors with self image of experienced supervisors using the SASB model	Findings show that sense of autonomy increased with the training to match that of experienced supervisors. Other results were not significant.	Small sample size possibly contributed to inconclusive findings