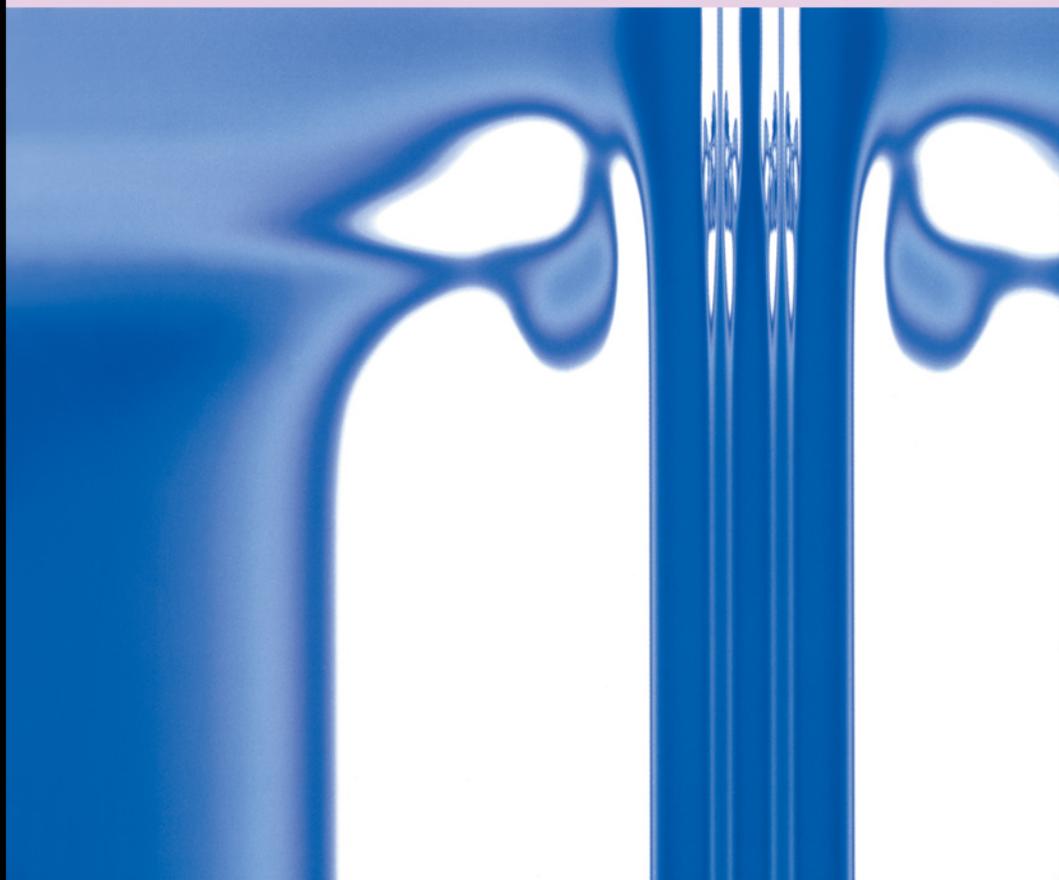


Edited by IAN FLEMING and LINDA STEEN

Supervision and Clinical Psychology

Theory, Practice and Perspectives



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Supervision and Clinical Psychology

Increased attention is now being paid to the role of supervision in both prequalification and post-qualification practice in clinical psychology in the UK. This definitive text addresses the issues of central concern to supervisors in clinical psychology.

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Ian Fleming and **Linda Steen** are joint Clinical Directors of the doctoral Clinical Psychology training programme at the University of Manchester. They have considerable experience of all aspects of training and a particular interest in supervision. As clinical psychologists in the NHS for over twenty years they have a wealth of experience of supervising others, including trainee clinical psychologists.

Supervision and Clinical Psychology

Theory, practice and perspectives

Edited by

Ian Fleming and Linda Steen

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Foreword

Clinical Psychology has come of age. One has only to attend a conference or read current government policy to realize just how far the therapies that clinical psychologists have developed have come in recent years. British clinical psychologists have played a valuable role in this march forward. To illustrate, at the recent annual conference of the British Psychological Society, Phillipa Garrety of the Institute of Psychiatry in London provided an overview of progress in our work with people who experience psychotic phenomena. She had been asked to prepare a systematic review for the relevant government body, the National Institute for Clinical Excellence (NICE), and had located over twenty control-led trials of cognitive behavioural therapy (CBT) for this potentially distressing experience. The great majority of these trials have been conducted in the UK by clinical psychologists, and the review indicated that CBT was effective. Similar signs of progress are evident if one reads policy documents produced by the Department of Health (e.g. the National Service Frameworks).

Given the advances that the profession has made on the therapy front, it becomes especially critical that comparable progress is made in relation to the systems that support therapists. For many years, clinical supervision has served as the firm foundation of clinical practice. It is timely that this foundation is now developed, so that advanced practice can be supported appropriately. This book is just such a development. It offers a rare combination of the scientific literature and clinical experience, designed explicitly to enhance supervision for clinical psychologists in the UK.

According to the authors in this book, the goals of clinical supervision are to encourage reflection, understanding and self-awareness in the supervisee, and to enable problem-solving. Principally, the aim is to enhance clinical practice, and its effectiveness, in the best interests of the client. Lastly, but in keeping with such quality control priorities, supervision serves as a 'gatekeeping' procedure, designed to ensure that those who qualify as clinical psychologists are indeed suitably fit to practise.

Given such important goals, it is indeed surprising that so little attention has been given to the topic, whether this is in terms of the training and development of the supervisors' relevant research, or the formal requirements placed upon

supervisors. Indeed, such has been the parlous state of the clinical supervision enterprise that one author has even taken the view that supervision ‘like love, cannot be taught’ (Scott, 1999:756). Clinical psychology is a precocious, growing profession and, partly because of its success in demonstrating the effectiveness of psychological therapies, the NHS has dramatically increased its demand for properly trained clinical psychologists. There is also an accompanying demand for supervision, not just in the period of initial training but also as a career-long basis for the kinds of practice-enhancing goals that are outlined above. In this context, it would be strange indeed if a book of this kind were to subscribe to Scott’s position. Rather, the authors provide an impressive range of material to suggest that, to contradict Scott, ‘like therapy, supervision can be taught’.

To illustrate this optimistic view, consider the contributions that are contained in the pages that follow:

- A historical summary is provided, to afford perspective (Wheeler, in [Chapter 2](#)).
- Evidence-based models are identified and refined ([Chapter 3](#), Beinart).
- A local analysis of the quality and quantity of training placements is presented ([Chapter 4](#), Turpin, Scaife and Rajan).
- The training courses in the UK are surveyed and a reflexive, psychologically informed approach clarified ([Chapter 5](#), Fleming).
- Sound reasoning and a distillation of a professional consensus on the factors that contribute to successful supervision is provided ([Chapter 6](#), Green).
- Ways of enhancing practice through such methods as facilitating reflection and critical thinking are noted ([Chapter 7](#), Patel).
- The importance of the socio-political context for the effective conduct of supervision is recognized ([Chapter 8](#), Dennis and Aitken).
- Rich information from workshops and surveys of both supervisors and supervisees is furnished to yield a refined list of what works in supervision ([Chapter 9](#), Cushway and Knibbs). A summary of four different models for providing supervision, emphasizing an integrative approach and the six ‘modes’ needed to make supervision successful is provided ([Chapter 10](#), Matthews and Treacher).
- Implications for the future training and accreditation of supervisors, and the links to continuing professional development, are teased out ([Chapter 11](#), Fleming and Steen).

One cannot help but be impressed by such a wide-ranging, well-grounded and upbeat account of what is possible in the name of clinical supervision. Indeed, I would suggest that, in addition to the aims of the book as outlined by Fleming and Steen in [Chapter 1](#), the book also has an implicit aim. It is to foster supervision from a rare base in the crystallization of exceptionally relevant experience (the assembled team of authors) and the intelligent use of key

literature. This is not to deny the value of their identified aims—namely, to provide a focus on the particular concerns of UK clinical psychologists and to document supervision practice within the National Health Service. These are indeed valuable aims, and are sufficient to arouse the interest of those working in this field on these islands. However, my reading of this book suggests that this rare blend of pragmatism and professionalism will invite a wider readership.

So far I have discussed the goals and methods inherent within this account of clinical supervision. I wish to close by identifying what I similarly perceive to be the (at times) implicit outcomes of the accounts that follow. I then want to link these outcomes to a particular orientation to our work, for which these authors are also to be congratulated. By the outcomes I refer to the following qualities that struck me: the emphasis of the chapters is unfailingly pro-supervision in that the authors, while recognizing the many obstacles and challenges inherent in providing effective clinical supervision, are biased towards finding solutions and giving issues a positive spin. The book is also highly accessible and applicable, clearly informed by many years of practice. This arises perhaps from working at one moment in the NHS ‘trenches’ where fundamental issues about supervision arise regularly, and at the next moment rubbing shoulders with those of a more academic institution in the host training courses. A further rare quality is that the book, based on this theory-practice integration, provides genuinely and unstintingly helpful guidance. Unlike the typical book of this kind, we are not asked to be persuaded by a vast array of recent literature but rather by material carefully selected for its relevance. This gives greater weight to this sifted material and shows much more clearly how such ‘theory’ links to the authors’ practice.

In conclusion, and to their great credit, it would seem to me that this group of authors have addressed the issue of clinical supervision as ‘reflective educators’. Reflective educators treat the education and training of clinical psychologists as a profession in itself (Peterson, 1995). Just as their clinical colleagues adopt the scientist practitioner model, these trainers of the next generation of clinicians seem to have adopted the appropriately parallel reflective educator approach to their duties. Specifically, they exemplify the approach that Peterson put forward so powerfully in a prestigious American journal. He argued that, whether we are trainers or clinicians,

every one of us needs to engage in a continuing process of reflection in action as we go about our educational duties... We need to take a close, critical look at our programmes, to question everything about them, and to come as near as we can to rational answers to the questions, before inserting, removing or sustaining various features of our programmes.

(Peterson, 1995:981)

Once you’ve had the pleasure of reading the richly informative, theorypractice integrated material that follows, I’m sure that you will join with me in

applauding these authors, under the guidance of the editors, Ian Fleming and Linda Steen, for approaching the educational duty of organizing supervision appropriately as true reflective educators. They have helped clinical supervision to come of age.

Derek Milne
Newcastle upon Tyne
April 2003

Chapter 1

Introduction

Ian Fleming and Linda Steen

The process of supervision like all human relationships is fraught with hazards.

(Dryden, 1991:69)

Supervision is held to be an essential requirement for learning and professional development, especially within professions working with other individuals. In their review of psychotherapeutic interventions, Roth and Fonagy (1996:373) conclude that supervision is 'an essential prerequisite for the practice of psychotherapy'. Similarly Holloway and Neufeldt (1995:207) state that 'supervision, as a psychotherapy training method is considered critical by educators...'

It is important and exciting to consider how people experience acting as a supervisor. What are the highs and lows? What causes excitement and anxiety? What are the intrinsic rewards? Also, how are these skills and attributes acquired and learned?

Some professions have mandatory requirements concerning all aspects of supervision. The British Association for Counselling and Psychotherapy (BACP, 2002), for example, requires all its members 'to have regular and ongoing formal supervision/consultative support'. In midwifery, there has been a statutory requirement, since 1902, for practising midwives to receive regular supervision. As will be discussed below, whilst there is a growing recognition of the role of supervision in post-qualification practice in clinical psychology, at present there is no statutory requirement for clinical psychologists to receive supervision for their clinical work, once qualified.

What is supervision?

Before proceeding, it is important to consider what is meant by the term 'supervision'. To supervise is to 'oversee the actions or work of [a person]' (*The Concise Oxford Dictionary of Current English*, 1990).

Within the literature on clinical supervision, the term 'supervision' has been interpreted and defined in numerous competing ways. Some professions have produced their own definitions of 'supervision'. The United Kingdom Central Council (UKCC), the professional body for nursing in the UK, for example, states that 'clinical supervision brings practitioners and skilled supervisors together to reflect on practice. Supervision aims to identify solutions to problems, improve practice and increase understanding of professional issues' (UKCC, 1996:3).

The British Association for Counselling and Psychotherapy (BACP) defines supervision as:

a formal arrangement for counsellors to discuss their work regularly with someone who is experienced in counselling and supervision. The task is to work together to ensure and develop the efficacy of the counsellor/ client relationship. The agenda will be the counselling work and feeling about that work, together with the supervisor's reactions, comments and confrontations. Thus supervision is a process to maintain adequate standards of counselling and a method of consultancy to widen the horizons of an experienced practitioner.

(BACP, 1996:1)

One of the crucial elements of this definition is the idea that the role of supervision is to protect the best interests of the client.

As will be discussed later in the book, other definitions of supervision derive more from specific orientations to clinical practice or explicit models of supervision than from professional ethos.

The Division of Clinical Psychology (DCP) of the British Psychological Society (BPS), whilst recognizing the importance of supervision throughout a clinical psychologist's career, stops short either of providing a definition or of endorsing any one particular model of supervision. The recently published DCP guidance on clinical supervision states: 'there is no one model or style of supervision that will apply to all clinical psychologists in all settings and at all times in their career' (BPS, 2003:2).

In the absence of an agreed definition of supervision within clinical psychology, one which seems to cover many of the relevant factors is that of Bernard and Goodyear:

An intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients that she, he or they see(s), and serving as a gatekeeper for those who are to enter the particular profession.

(Bernard and Goodyear, 1992:4)

This definition relates particularly well to supervision during pre-qualification training, referring as it does to ‘a senior member of the profession’, ‘junior members of that same profession’ and the functions of evaluation and gatekeeping ‘to enter the profession’. In view of the increasing recognition of the importance of post-qualification supervision within the profession, however, it is pertinent to consider how much of Bernard and Goodyear’s definition translates to this context, where there is likely to be a greater emphasis on peer and cross-professional supervision and where there is increased onus on the supervisee to be self-evaluative. These themes will be considered throughout the book and are drawn together in the final chapter.

Clinical psychology: the service context

Within clinical psychology in Britain, increased attention is being paid to the role of supervision in both pre-qualification training and post-qualification practice. The factors that have contributed to this are discussed later after an overview of the context in which the profession of clinical psychology operates in the UK.

It is pertinent at this time to examine these issues. Initially a small and possibly precocious profession within the National Health Service (NHS), clinical psychology has grown rapidly since 1980. The membership of the Division of Clinical Psychology (of the British Psychological Society) has grown from 966 in 1980 to 4,514 in 2001. In the past 30 years there has been an almost continuous growth in both the number of clinical psychology training programmes¹ (29 in the UK currently) and the number of clinical psychologists being trained (for example, up from 189 in 1993 to 390 in 2000 in England). To illustrate this point, the Manchester programme had an annual intake of nine people when we started in post as clinical tutors in 1994; the intake in 2002 was 21. This growth is expected to accelerate over the next few years on the back of manpower forecasts and identified roles for clinical psychology within the different National Service Frameworks in NHS planning (for example, DH, 1999).

Alongside expansion and increasing demand for clinical psychologists across all areas of the NHS, there is an increasing requirement for the scrutiny of clinical practice, most recently manifested in *clinical governance* (DH, 1998a).

This immediately raises the issue of the *effectiveness* of practice, and in turn of the role played in this by supervision. It also means that the training of people in the supervisory process needs to be examined.

Why another book about supervision?

There exists already an extensive and growing library devoted to supervision in the broadest sense, and a significant ‘stack’ to supervision in clinical professions

in the mental health trade. Key texts include Bernard and Goodyear (1992), Watkins (1997b), Kadushin (1992), Hawkins and Shohet (1989, 2000) and Carroll (1996). Why, you might ask, should there be any reason, other than author vanity, for an additional text?

Our starting point for this book was the absence of any text dedicated specifically to supervision in clinical psychology in the UK. This is despite the requirement for all *trainee* clinical psychologists to receive supervision of clinical work on placements. This requirement has been in place for many years.

More recently it has been accompanied by recommendations for *qualified* practitioners to also undergo supervision as part of good practice and professional development. Both the Division of Clinical Psychology's *Professional Practice Guidelines* (BPS, 1995b:9) and the DCP *Guidelines for Clinical Psychology Services* (BPS, 1998c:31) state that supervision should be organized for clinical psychologists at 'all levels and grades of experience'. In a similar vein, the DCP *Guidelines for Continuing Professional Development* (DCP, 2001a:8) acknowledge that 'all qualified clinical psychologists **whatever their level of experience** should have access to and be prepared to make constructive use of some appropriate supervisory facility to support their work'.

This 'gap' in the literature became apparent to us when, as clinical tutors on the Manchester University Clinical Psychology (Clin.Psy.D.) programme, we began to organize training for people who would supervise the programme's trainees. In the process of developing training for supervisors on the Manchester programme we became aware of some important issues. These are outlined below and support the value of the contribution that will be made by this book.

First, most of the books devoted to supervision within mental health professional practice are focused on counselling, social work and psychotherapy. Although much can be learned from this body of work, this book will be focusing on the particular concerns of clinical psychologists. The forms of supervision that have developed within clinical psychology, and their relationships to the psychological models that make up the dominant practice of clinical psychology in the UK, will be examined within the book.

Second, it seemed to us then that there was a need to document the experience of supervision in clinical psychology within the National Health Service. This would not be opposed to that mentioned above, but would complement it. In the process of finding out what was happening, clinical psychologists could be both consulted and informed.

Third, much, but not all, of the existing literature is from North America. Whilst we are at pains to deny any parochialism, we feel that there are limitations to how much this work will generalize to working in the National Health Service in the UK. Therefore this book will have a UK focus. This is certainly not for narrow chauvinistic or parochial reasons but because the majority of clinical psychologists in the UK work in the National Health Service and we wish the book to reflect the common constraints and opportunities for supervision within the particular culture of this system. It can be argued that the

NHS, through its dominant funding position for clinical psychology training in the UK, is the profession's *sponsor*; therefore national directives about practice within the general NHS will affect clinical psychology practice and professional development. The editors are unsure, however, as to how generalizable is much of the experience derived from other organizations of health care.

Supervision and clinical psychology: a growing relationship

As mentioned earlier, the importance of, and requirements for, supervision varies across different health and social welfare professions. It is fair to say that only in recent years has it been accorded significance within mainstream clinical psychology.

In recent years, professional bodies representing clinical psychologists in the UK have placed increasing emphasis on continuing professional development and the role that supervision can play in this. In part this has been a response to public concerns and a perceived need to demonstrate the requirements for *professionalism*. This has been augmented by concerns and initiatives at a government level for a public health service, actuated in demands for *clinical governance*.

With the planned introduction of statutory registration for all applied psychologists in the UK, the importance of supervision within the profession is likely to increase further.

What will the reader gain from the book?

Supervision and supervisor training usually require objectives and goals so, for the sake of consistency, we include some here.

It is hoped first that the reader will be excited by the possibilities contained within supervision. This book provides a collection in one work of chapters on important aspects of supervision written by leading practitioners and trainers, all of whom have been chosen for their experience in the field of supervision.

A second aspiration is that readers will gain knowledge about the most developed forms of practice in the UK and adapt these to their own practice.

Third, the book as a whole is intended to help ease the concerns of clinicians with respect to continuing professional development (CPD). It is intended that the book will help the reader to clarify the links between supervision, CPD and clinical governance as the last takes root within the NHS. The relevance of supervision to practise will be addressed. It is also hoped that readers will recognize the value to their practice of *supervising*.

A fourth goal involves those concerned in the organization of clinical psychology pre-qualification training. If successful in one of its objectives this book will act as a useful source for considering training issues. By design, contributors to this book are senior members of doctoral training programme teams.

Fifth, it is hoped that this book will enable readers to decide whether they need to have and use an explicit model of supervision in order to practise effectively both as a supervisor and as a clinician.

Sixth, it is hoped that the reader will be alerted to the important ways in which individuals' social and cultural history and features and their gender influence their supervision.

A final aspiration is that the content of this book can generate research that will enable the training community in clinical psychology (and in other related professions) to identify the key tasks involved in preparing clinicians to become supervisors.

What are the critical issues in supervision?

A survey of the literature suggests that there are a number of important questions still to be answered. These include the following:

Is there agreement on what tasks are involved in supervision?

Authors have developed a range of different models of supervision. In this book, these are introduced in the chapter by Sue Wheeler and developed further in Helen Beinart's chapter where she reviews different models of supervision and the research evidence that supports them. While there are many differences between the models of supervision, it can be argued that there is some common ground concerning the demands or tasks involved in supervision. In her chapter, Sue Wheeler cites the work of Carroll (1996) who identifies seven main tasks of supervision—namely, the relationship task, the teaching/learning task, the counselling task, the monitoring task, the evaluation task, the consultative task and the administrative task. Following a review of five social role models of supervision, Carroll (1999) concludes that there are some tasks, such as teaching, which are universally agreed, whereas others are particular to individual models and authors. Within clinical psychology, whilst there may not have been much explicit discussion of supervisory *tasks*, as reported in Chapters 5 and 6 of this book, developments in supervisor training would suggest that there is broad agreement amongst clinical psychologists on what the content of supervisor training should be.

Do we know what factors influence effective or 'good' supervision?

Throughout the history of supervision there has always been an assumption that it can be effective (see [Chapter 2](#) for a brief history of supervision). There have been numerous attempts to evaluate this and many brave research studies have floundered on methodological rocks in the process. In part, this is because of the difficulties of accounting for or controlling the array of interpersonal variables that

exist in any supervisory and therapeutic relationship involving a supervisor, a supervisee therapist, and a client.

In addition, there is the question of what would constitute a ‘successful’ outcome; this has been addressed by many writers, for example, Wampold and Holloway (1997). This issue is expanded upon in the current book by several of the contributors, notably Delia Cushway and Jacky Knibbs, David Green and Helen Beinart.

In a recent systematic review of this area of research, Ellis *et al.* (1996) analysed 144 studies and concluded that much of the empirical research on clinical supervision was not methodologically rigorous. This led Ellis and colleagues to set out criteria for future empirical research on clinical supervision (Ellis *et al.*, 1996; Ellis and Ladany, 1997).

It has been argued that in seeking to demonstrate effectiveness, past researchers may have been asking the wrong questions. This is reassuring, and for a number of years in the UK Derek Milne and co-workers have been considering effectiveness with one eye on the conclusions of Ellis *et al.* and another on what are the essential factors to demonstrate in effective supervision (Milne and James, 2002).

In much of the research on supervision, the supervisory *relationship* has come in for scrutiny, and interpersonal variables have been found to play a central role. This is reflected in the current book by its coverage in several of the chapters, for example those by Sue Wheeler, Helen Beinart, Delia Cushway and Jacky Knibbs, and Shane Matthews and Andy Treacher.

Can we effectively train people to be good and effective supervisors?

Following on from the question about whether supervision can be effective, we ask whether training can ensure effective supervision. An answer to this question precludes two other questions: can training be effective, and do we know what to train? Both these questions are considered in some depth in the current book in Chapters 2, 5 and 6.

Training supervisors should incorporate elements from the body of research demonstrating the effective ways of teaching skills. It is not enough to presume that a qualified therapist possesses the necessary skills for supervision, however, and the profession of clinical psychology needs to address how to enable, promote and value supervision in the way that other professions, such as counselling and social work, have done already.

With respect to the second part of the question, the answer can be a positive one. Many educationalists subscribe to Kolb’s (1984) model of experiential learning, in which new skills are acquired by encouraging the learner to work through an experiential cycle. Milne and his co-workers (Milne and James 2002; Milne and Howard, 2000) describe the application of this model to supervisor training. At present, it is not known how widely or systematically this model is

used by others in the training of supervisors; this is discussed more fully in [Chapter 5](#).

How do 'race', culture and gender impact on supervision?

Suggestions have been made (e.g. Fleming and Burton, 2001) that clinical psychology historically has ignored social context in favour of intra-personal space in its determinations of psychological distress. If there is substance to such an accusation then it would not be surprising to find an omission of social and contextual factors in supervision. Indeed, Carroll, a major figure in UK counselling psychology, has complained about UK supervision texts: 'All almost totally ignore the cultural dimensions of supervision, spending together approximately 3 pages on the topic' (1996:36).

In the USA, work examining the influence on supervision of culture and gender has increased in the past 20 years and is now extending to Britain, despite Carroll's rather pessimistic observation. Clearly, as cultural, gender and class issues are important in human interaction then they may be critical in supervision with its implications for trust, observation and evaluation.

In this book, there are chapters describing the influence in supervision of gender (Maxine Dennis and Gill Aitken) and 'race' and culture (Nimisha Patel). Furthermore, it is interesting to note ([Chapter 5](#)) how many training programmes for clinical psychologists are addressing these issues in the training provided for supervisors.

Whose responsibility is the training of supervisors and why?

Bernard and Goodyear (1998), with reference to the traditional lack of training for supervisors, use Hoffman's (1994) description of it as the mental health profession's 'dirty little secret'.

It is pleasing to know that there has been a significant change both in the importance accorded to supervision *and* to the training of supervisors in the skills deemed important for the activity.

There remains an important discussion about who has the responsibility for providing the training of supervisors. In this book, these issues are taken up by several of the contributors. Sue Wheeler's chapter is concerned with the wide range of available supervisor training in the UK. In [Chapter 5](#), Ian Fleming focuses specifically on supervisor training for clinical psychologists, giving a detailed description of the training currently provided by Clin.Psy.D. programmes in the UK. In [Chapter 6](#), David Green too considers the issues involved in training clinical psychologists in the tasks of clinical supervision and reviews the research in evaluating the effectiveness of such training.

In addition to training supervisors, many writers are now recognizing that effective training in supervision should also involve training supervisees to use supervision (Inskipp, 1999). As Inskipp notes, 'the supervision alliance is a

facilitative relationship which requires active and intentional participation by both parties' (1999:186). That this is an increasingly important issue is illustrated by the fact that it is taken up by several of the contributors to this book, notably in Chapters 2, 4 and 6.

Multi-professional training is being accorded prominence within the NHS at the time of writing. Many clinical psychologists are involved in both supervising and receiving supervision from members of other professions. Taken together these suggest that both inter-professional training in supervision and training for the supervision of members of other professions may become important issues in the near future. As such they serve to emphasize the importance of identifying whose responsibility it is to fund, resource and provide training for supervisors, and ongoing supervision for those supervisors.

What can we learn about different forms/models of supervision (e.g. group supervision)?

This is likely to become an increasingly pertinent question as qualified clinical psychologists view supervision as a necessary part of their clinical practice rather than as an 'optional extra'. Inevitably this will have resource implications, and traditional one-to-one models of supervision are likely to be neither feasible nor necessarily desirable. In relation to pre-qualification training, the BPS Committee on Training in Clinical Psychology (CTCP) paved the way for a move towards using models of supervision other than one-to-one when, in 1995, the then revised *Guidelines on Clinical Supervision* (BPS, 1995a) formally introduced the option of team supervision for trainees. The revised *Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology* (BPS, 2002a) take this one step further by explicitly stating that 'a variety of supervisory arrangements is acceptable. These include trainee to supervisor ratios of 1:1 and 2:1 and various forms of team supervision for groups of trainees' (section 8.4).

Models of group, team and peer supervision are reviewed extensively in Hawkins and Shohet's (2000) text on supervision.

In the current book, a number of contributors comment on future arrangements for supervision within clinical psychology. Graham Turpin, Joyce Scaife and Peter Rajan, for example, in their discussion of clinical psychology training placements, suggest having one main supervisor working alongside other supplementary supervisors. In her chapter, Sue Wheeler introduces the concept of group supervision, pointing out some of the benefits and pitfalls of this form of supervision. This is likely to be of increasing relevance to qualified clinical psychologists as they consider models of peer supervision (DCP, 2001a).

Is there a need for congruence of models between practice and supervision?

As both Sue Wheeler (Chapter 2) and Helen Beinart (Chapter 3) describe in their chapters in this book, early models of clinical supervision were direct extensions of psychotherapy models. These later gave way to supervision-specific models.

In Chapter 10, Shane Matthews and Andy Treacher review a number of different models of supervision, each one linked to a therapeutic model. They then go on to describe their particular approach to supervision. Early in their chapter they describe how their selection of a model for supervision was guided more by theory than by the scientist-practitioner paradigm. They argue that this form of practice provided them with confirmation of its value.

For the purposes of writing her chapter, for example, Sue Wheeler (Chapter 2) asked a panel of experts for their views about the importance of having congruence between clinical practice and supervision and found that there were some very mixed views about this.

This issue is addressed in several of the chapters, but, as will be seen from the discussion therein, there is currently no clear picture about the need for congruence between therapy and supervision models, although, unsurprisingly perhaps, there is some evidence that supervisors cite their preferred therapeutic model as the most significant factor influencing their supervisory behaviour (Putney *et al.*, 1992).

Post-qualification supervision and its relationship to continuing professional development

Accreditation for supervisors has been under discussion for some time. As an aspiration it forms an important part of quality assurance for clinical psychology training programmes. Alongside this there is a recognition that accreditation of individual supervisors or of supervising departments will require both explicit criteria against which judgements can be made and an apparatus for carrying out the process, as well as agreement by those to be accredited. These factors may well delay the aspiration becoming a reality.

Another lever acting upon individual practice in order to ensure quality is continuing professional development (CPD). Later in the book, the relationship between supervision and CPD is discussed, as is their link to accreditation.

Mention above of CPD and clinical governance ensures that readers consider the supervision that they receive after qualification or provide to others who are already qualified. This requirement is of recent origin and it is of interest to know about the quality and quantity of supervision qualified clinical psychologists are currently receiving.

In a recent survey of all clinical psychologists working in the NHS and universities in the north-west of England, 86 per cent of respondents reported that they received regular supervision, on average every two weeks (Golding, 2003).

This usually took the form of either peer or clinical supervision. Seventy-eight per cent reported being supervised by another clinical psychologist. Whilst the response rate of 49.7 per cent (224 clinical psychologists) suggests that these data should be interpreted with a degree of caution and that this may be an overestimate of the true state of affairs (cf. Gabbay *et al.*, 1999), the results certainly suggest that post-qualification supervision is on the agenda for clinical psychologists in the north-west of England. There is no reason to suppose that the picture in this part of Britain is any different from that elsewhere in the country.

In a smaller survey of 22 newly qualified clinical psychologists carried out in the north-west of England almost ten years previously (Verduyn *et al.*, 1994), 23 per cent reported receiving no supervision at all. Whilst it is not possible to compare these findings directly with those of the Golding (2003) survey, it is interesting to reflect on whether the situation has changed over the past ten years, particularly with regard to newly qualified clinical psychologists. In our experience as clinical tutors, newly qualifying clinical psychologists certainly see supervision as an important (if not crucial) factor when choosing a first post, and it is likely that the percentage not receiving supervision would be much lower now than it was ten years ago.

Related to the above, in addition to the information about supervision received, the Golding (2003) survey also found that supervision was the most frequently listed CPD training need for the year ahead. Moreover, both *receiving* and *providing* supervision were frequently cited as examples of CPD activity. Finally, in keeping with the findings of other similar studies carried out elsewhere in the UK (e.g. Knight and Llewelyn, 2001; Lavender and Thompson, 2000), *availability of good and regular supervision* was found to be one of the key factors most likely to keep staff in their posts.

Clinical psychologists are more familiar with pre-qualification (training) supervision and it is interesting to consider similarities and differences between this type of supervision and that required after qualifying. According to Hawkins and Shohet (2000), there are at least four main categories of supervision—namely, tutorial supervision, training supervision, managerial supervision and consultancy supervision. Additionally, within consultancy supervision, the relationship between supervisor and supervisee can be either *vertical* or *horizontal* (as in peer supervision). In a similar vein, Milne and Howard (2000) refer to Hart's (1982) three categories of supervision—namely, 'apprentice-master', 'client-therapist' and 'collegial'. Post-qualification supervision is most likely to involve either consultancy ('collegial') or managerial supervision.

In much of the literature there is little distinction made between the supervision that is used within pre-qualification training and that for post-qualification practice. Arguably, one clear distinction involves the *evaluative* and managerial components of the former.

However, as CPD takes root and becomes a crucially important feature of clinical governance and individual development, this distinction can be seen to

recede. Although any trace of real evaluation may be far from current practice in peer supervision within clinical psychology, there is no clear reason to presume that it will not be present in future forms of supervision. That it may be of a different form, and involve a requirement for clear definition and boundaries, does not preclude its existence.

In all types of supervision, a clear contracting process is considered essential (see, for example, [Chapter 2](#) of this book) for making explicit the expectations of both/all parties.

The editors: where does our interest in this area derive?

The editors' own perspective may be of interest. We trained together some 20 years ago on separate and distinct training programmes in the north-west of England. Our experience of supervision during training was (like that of many people we have interviewed) variable. As our careers progressed in different specialist areas (adult mental health, LS; people with learning disabilities, IF), we *became* supervisors (Pickvance, 1997). This development constituted promotion (in the sense that it seemed to confer on us by our profession seniority and competence), but was not accompanied by much.

After qualifying, LS worked in a Clinical Psychology department in which the head of department was closely involved in the organization of one of the North West's clinical psychology training courses,² and where several of the psychologists were regular contributors to both the course teaching and trainee supervision. Within this context, becoming a supervisor after having been qualified for two years was viewed as an inevitable part of one's career progression. At that time, whilst the course did organize regional supervisor training days and there was an active supervisors' group that met regularly to discuss issues of mutual concern, attendance of both was optional.

On qualification, IF worked for eight years in a large department that occasionally provided placements for local training courses. Learning about supervision came about from informal discussions with colleagues and the local Special Interest Group for clinical psychologists working with people with learning disabilities. He received no 'training' in supervision during these years. This picture remained basically unchanged during subsequent moves to two other services, although in the first of these he remembers receiving specific input from a clinical tutor attached to the training programme from which trainees were on placement with him. He can draw on memories of very helpful supervision during his own clinical training.

So the years (and the trainees) went past. Opportunities for supervision *as qualified clinicians* grew slowly and varied considerably depending on the department and employing organization. It is accurate to say that developments in supervision elsewhere rather passed us by.

In 1994 LS joined the University of Manchester's clinical psychology training programme as a senior clinical tutor, and IF joined in a similar capacity in the

next year. In the following years, the training programme underwent and enacted a number of changes. Both active and passive tenses are appropriate: the programme responded to a number of external pressures and made decisions about changes to improve the quality of training.

One of the general issues concerned the recruitment and retention of adequate numbers of high-quality clinical training placements and supervisors. From this there developed an increased interest in the process of supervision and the training of supervisors to achieve levels of competency. This interest has been supported by the other members of the Manchester programme team, and by the collegial culture of the Group of Trainers in Clinical Psychology (GTiCP) whose members are always willing to share ideas and experience in a most constructive way.

About the book

This book aims to provide the reader with an overview of the issues directly relevant to supervision within the profession of clinical psychology.

Chapter 2 begins with a historical overview of clinical supervision and sets the scene for the remainder of the book by describing supervision and supervisor training in the helping professions in general. The chapters that follow are all concerned with specific issues relevant to supervision in clinical psychology. The final chapter draws together the main themes of the book and considers future perspectives.

As with much of the writing on clinical psychology supervision to date, the emphasis in the book is on supervision of trainee clinical psychologists. As will be seen, however, many of the chapters cover issues of relevance to both pre-qualification and post-qualification supervision, and these themes are revisited in the final chapter.

Finally, whilst acknowledging the role of *research* supervision for both trainee and qualified clinical psychologists, the emphasis in this book is on supervision of *clinical* work. Consideration is given to research supervision in the last chapter.

About the contributors/authors

From amongst the Group of Trainers in Clinical Psychology (GTiCP), we have learned a lot about supervision. Many, but not all, of the contributors to this book are members of the GTiCP and major innovators in supervision developments in their own areas. In addition, we are extremely grateful to have contributions from Sue Wheeler who is a major figure in the counselling profession in the UK and an academic with a justly high reputation for research into supervision, and from the clinical psychologists, Gill Aitken, Maxine Dennis and Peter Rajan. Each of these has a wealth of experience of supervision and teaching.

Notes

- 1 Throughout this book, the word 'programme' will be used to describe the organization of clinical psychology training in the UK. The word 'course' will be used to describe supervisor training courses.
- 2 This was before they became programmes.

Chapter 2

A review of supervisor training in the UK

Sue Wheeler

Introduction

There have been many changes in the National Health Service in recent years, but perhaps the most dramatic change is the impact of clinical governance on the day-to-day work and professional development of everyone employed by the service. The government has responded to notorious cases of malpractice by establishing the National Institute for Clinical Excellence (NICE), which sets standards of service through the National Health Service Frameworks. Accountability to patients, organizations and the profession is currently a high priority for all clinicians. It is through clinical governance that organizations ensure good practice, by making individuals accountable for setting and monitoring performance standards.

While clinical supervision has always been a requirement for clinical psychologists in training, the demands for accountability are now such that supervised practice is becoming more prevalent amongst health professionals, including nurses and other medical practitioners. The Department of Health has defined supervision as

a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations.

(DH, 1993)

Butterworth (2001) summarizes the value of clinical supervision to clinical governance:

Clinical supervision focuses on matters of central importance in the provision of safe and accountable practice. The concept of clinical supervision is focused on: organisational and management issues, clinical

case-work, professional development, educational support, confidence building and interpersonal problems.

(Butterworth, 2001:319)

For many years the British Association for Counselling and Psychotherapy (BACP) (formally British Association for Counselling, BAC) has made supervision a requirement for all practising counsellors and therapists, regardless of their length of experience (BACP, 2002). While the British Psychological Society (BPS) encourages professional development, accountability and regular use of supervision, it is not a requirement. Indeed, in response to a question about chartered psychologist status and supervision, the frequently asked questions page of their website replies that,

Once you have completed an accredited training course in Clinical psychology you are fully qualified to practise without supervision, therefore eligible to apply for Chartered Status. You might need further experience under supervision if you want to specialise say in Child psychology, but this is not a requirement for Chartered Status.

(BPS, 2002b)

The UKCP (United Kingdom Council for Psychotherapy) also stops short of making supervision a requirement for psychotherapists. However, the practice of supervision is of considerable interest to professions. Kilminster and Jolly (2000) see clinical supervision as having a vital role in postgraduate medical education, but acknowledge that a limited amount of medical literature addressing supervision currently exists. Clinical supervision has an important role to play in safeguarding the interests of patients and clients, and is increasingly being recognized and valued by professional groups who did not previously see it as necessary. These new groups of health professionals, in particular, are exploring the existing literature and research on supervision in order to develop their own models of supervision and find ways of promoting it.

This chapter sets the scene for the rest of this book by looking at the historical development of clinical supervision and the provision of training for supervision, and then by reviewing research literature relevant to the training of supervisors. While the intention is not to provide a blueprint for supervisor training, a syllabus for such a course could probably be constructed from the information presented. Standards for supervisor competence are discussed, including the question of 'What makes a good supervisor?', followed by a debate about how such standards can be developed through training. The numerous considerations of a training programme, such as models of supervision, contextual issues, theoretical orientation, the supervisory relationship, teaching methods, ethics, contracts, gender and equal opportunity issues, group supervision, evaluation and assessment of competence, are reviewed, incorporating research evidence to support suggestions wherever possible. It should be noted that much of the

research discussed has been conducted in North America and the subjects have almost invariably been trainee counsellors and therapists. However, both trainees and experienced therapists, psychologists or counsellors can benefit from good supervision, and training supervisors to be competent in that role will benefit all the professionals that use their services, as well as the clients for whose benefit such provisions exist.

History of supervision

The supervision of clinical practice has had a place in the training of analysts, therapists and social workers particularly, since almost the beginning of therapeutic practice (Jacobs *et al.*, 1995). In his report of the case of Little Hans, Freud describes how he worked with the boy's father, who was conducting the therapy with his son. Max Graf, the father, had his own ideas about the development of his son's neurosis, but Freud used the relationship with Max Graf to further develop his own views on childhood sexuality. The supervision that is described is chaotic and intrusive, and there is a lack of clarity about the relationships fostered between father, son and analyst/supervisor. When thinking about Freud and his work, it seems inevitable that other therapists would wish to consult him and discuss their cases. Much of the communication was through letters and personal meetings, nothing that resembles the formal structures of supervision that are to be found today. As the demand for training in psychoanalysis grew, it became more important to move beyond the old apprenticeship model. Formal training courses were developed by an organizing body, with the development of a syllabus, admissions criteria, criteria for assessment and other systematic education procedures. In the early days of therapy training it was custom and practice for trainees to discuss their cases with their own analyst. In 1924, the Congress of the Berlin Institute published the requirement that candidates have at least two years of clinical work as part of their education. The idea of supervision arose as analysts became tired of hearing about their patients' patients. Karl Abraham, Max Eitingon and Georg Simmel were some of the first supervisors at the Institute, but others soon followed (Jacobs *et al.*, 1995).

By the 1930s the practice of social work as a professional activity had become established, and case-work had a more therapeutic aim than appears to be the case today. The clients' individual psychodynamics were seen to contribute towards their current difficulties and were the focus of attention. In 1936, Robinson described the supervisor's task, which was to pay attention to ways in which the client and the supervisees were relating, in order to understand more about the client's interpersonal difficulties, rather than focusing on the personal history of the supervisee, as analysts had previously. Kadushin (1968) and Mattinson (1977) developed their own ideas about supervision, within the context of social work, which were not widely influential with other professions at the time.

In 1987, Hess articulated ways in which the practice of therapy and supervision are different and require different skills. He asserted that supervisors must be good therapists, but they need training to be good supervisors as the focus of the endeavours are different. During the last three decades, interest in supervision has grown. In their classic text, *The Teaching and Learning of Psychotherapy*, Ekstein and Wallerstein (1972) describe the practice of supervision:

The supervisor is directly related to the student but has a quasi-indirect relationship to the patient. On one hand his responsibility is to teach psychotherapeutic skills to the student, but there is an additional responsibility in maintaining clinical standards and seeing that patients benefit from the service which is being extended.

(Ekstein and Wallerstein, 1972:12)

With the exception of the work of Janet Mattinson, who worked with the Tavistock clinic in London, the development of supervision in Britain seems to have followed on from research and practice developed in the USA. Many models of supervision have been derived by American researchers (Fleming, 1953; Hogan, 1964; Littrell *et al.*, 1979; Stoltenberg, 1981; Loganbill *et al.*, 1982), and it is only in recent years that British texts have appeared to provide models of supervision for British audiences. Hawkins and Shohet (1989) published their classic text, *Supervision in the Helping Professions*, which offered a process model of supervision. Page and Wosket (2001) followed on with their cyclical model of supervision. Carroll (1996) offered an alternative model of supervision based on his doctoral research. Meanwhile, Inskipp and Proctor (2001a, 2001b) have been writing about, and teaching, supervision for two decades.

In a recent review of supervision research (Wheeler, 2002), over four hundred research articles were found related to supervision, of which only 11 boasted British authors. Hence when addressing the topic of supervision in Britain, reference is always being made to American research literature which informs our practice. Supervision is still predominantly only a requirement for counselling and psychotherapy trainees in the USA, hence most research literature refers to supervision with trainees.

Supervision training in the UK

Having established that supervision is a good thing for trainee psychotherapists, psychologists and counsellors, the question is raised of whether all supervisors are competent. There is some evidence to suggest that training in supervision has a positive effect on supervisor behaviours (Stevens *et al.*, 1998; Borders *et al.*, 1996; Nordlund, 1999). However, the training of supervisors is a relatively recent activity in counselling and psychotherapy and particularly in clinical

psychology. In an attempt to trace the history of supervisor training in Britain for the purpose of writing this chapter, and in the absence of any documentary evidence, in 2002 I asked ten expert supervisors in the field of counselling and psychotherapy to complete a short questionnaire. These experts have all been involved in supervisor training, have written extensively about supervision, or have engaged in supervision research. The first question asked when they had become aware of courses in supervision. On average, respondents replied that they had become aware of supervision training about 12–15 years ago. One respondent mentioned the late 1970s and another 1983. One person was involved with a special project with the Department of Education, training school counsellors and supervisors between 1972 and 1974. In 1989, Hawkins and Shohet were advocating that supervisor training be provided, ranging from introductory to advanced level. Inskipp and Proctor started CASCADE, an organization promoting supervisor training and publishing materials related to supervisor training in 1988. At about the same time, the Westminster Pastoral Foundation also began supervisor training courses, with a psychodynamic emphasis. In relation to clinical psychology, Milne and James (2002) claim that training and monitoring of clinical psychology supervisors has been a part of good practice for more than a decade. This training is most commonly provided by prequalification clinical psychology training programmes (see [Chapter 5](#)). To date clinical psychologists have infrequently participated in extensive training that is rapidly becoming a continuing professional development expectation of counsellors and psychotherapists.

Standards for supervision

Supervisors' training courses for counsellors and psychotherapists now proliferate, and are to be found in universities and training agencies that offer substantial training courses in counselling or psychotherapy. There are generic supervisor training courses that attract other professional groups, such as nurses, occupational therapists, doctors, managers, social workers, as well as therapists and psychologists. A brief look at publicity related to supervisor training courses reveals that training may be offered for anything between one day and two years, and may lead to an attendance certificate, undergraduate or postgraduate certificates, diploma or even a Masters degree. The array of courses is confusing and no recognizable standards are set for supervisory practice. The British Association for Counselling and Psychotherapy (BACP, 2002) has an accreditation scheme for supervisors of counsellors and psychotherapists that has specific requirements, including the following:

- The candidate has an individual BACP membership.
- Complies with the *Ethical Framework for Good Practice in Counselling and Psychotherapy*.
- Is a BACP Accredited Counsellor or the equivalent.

- Has undertaken not less than 600 contact hours over three years with clients.
- Has demonstrated in counselling supervision a capacity for safe and effective counselling practice.
- Can show evidence of continuing professional development.
- Has satisfactorily completed a substantial structured training programme in supervision, *or* has followed a programme of learning with a supervisor.
- Is currently practising as a counselling supervisor.
- Has had a minimum of two years' practice as a counselling supervisor.
- Has had regular supervision from an experienced counselling supervisor.
- Has completed a minimum of 180 contact hours with supervisees over a maximum of three years, immediately prior to application.
- Can provide evidence of a range of experience, i.e. work with trainees and experienced counsellors.
- Can provide evidence of the way in which he/she uses his/her authority as a counselling supervisor to promote the safety of the client.
- Can provide evidence of an identified theoretical framework in his/her practice.
- Can demonstrate an awareness of the values, beliefs and assumptions which underpin his/her work.
- Can provide evidence of a capacity for self-regulation.

This is an evidence-based approach to accreditation and does not set standards. A second question asked of the ten experts was how much experience therapists should have before becoming supervisors or embarking on supervisor training. Responses varied, but the typical response was as follows: 'I think people should have experience of working as a psychologist, counsellor or social worker for a minimum of three years, full-time, before taking on the mantle of supervision. This allows them some time after qualification to gain experience and allow the knowledge and skills required through training to be consolidated.' 'Potential supervisors must have had the experience of being supervised themselves for a minimum of five years, preferably with several different supervisors.'

Supervisor training courses have varied requirements in terms of previous experience of supervising others. Some courses require that trainees already have experience of supervision and stipulate a minimum number of hours of supervision as an entry requirement. Some courses require trainees to have had a minimum amount of experience of being a supervisor with consultative support before they achieve the final qualification. Other courses take the view that training in preparation for supervision should be open to anyone with sufficient experience of being a therapist. The panel of experts were divided in their views, but agreed that experience as a therapist was essential. Several people suggested that very experienced therapists might take on supervisees before having training, but relatively inexperienced practitioners should definitely have training first to ensure that they are fully conversant with codes of practice and legal issues at the very least. Another commented that 'many of the people on my training course

have already started supervising before they begin training and they are hungry for information, bring questions and are ready for learning'. Another respondent suggested that 'potential supervisors attend a brief introduction and read relevant literature on supervision before embarking on a course, but have a course firmly in view'. Emphasis was also placed on trainee supervisors having a consultant for supervision, who was prepared to take on an inexperienced supervisor and monitor them closely.

How much training in supervision is enough?

When asked how many hours of training supervisors should have, responses varied between a minimum of 45 hours of theory and 45 hours of practice as supervisors, to a maximum of 200 hours. There was general agreement that they should have roughly the same amount of theory and practice with consultant supervision. Some respondents stressed that the basic supervision course would not necessarily prepare people to work with groups, in specific contexts, or with organizations. One person commented that training should be staggered over a period of time and should not be concentrated in one block. 'Supervisor training interspersed with practice, with periods of time for reflection between training sessions, seems to be a more reflective way to learn than in intensive training blocks.'

The BACP Directory of Counselling and Psychotherapy training courses in Britain (2001) advertises a range of supervisor training courses that offer diverse qualifications. Most respondents to the survey suggested that supervisor-training courses should be postgraduate level, or at least something that could be described as a professional training level. Some were concerned that supervision does not necessarily require academic competence: 'I would be concerned about someone who passed the academic requirements of a course who was poor at facilitating the clinical work of others.' Another said: 'Normally it should be postgraduate level, but some excellent training courses concentrate on the practice, skills and personal awareness needed in supervision, without high academic demands.'

Contextual issues

Recently the CPC (Counsellors in Primary Care Association) has been concerned about the standards of supervision offered to practitioners in primary care settings. Drawing on the research of Burton *et al.* (1998), sometimes there was a lack of congruence between supervisor and supervisee when the supervisor did not have experience of working in primary care settings. In response to this concern a division of the organization has been established that addresses itself to supervisory issues.

Whether supervisors should have experience in the context of their supervisees is a debatable topic. The experts consulted were again divided in

their responses to the question of whether supervisors should have direct experience of the context in which their supervisees are working. One respondent said: 'No. I feel strongly about this, we need plurality. It would be sad if all supervision became context-specific because it would inhibit the fertilization of ideas and the opening up of new perspectives.' On the other hand, another said: 'I think supervisors should have direct experience of the context and client group of their supervisees if their supervisees are in training. Trainees need someone who knows the context well. It is not necessary for qualified workers.' The special point was made that, in working with some groups, it is essential that supervisors have direct experience. For example, 'supervisors who are working with children must understand enough about the law related to children and ethical issues'. The final pertinent comment on this issue: 'This is where the length and content of the training becomes important. The supervisor must be able to orientate themselves to the supervisees' context and circumstances and have the ability to fill in contextual gaps rather than having the exact experience of working with a particular client group.'

Theoretical orientation

Some supervision courses are set up to work with potential supervisors within specific theoretical orientations. A course offering psychodynamic supervision training will be very different from one offering generic supervision open to a range of professionals. There is some evidence that congruence of theoretical orientation between supervisor and supervisee enhances the supervision alliance (Putney *et al.*, 1992). However, given the plethora of therapy models, if every supervision training course were specific to theoretical orientation, there would be more courses than students. When asked whether supervisor training courses should offer a specific theoretical orientation, the expert group were again divided between those who saw theoretical congruence as essential and those who believed in diversity. 'I believe that supervision should be regarded as a profession in its own right, with the principles, theory and skills being clearly connected to practice. There can be a richness in working with people from other orientations.' On the other hand: 'I strongly believe that it is important that supervisor training is provided in the theoretical orientation of potential supervisees. At the same time I believe that all supervisors should have a strong understanding of the three main theoretical paradigms influencing psychotherapy, behavioural, humanistic and psychoanalytic, and the application of theory to practice in each of these modalities.' Considering the supervision of trainees, another respondent said that 'theoretical congruence between supervisor and supervisee in training of the therapist is crucial. Supervision has such a crucial role to play in training therapists, the supervisor must be able to offer very specific feedback about skills and practice.' It seems that candidates looking for supervisor training courses will have considerable choice between courses that offer a specific therapeutic modality and others that offer plurality.

Supervision as profession?

There are certainly practitioners in Britain whose professional identity is specifically related to supervision. For example, Peter Hawkins and Robin Shohet, Michael Carroll and Brigid Proctor have developed their careers to provide not only clinical supervision to psychotherapists but also consultancy to individuals and organizations. The panel of experts was asked whether a specific professional identity should be developed for supervisors in organizations and professional associations to which they might belong. Most respondents were not in favour of the suggestion, although some thought it was inevitable: 'all supervisors should be practising therapists. I do not think that supervision should have a specific separate professional identity. The two roles of therapists and supervisors should be delineated clearly but not in a hierarchical manner.' 'I think supervision will become something of a profession in its own right eventually (as it is in mainland Europe), for it is strongly connected to organizational consultancy, coaching and mentoring, and is relevant to a variety of professions. Supervisors will be seen as skilled facilitators of reflection.'

Experiences of supervisor training

The panel of experts was asked about their experiences of supervisor training and their satisfaction with it. In general, supervisor training has been experienced as helpful. Specific mention was made of 'supervisor training providing a greater understanding of organizational and personnel management issues, which are useful in supervising counsellors working in various agency settings rather than private practice'. Another commented on the generic training they had taken, which 'meant I could benefit from seeing other people of different orientations at work while integrating core skills into my own approach'. Criticisms included the following: 'I had one very eminent supervisor trainer who was very able, but he told me what to do and what to say'; 'courses can be too rigid'. 'There is a danger that courses can be too theoretical and not look carefully enough at actual supervisory work'; 'courses must encourage the supervisor to be a facilitator of learning, rather than an expert'. 'The training was good but there were many areas that were missed such as cross-cultural supervision and organization dimensions.' 'Supervision training should include a strong element of training in ethical thinking and decision-making, along with some systematic training about how to deal with inappropriate practice by supervisees and the supervisor's role in relation to complaints.'

What makes a good supervisor?

There are many perspectives on what makes a good supervisor. Personal characteristics, the experiences of supervisees, the impact of supervision on therapeutic work, contextual or cultural issues that impact on supervision and the

supervisor, theoretical orientation and the knowledge base of the supervisor, as well as issues such as age, gender and experience. Weaks (2002) reported on her qualitative enquiry into what supervisees think makes for good supervision. Three key constituents were identified as 'core conditions', which were necessary for an effective supervision relationship to become established: equality, safety and challenge. Shanfield *et al.* (1992), assessed the behaviour of supervisors, and found a high level of agreement about the use of empathy, focus on the supervisees' immediate experiences and making in-depth comments that facilitate understanding of the client. In a study involving the supervision of nurses who were asked what they found most helpful about their supervisors, it was the ability to form supportive relationships that was most important. Having relevant knowledge/clinical skills, expressing a commitment to providing supervision, and having good listening skills were also important characteristics of their supervisor. They viewed their supervisor as a role model, someone they felt inspired them and looked up to, and had a high regard for their clinical practice and knowledge base (Sloan, 1999).

The supervisory relationship

Evidence concerning the effectiveness of supervision and the satisfaction of supervisees, in clinical psychology, counselling, nursing, occupational therapy and psychiatry, regardless of theoretical orientation, points to the relationship between supervisor and supervisee as being the most important factor (Kilminster and Jolly, 2000; Ladany *et al.*, 1999a; Magnuson *et al.*, 2000b; Sweeney *et al.*, 2001).

Not surprisingly, supervisees respond to a climate of trust, understanding and acceptance when making themselves vulnerable by presenting their therapeutic work for scrutiny. While in training, supervisees look to the supervisor to provide them with support, guidance and encouragement, but anxiety about exposing potential mistakes to an authority figure is ever present. The supervisory relationship is influenced by personal characteristics (White, 2000), some of which are fixed and others dynamic. Constant factors include gender and sex-role attitudes, and the supervisor's style, age and race. Relationship dynamics such as power and intimacy, as well as stages of the relationship, are examples of dynamic sources. Uncertainty about supervisory expectations and methods of evaluation, or ambiguity and role conflict (Ladany and Friedlander, 1995), as student, therapist or colleague, also affect relationship dynamics.

The Supervisory Alliance Inventory (Efstation *et al.*, 1990) is frequently used in supervision research. Patton and Kivlighan (1997) found that the supervisory alliance was significantly related to the client's perception of the counselling alliance. This implies that the supervisory relationship has an influence on the outcome of counselling, as the alliance is a predictor of outcome (Marziali, 1984). Ladany *et al.* (1999a) found that, although the supervisory alliance over the course of supervision did not predict supervisory outcomes, trainees were more

satisfied with supervision the greater the emotional bond between them and their supervisor. Supervisees become less dependent on their supervisors' overtime (Kauderer and Herron, 1990).

Clinical psychology graduates were surveyed and 38 per cent of trainees reported a major conflict with their supervisor, which inhibited their ability to learn from supervision (Moskowitz and Rupert, 1983). Therapeutic orientation, style of supervision and personality issues were the main areas of conflict. While theoretical orientation can be a source of conflict, similarity in theoretical orientation and interpretive styles contributes to good supervision experiences and a positive relationship (Kennard *et al.*, 1987). Supervisors were found to be able to repair ruptures in the supervisory alliance more easily when they take into account the developmental level of the trainee involved (Burke *et al.*, 1998).

Disclosure in supervision

Given that supervision is charged with ensuring that clients get the best possible service from the therapist, the relationship must be one within which supervisees are able to disclose their most intimate thoughts, fantasies and experiences with the client. Yourman and Farber (1996) suggest that while usually presenting an honest picture of the work with patients, they consciously distort and/or conceal some material at least some of the time. Numerous studies have investigated disclosure in supervision on the part of both the supervisor and the supervisee. The relationship is seen to be enhanced when the supervisor shares his/her own experiences (Ladany *et al.*, 2001) and the supervisory style is interpersonal, sensitive and task oriented. Supervisor nondisclosures can be very unhelpful. Ladany and Melincoff (1999) found 12 categories of nondisclosure for supervisors, the most frequently cited being the negative reactions to the trainee's counselling and professional performance, as well as negative reactions to the trainee's supervision performance. The conclusion is that supervisors' use of disclosure, to some extent, strengthened the working alliance.

Webb and Wheeler (1998) investigated what supervisees find difficult to disclose in supervision. They concluded that erotic thoughts and feelings about supervisor or client and difficulties in the supervisory relationship will be hard to discuss. Also there is less disclosure with supervisors who are imposed or who have an assessment function, rather than those that are chosen. Supervisees were likely to disclose more in individual rather than in collective supervision and when they were supervised independently of the setting in which they practised as counsellors. Negative reactions to the supervisor were the most frequent type of nondisclosure. Other reasons for nondisclosure of issues included perceived unimportance, material being too personal, and a poor working alliance with the supervisor.

Preparation for supervision

The effects of a role-induction procedure on beginning counsellor-trainees' perceptions of supervision, using a ten-minute audiotaped summary of Bernard's model of supervision, were examined. Trainees evaluated supervision more negatively over the time period before the role induction. Following role induction, trainees reported a clearer conceptualization of supervision and a greater willingness to reveal concerns to their supervisors (Bahrack *et al.*, 1991). Olk and Friedlander (1992) developed a Role Conflict and Role Ambiguity Inventory and found that beginning trainees reported higher levels of role ambiguity than more experienced trainees, but that role conflict was only problematic for advanced trainees who experience little ambiguity.

Effectiveness of supervision

Ultimately, supervision is expected to have an impact on the therapeutic work between therapist and client. Demonstrating that this is the case has many methodological difficulties. There is as yet scant evidence to support the effectiveness of supervision. Lenihan and Kirk (1992) monitored clients of trainees in close supervision who adopted prescriptive techniques, and found that clients progressed and that therapeutic changes occurred. Couchan and Bernard (1984) found that follow-through from supervision to counselling, as measured by counsellor behaviour, was greatest when supervision was given four hours before the therapy session. Milne and James (2000) conducted a systematic review of effective cognitive behavioural supervision and found 28 empirical studies of change processes occurring between participants in what they describe as the educational pyramid: consultant and supervisor, supervisor and supervisee, and supervisee patients. They describe close monitoring of the supervisee, providing a model of competence, specific instructions, goal-setting and feedback on performance as the main methods of supervision, which seemed to benefit the supervisees. Their final conclusion was that cognitive behavioural supervision is valuable in the support and training of practitioners.

Training supervisors

Given the substantial evidence that suggests that supervisors can enhance their skills and practice through training (Milne and James, 2002; Russell and Petrie, 1994; Holloway, 1997), but in the absence of any verified template for training supervisors, what follows are suggestions, based wherever possible on empirical evidence, of what might be included in a supervisor training course. Traditionally supervisors learn skills through the experience of being supervisees, taking on the model presented to them by their supervisor, or by adapting the therapeutic skills learned in their training as therapists. While these methods have some

merit they also have considerable limitations. Bad practice can easily be handed down from generation to generation without some new import from an external source.

Models of supervision

Supervision has its own theory and practice associated with it. Models of supervision provide a reference point, a structure or framework that gives the work coherence, and makes sense of common difficulties. A model might indicate which behaviours are appropriate at a particular time with particular supervisees, or might prescribe a range of tasks or functions that need to be fulfilled in order to provide adequate supervision. Some models describe how supervision should be conducted with respect to a particular model of therapy. There are many models to choose from and new ones emerge all the time. Supervisors might be trained in the particular model chosen by the course directors, or they might be encouraged to review existing models and develop their own. Whichever path is chosen, supervisor competence will be enhanced if the supervisor knows and understands which model they are using and why. Similarly, when it comes to evaluation or assessment of supervisor competence, a model of supervision provides a frame of reference by which performance can be judged. Scott *et al.* (2000) surveyed training courses in supervision accredited by the American Psychological Association and found that 20 per cent of supervision training courses have no formal or informal methods to evaluate supervision competence.

Effective supervision requires the supervisor to have good communications skills. Kilminster and Jolly (2000:840) reviewed literature on the skills and qualities of effective supervisors and concluded the following:

- Supervisors need to be clinically competent and knowledgeable, and have good teaching and interpersonal skills.
- The relationship between the supervisor and trainee changes as the latter gains experience.
- Helpful supervisory behaviours include giving direct guidance on clinical work, linking theory and practice, joint problem-solving, offering feedback, reassurance and role models.
- Trainees need clear feedback about their errors; corrections must be conveyed unambiguously so that trainees are aware of mistakes and weaknesses they may have.
- Ineffective supervisory behaviours include rigidity, low empathy, failure to offer support, failure to follow the supervisees concerns, being indirect and intolerant and emphasizing negative aspects in the evaluation process.

Ronnestad *et al.* (1997) investigated levels of supervisory activity and confidence in relation to a number of therapist characteristics, and reported that

supervising work of other therapists is a normal part of professional development. They noted that supervisory confidence increases noticeably with early supervisory experiences and thereafter progressively and slowly. There is no substitute for experience when guidance and feedback are to be given to trainee therapists, but interpersonal skills required to communicate such guidance can be enhanced through training. Stevens *et al.* (1998) examined the influence of experiencing training on supervisory stance, supervisory confidence, and self-efficacy, and found that training was positively associated with more positive, less critical, dogmatic approaches to supervision but that experience was not. They found no support for the notion that experience alone is sufficient to enhance the supervisor's development.

Methods and teaching

Numerous authors have offered suggestions for a curriculum for training supervisors. Inskipp and Proctor (2001a, 2001b) have produced a comprehensive manual for training supervisors that provides a wide range of creative suggestions for experiential learning. Hollo way (1999) offers a framework for supervisor training. Bradley and Whiting's model of supervisor training has four major goals:

- 1 To provide a theory or knowledge base relevant to supervisory functioning;
- 2 To develop and refine supervisory skills;
- 3 To integrate theory and skills into a working supervisory style; and
- 4 To develop and enhance the professional identity of the supervisor.

(Bradley and Whiting, 2001:363)

The syllabus for a supervision course might include all or some of the following: ethics, law, organizational issues, supervisory relationships, supervision models, supervision skills, evaluating trainees, contextual issues, equal opportunities issues, using authority, supervision process, research, managing complaints and mistakes, contracts, creative techniques and group supervision.

Inevitably the range of topics requires a range of teaching and training methods. Scott *et al.* (2000) found that methods of conducting training in supervision vary across institutions and include didactic instruction, individual supervision, group supervision and assigned reading. They found that reviewing audio or videotapes of supervision sessions were used to a lesser extent. Using audiotapes or videotapes in supervisor training can be a valuable resource when used to explore and enhance relationship skills, given the importance of the relationship to supervisory practice.

Supervisor trainers need to be very careful about what they offer in a training programme, with thought given to the model of supervision they are teaching and the way that good teaching mirrors that model. Didactic teaching will reinforce the notion that supervision is a didactic experience, modelling a relationship in

which one person knows, and the other needs to learn, If supervisees are to become reflective practitioners (Schon, 1986), then both supervisors and trainers need to model those skills.

Ethics

A critical role of the supervisor is to ensure the ethical practice of supervisees; hence training in supervision must include close attention to ethical issues. The relevant ethical codes relating to specific professions need to be reviewed critically to ensure that they are clearly understood. Understanding ethical codes, however, is relatively straightforward in theory but not so easy to put into practice. For example, Erwin (2000) measured supervisors' responses to sensitive case studies, and found that the majority of supervisors received low moral sensitivity scores for a case involving breach of confidentiality and dual relationships. Miller and Larrabee (1995) surveyed counsellors about intimacy in counsellor education and supervision, and found that 16 per cent of respondents reported sexual encounters with supervisors or educators while involved in counsellor training programmes, a lower percentage than was found in studies of female psychologists and supervisors (Glaser and Thorpe, 1986; Pope, 1989). This suggests that supervisors have a lot to learn about ethics and need to apply them to their own practice. An investigation of psychiatric residency training directors revealed that their faculty supervisors were not familiar with issues of accountability and that little effort was made to rectify this (Schulte *et al.*, 1997). In Britain, King and Wheeler (1999) consulted expert supervisors about the responsibility they consider themselves to have for their supervisees, particularly those in private practice. Most expressed reluctance to take action against supervisees who were in breach of their ethical codes. Ladany *et al.* (1999b) investigated supervisor ethical practices and found that 51 per cent of the supervisees sampled reported at least one ethical violation by their supervisors. The most frequently violated guidelines involved inadequate performance evaluation, confidentiality issues, and ability to work with alternative perspectives of the supervisees' work.

As a result of their study, Nickell *et al.* (1995), investigating sexual attraction with clients, recommended that supervisor training programmes should address gender differences, using touch therapy, sexual attraction issues, and codes of ethics. There is a difference between bad supervision (ineffective supervision) and harmful supervision (that traumatizes the supervisee). Supervisor training must seek to ensure that supervisors who are deemed to be competent as a result of training are unlikely to be either bad or harmful in their supervisory practice.

Contracts

An aspect of ethical practice that has received little empirical investigation is the use of contracts for supervision. Osborn and Davies (1996) highlight the

importance of written contracts for supervision and suggest five principles to be addressed in such contracts:

- 1 clarify the methods, goals and expectations of supervision;
- 2 clarify the mutuality of the relationship;
- 3 clarify ethical principles;
- 4 detail practical issues related to the service provided;
- 5 ally supervision with counselling and consultation.

Proctor (1997) highlights the need for a working agreement to underpin the supervisory relationship. She says, 'the initial contracting weaves a container for the work together and also sets markers by which both parties can guide and prioritize their direction at points of choice or confusion' (1997:190). Carroll (1996) described seven supervision tasks as a result of his research inquiry into roles and tasks reported by experienced supervisors. These tasks include creating a learning relationship, teaching, counselling, consulting, evaluating, monitoring professional ethical issues and working with administrative/organizational aspects of clients' work. All of these tasks can be negotiated and included in a working agreement. One crucial aspect of contracts, particularly when working with trainees, is a clear understanding of the methods of assessment or evaluation of the work. The contract is not only with the supervisee but also with the training agency that takes responsibility for the supervisee's work (Izzard, 2001).

Training supervisees

While training supervisors, time should be found to stress the importance of training supervisees to fulfil their role and make the best use of supervision. In a study by Bahrack *et al.* (1991), trainees were found to evaluate their experience of supervision more negatively before they were given some training in using supervision effectively. The training programme introduced them to the model of supervision to be used, and following the session they reported a clearer conceptualization of supervision and a greater willingness to reveal their concerns to their supervisors. Inskipp (1999) suggests three main reasons why supervisees should be trained to use supervision: (1) It is empowering for the supervisee, (2) they need to take an active part in negotiating a working alliance, a relationship that enables them to learn, and (3) they need to take an active part in negotiating the working agreement, including the contract. She suggests that supervisees need to be empowered to use the supervisory relationship in a way that increases their confidence and enables them to engage actively with their side of the contract and working agreement.

Supervising and evaluating trainees

It has already been noted that most research literature refers to inquiries conducted in the USA, usually with trainees. Hence most research referred to in this chapter relates to supervision with trainees. However, there are some important points that need to be noted with respect to trainees when training supervisors in Britain. Probably the most important and stressful issue is assessment. Samec (1995) studied the experiences of supervisors who failed the clinical work of candidates, and stresses that supervisors need support when they decide to fail a candidate's clinical work, as the process may be traumatic for both supervisor and supervisee. Supervisors tend to judge candidates according to their ability to make use of supervision. This is always complicated because, if a supervisee finds it difficult to engage in supervision, they are not always consciously aware of what impedes them. The impact of the supervisor on the relationship cannot be underestimated. Carey *et al.* (1988) demonstrated that the supervisor's expertness, attractiveness, and trustworthiness were related to supervision outcome measures.

Criteria for the evaluation of competence needs to be clearly defined. Overholser and Fine (1990) define five domains as contributing to clinical competence: actual knowledge, generic clinical skills, orientation-specific technical skills, clinical judgement and interpersonal attributes. Bernard and Goodyear (1998) advise that evaluation must be conducted sensitively and offer the following conditions that supervisors should remember:

- 1 The relationship between supervisor and supervisee is unequal.
- 2 A clear contract is needed.
- 3 Supervisee defensiveness should be taken into account and addressed.
- 4 Individual differences need to be discussed.
- 5 Evaluation procedures and processes should be clearly defined.
- 6 Evaluation should be a formative as well as a summative process that is present throughout supervision.
- 7 Life events external to the supervisory relationship should be taken into account for the final evaluation.
- 8 The evaluation must be institutionally supported. Supervisor decisions need to be trusted and honoured, while respecting the supervisee's right to reply.
- 9 Avoid rushing to conclusions at an early stage of the supervision.
- 10 Supervisors should invite feedback on their own performance.
- 11 Attention must be paid to the supervisory relationship. If it falters, evaluation becomes questionable.
- 12 Supervisors should enjoy supervision.

Finally, on the topic of assessment in supervision, the benefits of self-assessment in conjunction with supervisor assessment should not be underestimated. Dowling (1984) and Hilderbrand (1989) both found that supervisees tend to

assess themselves and their peers accurately, and selfevaluation helps to develop the reflective practitioner. However, such positive findings should be viewed with caution, particularly as Steward *et al.* (2001) found that the self-evaluations of novice supervisees depended on their perceptions of supervisor style. The more attractive they perceived their supervisors to be, the lower they rated themselves.

Contextual and organizational issues

'Organizations have their own cultures, some of which are supportive of counselling, some of which tolerate it and some of which are embarrassed by it' (Carroll, 1996:125). Supervisors need to be prepared to deal with the complex dynamics of institutions that impinge on therapeutic work. The dynamics of the patient, therapist and supervisor triad are interwoven with the dynamics of the institution itself, of the staff team and of the relationship between the supervisor and the service. The supervisor has to balance the needs of trainees, the dynamics of the team and the organization, which can be contradictory and confusing (Anastasopoulos and Tsiantis, 1999). Copeland (1998) investigated the dilemmas that supervisors experience when working in organizations, which are different depending on whether the supervisor is an employee of the organization or contracted externally. The roles, responsibilities and contracts need to be carefully defined in order to ensure clarity in the supervisory relationship and clear lines of accountability. It is also crucial that supervisors have some understanding of the context in which they are contracted to work. For example, as mentioned earlier, Burton *et al.* (1998) investigated primary care counsellors' experiences of supervision, and found that supervisees were sometimes dissatisfied with their supervisor's understanding of the complex dynamics of the primary care environment.

Supervision process

Potential supervisors need an understanding of the process of supervision, particularly the parallel process. It is through the parallel process that supervisors can come closest to understanding the experience that the therapist has in the presence of the client. Searles (1955) first described it as the reflection process in his writings on psychoanalytic supervision. Mattinson (1977) analysed interactions between therapists and clients and supervisors and therapists and observed that thoughts and feelings that were unspoken in the therapeutic relationship sometimes seemed to surface in the supervisory relationship. At times, the supervisor's response to the supervisee mirrors the supervisee's response to the client. An awareness of this reflection or parallel process can provide insight into the unconscious processes of the client in the relation to the therapist. If it remains out of awareness, a vital clue is missed and a misjudgement of the supervisee is possible. Raichelson *et al.* (1997) investigated

the degree to which parallel process existed in supervision, and found that in a review of 300 therapists studied few denied the existence of parallel process. They found that there were some differences in therapeutic orientation, with the psychodynamic therapists consistently reporting the importance of parallel process. Doehrman's (1976) research revealed that parallel process is bi-directional. In other words, just as the counsellor may unconsciously imitate the client in supervision, the counsellor may unconsciously imitate the supervisor in their therapy with the client. Hence, when the dynamics of the supervisor/supervisee relationship do not match that which is expected, attention to parallel process may solve the problem.

Issues of difference in supervision

In modern Britain attention to issues of difference is crucial to all aspects of supervision and therapy. Issues of race, culture, gender and sexual orientation may have an impact on the supervisory relationship and need to be considered. Research findings on the impact of difference in supervision are inconsistent. Gardner (2001) studied cultural perspectives of the supervisory relationships, and found no significant differences between race and supervisees' perceptions of empathy, respect and congruence. On the other hand, racial identity interaction predicts aspects of the supervisory alliance. When supervisory pairs are similar in racial identity they are more likely to agree about the supervision process (Ladany *et al.*, 1997). Evidence that supervisors need training in issues of difference is found in the work of Duan and Roehlke (2001), who noted that, in cross-racial supervision dyads, supervisees were more sensitive to cultural/racial issues than supervisors, and supervisors reported making more efforts to address cultural issues than supervisees perceived.

Race and gender are often investigated together. For example Wells (2001) investigated gender roles, and racial and gender attitudes, and found that, as therapist experience increased, more emphasis was placed on gender and race in the therapeutic relationship. However, many supervisors had not received training in multicultural counselling or indeed in clinical supervision. Gatmon *et al.* (2001) found that when discussions in supervision include cultural variables, supervisees report enhanced supervisory working alliances and increased satisfaction with supervision. The power relationship in supervision, when the interaction is between male supervisors and female supervisees, needs to be carefully monitored. An investigation into the effects of gender in group supervision highlighted that, on average, male supervisees were asked for their opinion more than twice as often as female supervisees. Male supervisees were given less direction than their female counterparts (Granello *et al.*, 1997). Nelson and Holloway (1990) similarly found subtle and highly complex differences between the way that male and female supervisees were encouraged to communicate in supervision. Female trainees tended to relinquish power to the supervisor.

Creative techniques in supervision

Evidence for the use of creative techniques in supervision is lacking, but, nonetheless, including sessions on the use of creativity in supervision can be an asset to any supervision training course. Numerous authors have contributed their ideas of creative supervision, including Inskipp and Proctor (2001a, 2001b) whose supervisor training manuals are a rich source of exercises and teaching materials. Houston (1995) draws on her experience as a Gestalt therapist to produce some exciting and unconventional methods of reaching the heart of the client. Wilkins (1995) suggests creative methods of working with supervision groups, which Proctor (2000) extends in her book on group supervision.

Group supervision

Supervisors are often called on to provide supervision in groups and they need preparation to fulfil this role. An awareness of group dynamics will be a good start. Bernard and Goodyear define group supervision as

a regular meeting of a group of supervisees with the designated supervisor, the purpose of which is to further the understanding of themselves as clinicians, or of clients with whom they are engaged, or service delivery in general, aided in this endeavour by their interaction as part of the group process.

(Bernard and Goodyear, 1998:111)

Prieto (1996) reviewed the literature on group supervision and confirmed the lack of hard evidence supporting its effectiveness. However, there are perceived to be many advantages of group supervision, including an economy in time, money and expertise, less supervisee dependence, opportunities for vicarious learning, exposure to a broader range of clients, diversity of feedback and greater opportunity to use action or creative techniques. Limitations also exist, such as individuals being overpowered by the group, concerns about confidentiality, group dynamics impeding learning, and the potential for scapegoating in the group. Jones (2000) investigated damaging incidents in group supervisions and noted many complaints from group members about the treatment they had received in such groups. Complaints included the lack of congruence of theoretical orientation with the group facilitator, who was perceived to favour supervisees who were sympathetic to her theoretical position, and being assessed negatively in front of other group members. Aronson (1990) claims that the effectiveness of supervisory groups depends on the contributions of the leader, the group members' interaction with the each other and with the leader, and group identity that leads to members valuing being a member of the group.

Conclusion

There is now a vast literature on supervision that can be consulted when a training programme for supervisors is planned. There are also many incentives to provide supervisor training, given the importance and complexity of the task and the imperative to ensure that professions providing psychological therapies are seen to be self-regulating and working towards offering high standards of care that adhere to strict ethical codes. The apprenticeship model has something to offer potential supervisors and learning from experience is valuable, but it is arguable that the weight of responsibility that the supervisor carries warrants a good foundation through comprehensive, in-depth training. Supervisors bear some of the responsibility for the future development of professional practice; they need to be prepared.

Chapter 3

Models of supervision and the supervisory relationship and their evidence base

Helen Beinart

Most clinical psychologists are unaware of the large body of literature on clinical supervision, and most of us, as beginning supervisors, rely on our existing knowledge of psychotherapy models and our transferable therapeutic relationship skills. This situation is not entirely surprising because the supervision literature is largely based on psychotherapy and counselling and there is very little written about clinical supervision for clinical psychologists in the UK. Hopefully, this book will make a difference.

This chapter focuses on models of supervision that are generic; that is, not based on psychotherapy models but developed to aid our understanding of supervision and the learning and training of supervision in its own right. Selected models are described and their evidence base examined. Models of the supervisory relationship are then described as the evidence points towards the overriding importance of the supervisory relationship in understanding supervision. The complexity of developing an evidence base for supervision and methodological issues that have beset this field are discussed, followed by some suggestions for methodologically competent studies. The author then briefly describes her research on the supervisory relationship and her own (evidence-based) model. This leads to general discussion about what supervisors (and supervisees) can do to enhance the effectiveness of their supervision.

Models of supervision can be divided into two broad categories: those based on psychotherapy theories and those developed specifically for supervision. Early supervision models were direct extensions of psychotherapy theories. The earliest of these were based on psychodynamic theories (e.g. Ekstein and Wallerstein, 1972), followed by humanistic or person-centred supervision (e.g. Rice, 1980; Patterson, 1983), behavioural (e.g. Boyd, 1978), cognitive behavioural (e.g. Liese and Beck, 1997), systemic (e.g. Liddle *et al.*, 1997) and narrative (e.g. Parry and Doan, 1994). Authors such as Lambert and Arnold (1987) have suggested that research on the effectiveness of supervision is tied to knowledge about the effectiveness of psychotherapy. Bernard and Goodyear (1998) argue that whilst there are clear influences between supervision and therapy, there are substantial drawbacks to using therapy models for conceptualizing supervision. As supervision differs from therapy, therapeutic

models have proved too narrow to explain the complexity of supervision and have possibly restricted the evidence base by offering few directions for research and practice in supervision (Bernard and Goodyear, 1998). Schon (1983) suggests that professional training draws on two different realms of knowledge: theory and research that forms the basis of an academic programme and knowledge derived from practitioner experience. The recent growth of the therapy professions has led to an increasing emphasis on practitioner-led supervisor training, and much of the writing on supervision, particularly in the UK, reflects the realm of knowledge based on practitioner experience (e.g. Proctor, 1997; Scaife, 2001a). Psychotherapy-based models do not provide a framework for training beginning supervisors as opposed to therapists. This has led to a shift from therapy-based models to the development of generic or supervision-specific models. This chapter will focus on the main generic models that have been specifically developed to explain the complex phenomenon of supervision. These can be divided broadly into the developmental models (e.g. Littrell *et al.*, 1979; Loganbill *et al.*, 1982; Stoltenberg, 1981; Hess, 1986; Stoltenberg and Delworth, 1987; Stoltenberg, *et al.*, 1998) and social role models (e.g. Bernard, 1979; Friedlander and Ward, 1984; Hawkins and Shohet, 1989; Williams, 1995; Carroll, 1996). Recently, Holloway (1995) developed the Systems Approach to Supervision—a more contextually based model which developed from the social role models.

Developmental models

Developmental models attempt to explain the complex transition from inexperienced supervisee to master clinician (Whiting *et al.*, 2001). There has been a great deal of model development and research into the developmental models, such that they have been called the ‘Zeitgeist of supervision thinking and research’ (Holloway, 1987:209). Most developmental models share the fundamental assumptions that supervisees develop through a series of different stages on their journey towards competence and that supervisors need to adjust their supervisory style and approach to match the supervisee’s level of development as a counsellor/therapist (e.g. Stoltenberg, 1981). Worthington (1987), in his comprehensive review of the developmental literature, suggested that models and studies can be divided into those that address the supervision of the developing supervisee (e.g. Loganbill *et al.*, 1982) or those that address the development of the supervisor (e.g. Hess, 1986).

Early developmental models (e.g. Littrell *et al.*, 1979; Stoltenberg, 1981) proposed stage-based models—for example, it was assumed all supervisees developed through the same stages, from novice to master counsellor, for a range of different clinical skills regardless of previous experience or individual difference. In response to criticisms of the early models and the growing literature base, Stoltenberg and Delworth (1987) and Stoltenberg *et al.* (1998)

developed the Integrated Developmental Model (IDM) of supervision. This model will be discussed in some detail here.

Integrated Developmental Model (IDM)

Stoltenberg *et al.* (1998:1) state, ‘understanding change over time in one’s ability to function as a professional is fundamental in the practice of clinical supervision’. The IDM developed by Stoltenberg and Delworth (1987) suggests three overriding structures to monitor supervisee development over three developmental levels across various domains of clinical training and practice. These three structures are self- and other awareness (cognitive and affective), motivation, and autonomy. Level one supervisees are seen as anxious, highly motivated and dependent on their supervisors for advice and guidance. The primary focus is on the self while dealing with anxiety about performance and evaluation. Level two supervisees have acquired sufficient skills and knowledge to focus less on themselves and to increase their focus on the client. Motivation and autonomy vary at this stage depending on levels of confusion and ambivalence. Level three supervisees develop the ability to balance the client’s perspective appropriately whilst maintaining self-awareness. Motivation stabilizes as the supervisee begins to function as a relatively autonomous professional.

The Integrated Developmental Model (IDM) recognizes that developmental levels might vary across different types of professional activity. The following categories are used to describe professional tasks or domains: intervention skill competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics. The IDM allows for skills to develop differently—for example, a trainee might reach level three in the area of assessment techniques but be operating at level two for client conceptualization.

In addition to addressing supervisee developmental need the IDM also identifies different tasks for supervisors at each development level. At level one the supervisor provides structure and encourages the early development of autonomy and appropriate risk-taking. The supervisor’s tasks include containing anxiety and providing a role model. At level two the supervisor provides less structure and encourages more autonomy. Tasks include clarifying trainee ambivalence, modelling and providing a more facilitative and less didactic focus. At level three the supervisor focuses more on personal/ professional integration. The supervisor’s task is to ensure consistency in performance across domains, identify any deficits and work towards integration and refining a professional identity.

Evidence base of the developmental models

The developmental models have stimulated much supervision research. However, there are few research studies that explicitly investigate supervisee development over time; to do this in a meaningful way, longitudinal studies are needed. Despite this, on the basis of their review, which takes into account the conceptual and methodological rigour of the studies, Ellis and Ladany (1997) tentatively conclude that supervisees may increase in autonomy as they gain experience and that beginning supervisees may prefer structured supervision. However, the need for structure appears important across all levels of experience if dealing with a clinical crisis (Tracey *et al.*, 1989). Rabinowitz *et al.* (1986) found that the needs for structure and support were present at the beginning of new supervisory relationships regardless of experience. Friedlander and Ward (1984) suggest that supervisory style and attitude outweigh specific factors such as structure and format of supervision. There is some support for the developmental models from one study (Borders, 1990), which found some increase in trainee autonomy over one semester. Although there have been studies that have specifically tested Stoltenberg and Delworth's IDM (1987) poor methodologies lead Ellis and Ladany to conclude that the IDM has not been adequately tested and 'no tentative inferences from the data to the models seems justifiable given the inadequate rigour of the studies' (1997:483).

Although the developmental models make intuitive sense there is very little research evidence to support them. Most studies have methodological problems—for example, the use of cross-sectional designs that do not answer questions about development over time. However, there is some research evidence to support the concept of increasing trainee autonomy over time and also some evidence that beginning trainees benefit from more structured supervision experiences. Given the number of theories and studies in this area, these findings are disappointing. Early developmental theories assume the supervisory relationship; however, more recent publications (Stoltenberg *et al.*, 1998) suggest that good supervisory relationships encompass warmth, acceptance and understanding, and create an atmosphere of experimentation. The supervisory relationship provides a learning context in which the supervisee matures regardless of stage of development.

Social role models

The fundamental assumption underlying social role models is that the supervisor undertakes a set of roles that establish expectations, beliefs and attitudes about what functions the supervisor will perform. Several models of supervision include the tasks and functions (role) of the supervisor—for example, Friedlander and Ward (1984), Williams (1995) and Carroll (1996). The most comprehensive of these models, which will be discussed in detail here, was developed by Bernard in 1979 and developed by Bernard and Goodyear in their 1992 and 1998 texts.

The Discrimination Model

Bernard developed the Discrimination Model as a teaching tool in order to provide a map for supervisor training. It is called the Discrimination Model because it assumes flexibility on the part of the supervisor to respond to specific supervisee needs. There are two axes (roles and foci) within the model, consisting of three basic supervisor roles (therapist, teacher and consultant), and three basic foci of supervision (process, conceptualization and personalization). Using this model there is thus a matrix of nine choices for supervisor intervention. Bernard (1997) describes the Discrimination Model as atheoretical in that it can be used across any model of psychotherapy. The roles of therapist, teacher and consultant are relatively self-evident and will not be described in detail here. The three foci or learning dimensions are described as the primary functions of a competent therapist. Process skills are the basic psychotherapy techniques and strategy such as engagement and interviewing skills. Personalization refers to the personal or feeling elements of the supervisee's experience, such as the ability to manage the client's feelings as well as their own within a therapy session. Conceptualization is a more covert cognitive skill that involves the tasks of thinking, analysis and theory-practice links involved in formulation. All of these learning dimensions are thought to be key within any one supervision session. However, the emphasis between foci is likely to vary according to the theoretical orientation of the supervisor and the supervisee's level of development. For example, supervisors of beginning supervisees are likely to focus more on specific process skills such as interviewing, whereas supervisors of more experienced supervisees are likely to focus on self-reflection (personalization) and refining formulations (conceptualization).

Evidence base of the Discrimination Model

Bernard and Goodyear (1992) acknowledge that the Discrimination Model is rooted in technical eclecticism. The strength of this is that it provides a means of training flexible and responsive supervisors; however, it fails to address important issues such as evaluation and the supervisory relationship. There is some evidence to support elements of the model. Stenack and Dye (1983) found that supervisees were able to differentiate different supervisor behaviours within the three supervisor roles of teacher, consultant and counsellor. Ellis *et al.* (1988), in two well-designed studies, explicitly tested the three-by-three model using supervisee judgements of dissimilarities between the nine role-function combinations. They found that supervisee perceptions were similar to supervisor perceptions and consistent with the model. However, it was also suggested that Bernard's model was simplistic as relationship issues were not included.

The Discrimination Model is thus a testable model in which to conceptualize supervisor roles in relation to supervisee needs. There has not been a great deal of research to test the model; however, there is some evidence to support a shared

understanding between supervisors and supervisees that these roles occur during supervision. A major criticism of the model is the failure to take account of the role of evaluation within the supervisor roles and the failure to address the relationship dimension within supervision. The model could thus be seen as partially useful but incomplete in that it oversimplifies a complex area.

The Systems Approach to Supervision

The Systems Approach to Supervision (SAS) was developed as a dynamic model capable of assisting supervisors in a systematic assessment of supervisee learning needs and supervision teaching interventions (Holloway and Neufeldt, 1995). Holloway's (1995) model builds on social role models but sees the supervisory relationship as core and takes into account a range of contextual factors. These contextual factors include the client, the trainee, the supervisor and the institution. Holloway presents her model diagrammatically with the relationship at the centre. The role of the supervisor, or the task and function, is identified in the foreground and the four contextual factors are represented in the background. It is proposed that these seven dimensions or components of the model (relationship, client, trainee, supervisor, institution, tasks and function) are part of a dynamic process in that they mutually influence one another (hence, systems approach). Each factor can also be examined independently.

The SAS model addresses the complexity of the process of supervision and provides a map for analysing a particular episode of supervision in terms of (a) the nature of the task, (b) the function the supervisor is performing, (c) the nature of the relationship, and (d) the contextual factors relevant to the process.

Holloway (1995) has identified three elements within the relationship: (a) the interpersonal structure of the relationship, including the dimensions of power and involvement; (b) the phase of the relationship referring to the development of the relationship specific to the participants; (c) the supervisory contract which includes establishing a set of expectations regarding the tasks and functions of supervision.

Holloway defines the tasks of supervision as 'the body of professional knowledge requisite of the counsellor role' (1995:12). She divides these into five broad areas: counselling skills, case conceptualization, professional role, emotional awareness and self-evaluation. The functions of supervision are defined as the specialist or professional activity of the supervisor. The five main functions that the supervisor carries out during supervision are: monitoring/evaluating, instructing/advising, modelling, consulting, and supporting/sharing. Similar to the Discrimination Model, Holloway depicts the tasks and functions of supervision as a grid. She describes the interaction of deciding what to teach (task) with how to teach it (function) as the process of supervision.

The supervisory relationship and the tasks and functions of supervision are influenced by contextual factors relating to the supervisor, the client, the supervisee and the institution. Supervisor factors include the supervisor's

previous professional experience, their expectations regarding roles of supervisor and supervisee, their theoretical orientation, and cultural elements, including race, ethnicity, gender and self-presentation. Supervisee contextual factors include previous experience in counselling and use of supervision, theoretical orientation, supervisee learning style and needs, cultural characteristics and supervisee self-presentation. Client contextual factors include client characteristics, identified problem and diagnosis and the counselling relationship. Institutional contextual factors include organizational structure and climate, and professional ethics and standards.

Evidence base of the Systems Approach to Supervision

Unlike the previous two models described, the SAS cannot be criticized for simplicity. It is the first supervision-specific model that has attempted to place development and social role within the context of a supervisory relationship that is influenced by a range of contextual factors.

Holloway has based the model on existing evidence. However, as yet, there are no studies that have tested the whole model. The strength of the Holloway model is that she attempts to integrate the complexity of the supervisory relationship into her theory. This goes some way to respond to the plea from Ellis and Ladany (1997:466) 'that until the unique qualities of the supervisory relationship are both acknowledged and integrated into theorising about the supervisory relationship our understanding will continue to falter'. However, there is still a long way to go to develop an evidence base that fully describes the supervisory relationship. In part, this is due to a lack of adequate instruments to measure the relationship in supervision.

There is some evidence to suggest that the structure of the relationship is predictable (Holloway, 1982), that social influence factors may have some impact on supervisor perceptions of supervisee performance (Carey *et al.*, 1988), and that supervisees expect supervisors to be trustworthy, expert and attractive (Friedlander and Snyder, 1983). Trustworthiness accounted for the largest proportion of the variance in judgements about the relationship and was related to trainee performance with clients. In one of the few studies of clinical psychology trainees in Britain, D.R.Green (1998), using a qualitative research methodology, found that 'special knowledge', 'credibility' and 'integrity' were terms used by trainees to describe influential supervisors. He argues that these combined characteristics of sapiential authority are similar to the construct of trustworthiness. There is also some evidence to suggest that trainees who reported positive supervisory experiences were evaluated more highly by their supervisors (Kennard *et al.*, 1987).

A series of microanalytic studies which use content analysis to understand the detailed interactions within supervision sessions draw the following conclusions: (a) supervision and counselling processes are distinct, (b) there are significant changes in discourse across the relationship, (c) there is a predominant pattern of

verbal behaviours which resembles teacher/student interactions, and the structure of the supervisory relationship has hierarchical characteristics (Holloway and Poulin, 1995). There is also some recent evidence to suggest that goal-setting and providing specific instructions are associated with benefits to supervisees (Milne and James, 2000). The above findings provide some support for the hierarchical nature of the supervisory relationship, the role of social influence and the importance of a supervisory contract.

In summary, the SAS is the most comprehensive model of supervision to date but has not yet been fully tested. Each element of the model is based on existing research, but it is not clear how these various variables are interrelated. The strength of this model is that it provides an account of the supervisory relationship, which was missing in earlier models. There is mounting evidence to suggest that the supervisory relationship is key to supervisee experience of supervision, and possibly to performance in the workplace (Olk and Friedlander, 1992). The next section will explore models of the supervisory relationship, and their evidence base, in more detail.

Theoretical perspectives: models of the supervisory relationship

Hess (1987) stressed the importance of the supervisory relationship but clarified that it was not the supervision. The supervisory relationship is unique in that it comprises at least three people, client(s), therapist (supervisee) and supervisor. This has led to the concept of parallel process, which has its roots in psychodynamic supervision in the concepts of transference and counter-transference. Parallel process refers to the process or dynamics in the supervisory relationship replicating or mirroring those in the therapeutic relationship (Hawkins and Shohet, 1989). The concept of parallel process has been developed and expanded by systemic family therapists into isomorphism, which refers to relational and structural similarities between therapy and supervision rather than intrapsychic parallels. Although these concepts have been widely adopted in the practice of supervision within their respective psychotherapeutic traditions, there is very sparse empirical support for them (Bernard and Goodyear, 1998). The models of the supervisory relationship discussed in detail below refer to supervision specifically and are generic with regard to psychotherapeutic model.

Bordin's model of the supervisory working alliance

Bordin (1983) defines the working alliance as 'a collaboration for change' consisting of three aspects:

- 1 Mutual agreements and understanding of the goals.
- 2 The tasks of each of the partners.
- 3 The bonds between the partners.

Bordin suggests that the clarity and mutuality of the agreement contributes to the strength of the working alliance. Once goals are mutually agreed the tasks by which each of the participants may achieve those goals needs to be part of the mutual understanding. Bonds are associated with carrying out a common enterprise and sharing experience. Bordin argues that time spent together, mutual liking, caring and trusting, and the public/private dimension of the relationship influence the development of bonds. Bordin (1983:38) lists the goals of the supervisory working alliance as follows:

- 1 Mastery of specific skills.
- 2 Enlarging understanding of clients.
- 3 Enlarging awareness of process issues.
- 4 Increasing awareness of self and impact on process.
- 5 Overcoming personal and intellectual obstacles toward learning and mastery.
- 6 Deepening understanding of concept and theory.
- 7 Providing a stimulus to research.
- 8 Maintaining the standards of service.

Bordin identifies three main tasks for the supervisee that include preparation of oral or written reports of their work, objective observation of therapeutic work (either direct, sound or videotaped recordings), and selection of problems and issues for presentation. The supervisor's tasks include coaching, giving feedback, focusing on areas of difficulty or gaps for the supervisee, and deepening theoretical or personal understanding. The supervisory process is managed through establishing the contract and providing mutual ongoing feedback and evaluation.

Evidence base of the supervisory working alliance

The main construct underlying the working alliance model is mutuality between supervisor and supervisee perceptions of the supervisory relationship. This has resulted in the development of useful measurement tools that explore both sides of the supervisory relationship; however, researchers have operationalized the supervisory working alliance differently. Efstation *et al.* (1990) define and measure the alliance as client focus, rapport, and identification from the supervisor's perspective and client focus and rapport from the supervisee's perspective. The supervisory working alliance was operationalized by Ladany and Friedlander (1995) as mutual agreement on the goals and tasks of supervision and emotional bond between supervisor and supervisee. Efstation *et al.* (1990) found that the supervisory working alliance was related to supervisor style (attractiveness, interpersonal sensitivity and task orientation) and supervisee self-efficacy. Ladany and Friedlander (1995) found that it was related to supervisee role conflict and ambiguity; that is, the supervisee experiencing

competing or unclear role expectations. Ladany *et al.* (1996) found that the working alliance was also related to satisfaction with supervision.

Holloway's model of the supervisory relationship in a Systems Approach to Supervision

Holloway (1995) describes the relationship of supervision in more detail than any other current author. She also attempts to base it on available evidence:

In the systems approach to supervision, relationship is the container of a dynamic process in which the supervisor and supervisee negotiate a personal way of using a structure of power and involvement that accommodates the supervisee's progression of learning. This structure becomes the basis for the process by which the supervisee will acquire knowledge and skills—the empowerment of the trainee.

(Holloway, 1995:41–42)

Holloway identifies three essential elements of the supervisory relationship:

- 1 Interpersonal structure of the relationship—the dimensions of power and involvement.
- 2 Phases of the relationship, relational developments specific to the participants.
- 3 Supervisory contracts—the establishment of a set of expectations for the tasks and functions of supervision.

Interpersonal structure

Supervision is seen as a formal relationship in which the supervisors' tasks include imparting expert knowledge, making judgements of trainees' performance and acting as gatekeepers to the profession. The supervisory relationship is hierarchical in the sense that these tasks suggest that power rests with the supervisor. The SAS interpersonal structure of the supervision relationship is based on Leary's (1957) Theory of Interpersonal Relations. This is described as power through involvement. Each individual brings to the relationship interpersonal histories that influence the level of involvement or attachment within the supervisory relationship. Affiliation influences the exercise and effect of power in the supervisory relationship and creates more individualized rather than role-bound relationships. Both supervisor and supervisee influence the distribution of power or the degree of attachment to one another.

Phases of the relationship

Based on the socio-psychological literature, Holloway argues that supervisory relationships develop over time from formal to informal interpersonal relationships. In the early phase participants rely on general sociocultural information about roles. However, as more information is gathered the relationship becomes more individualized and predictable. As the supervisory relationship evolves to a more interpersonal one there is reduced uncertainty and participants become more open and vulnerable and are more likely to self-disclose. Although supervision provides a general set of expectations, as the relationship develops it is individualized according to the learning needs of the supervisee and the teaching approaches of the supervisor. Each participant needs to learn the idiosyncratic reciprocal rules in interactive process. Holloway uses Mueller and Kell's (1972) conceptualization of the beginning, mature, and terminating phases of the supervisory relationship. The beginning phase consists of clarifying the relationship, establishing a supervision contract and working on specific competencies and treatment plans. During the mature phase the relationship becomes more individualized and less rolebound, which allows greater social bonding and influence. It also deals with developing formulation skills, working on self-confidence and exploring the personal/professional interface. The terminating phase allows increased autonomy and the need for less direction from the supervisor. The development of theory practice understanding in relation to specific clients is characteristic of this phase.

The supervisory contract

The supervisory contract is seen as important as a way of negotiating both goals and tasks but also parameters of the relationship. This clarifies both content and relational characteristics and establishes mutual expectations of the supervisory relationship. The evidence base of the Systems Approach to Supervision was discussed earlier and will not be repeated here.

Methodological issues

It is evident that research into supervision is complex and in its early stages. There have been several recent review papers that look at the effectiveness of supervision (Holloway and Neufeldt, 1995; Ellis *et al.*, 1996; Ellis and Ladany, 1997; Neufeldt *et al.*, 1997; Lambert and Ogles, 1997).

Holloway and Neufeldt (1995) argue that although there is evidence to support supervision enhancing psychotherapeutic skills in supervisees few studies exist which relate the role of supervision to client change. Ellis *et al.* (1996) provide a methodological critique of supervision research from 1981 to 1993. They examined 144 clinical supervision studies and concluded that the majority of the studies were not based on theory, did not test clear hypotheses, used unvalidated

measures and were beset with Type 1 and 2 errors. They found that investigations of supervision were unlikely to detect true effects and very likely to find spurious significant results. They also identified features of a well-designed supervision study for use in future research.

Ellis *et al.* (1996) suggest that methodologically sound studies should aim to test specific theories or models of supervision and develop clear research questions and hypotheses informed by these theories or models. Methodologies should attend to the representativeness of the sample, use longitudinal designs to test developmental models, use psychometrically sound measures appropriate to the supervision context and attend to statistical power; that is, control Type 2 error. They also stress the importance of internal consistency of aims, hypotheses, method and analyses. Data analyses should ensure that the assumptions of statistical tests are met and that the tests relate directly to the hypotheses. The interpretation of results should attend to the strengths as well as the weaknesses of the study, explore alternative explanations and discuss the generalizability of the results.

Clearly this advice falls into the positivistic and quantitative research tradition, but the issues raised about good-quality research are equally valid for qualitative research methodologies, which should be rigorous within their own context.

Lambert and Ogles (1997), in their comprehensive review of the effectiveness of psychotherapy supervision, conclude that it is tempting to assume on the basis of psychotherapy research that training and supervision are effective. They warn that there are no good outcome studies that make a clear connection between training and therapy outcome. In particular, it is not known how elements of training programmes such as teaching, supervision or practice contribute to the development of effective practitioners.

The methodological issues inherent in this field of research are complex. Ellis and Ladany (1997) conclude that the overall quality of research over the past 15 years has been 'sub-standard'. There is a general lack of replicated studies and huge conceptual and methodological problems within the studies. Although there are many theories and many studies, much of the research is atheoretical or does not explicitly test theory. Ellis and Ladany found that only seven theories had been explicitly tested, and only two of those on more than two occasions. The absence of replication studies makes it difficult to establish the value of the theories or previous findings. A final methodological issue within supervision research is the lack of viable measures specific to clinical supervision. There are very few measures that assess supervisee competence, evaluate supervisee performance or measure the quality of the supervisory relationship. Although new measures are beginning to be developed their psychometric properties are as yet unclear.

Until recently (for example, D.R.Green, 1998; Milne and James, 1999, 2000), there has been very little research about the evidence base for clinical supervision for clinical psychology in the UK. Much of the theory and research discussed above stems from the USA and is based on the psychotherapy, counselling and counselling psychology literature. It is unclear how

generalizable findings from counselling and psychotherapy are to clinical psychology; for example, Lawton and Feltham (2000), suggest that supervision in counselling is more process-focused than supervision in clinical psychology; which tends to be more goal-oriented. Similarly, training methods and routes in the USA (Cherry *et al.*, 2000) are dissimilar to those in the UK, particularly with regard to the way clinical placements are structured, supervised and monitored, and hence findings may not be generalizable.

A grounded theory of the supervisory relationship

Recent research by the author (Beinart, 2002) explored the factors that predict the quality of the supervisory relationship and attempted to meet the qualities of a methodologically sound study, as described above. The study tested aspects of the two models of the supervisory relationship described earlier (Bordin, 1983; Holloway, 1995). The study used both quantitative and qualitative methodologies to answer the main research question that asked supervisees to rate and describe the characteristics and qualities of the supervisory relationships that had contributed most and least to their effectiveness as a clinical psychologist. A sample of clinical psychology trainees and newly qualified clinical psychologists (up to two years postqualification) from the South of England was used. Data was collected on just under a hundred supervisory relationships.

The quantitative study found that satisfaction with supervision, rapport between supervisee and supervisor, and the supervisee feeling supported by the supervisor were the main qualities of supervisory relationships perceived to be most effective by supervisees.

A grounded theory analysis of the qualitative data, derived from written answers to open-ended questions about the quality of the supervisory relationship, suggested that there were nine categories that described the supervisory relationship. These were: boundaried, supportive, respectful, open relationship, committed, sensitive to needs, collaborative, educative and evaluative.

A grounded theory was developed that proposed that a framework for the supervisory relationship needed to be in place for the process or business of supervision to occur. The main aspect of the framework was the development of a boundaried relationship. This included both structural boundaries, such as time, place and frequency of supervision, and personal/professional boundaries that enabled the supervisee to feel emotionally contained within the supervisory relationship. The other aspects of the framework were the development of a mutually respectful, supportive and open relationship, where the supervisee felt that the supervisor was committed to the supervision, and regular two-way feedback. The model was adapted from Rogers's (1957) concept of necessary and sufficient conditions of therapeutic change. In supervision certain optimal

relationship conditions seem necessary for the more formal process of supervision to take place effectively.

Clinical psychology supervisees described a strong preference for collaborative supervisory relationships where both parties were involved in setting the agenda and the goals of supervision. A certain amount of flexibility of both approach and therapeutic model seemed to aid the collaboration. The two tasks of education and evaluation were helped if the supervisor was sensitive to the supervisee's needs, both in terms of their previous experience and stage of training and the personal impact of the work. Unlike previous studies (e.g. D.R.Green, 1998) the wisdom and experience of the supervisor seemed less important than opportunities to observe the supervisor's work and have curious and stimulating discussions. The most important aspect of the educative code seemed to be collaborative work on formulation, which included theory-practice links. Again, flexibility was important to supervisees who found didactic supervision or inflexible adherence to models less helpful. Interestingly, the evaluative aspect of supervision was only an issue in poorer-quality supervisory relationships. Supervisees valued and appreciated feedback and challenge in good collaborative relationships, and the formal elements of evaluation did not seem to impact on this.

Implications and conclusions

This chapter has described a selection of generic models of supervision and the supervisory relationship in some detail. It has presented the evidence base for the models and the complexity and difficulties of supervision research, which raise a range of methodological issues. A brief discussion of the author's recent research followed. What are the implications of these discussions and findings for clinical psychologists, supervisors and supervisees? Clearly, and as always, there is a need for more good-quality research and better theory development based on this research. There is an enormous amount of practitioner experience that can and does add to the existing body of knowledge.

Findings are beginning to emerge about what is and is not helpful in supervisory relationships. Unsurprisingly, helpful supervisory relationships seem to be rather similar to other good relationships and are based on mutual trust and respect. The research described above suggests that it is worth taking the time at the beginning of the relationship to establish rapport. Contracting and the exploration of expectations and hopes are helpful in the development of effective supervisory relationships. Setting clear boundaries, both in terms of structure and what can be brought to supervision, is helpful. The supervisor maintaining interest and curiosity and showing some commitment to making the process work seems necessary for good relationships to develop. Conversely, it is not helpful to display a lack of interest or commitment to supervision, often displayed by turning up late and not maintaining the structural boundaries that might be expected. Neither is it helpful to ignore the power relationship inherent

in the supervisory relationship, which can make it difficult for supervisees to address issues such as persistent interruptions or lateness. It is worthwhile to set aside time at the beginning of a new supervisory relationship to address the needs of a particular supervisee and clarify expectations on both sides. It is not helpful to assume that supervisees will be similar and will find similar support or interventions equally helpful.

Supervisees need to take responsibility for taking an active part in supervision. This involves playing a part in a collaborative relationship, showing interest and enthusiasm, identifying needs clearly, arriving at a supervision meeting properly prepared having thought through issues and priorities, being open and receptive to feedback and being prepared to give clear and honest feedback to the supervisor. It is not helpful when supervisees fail to raise issues that they are struggling with, get defensive when offered feedback or do not take the advice of their supervisor without good reason or discussion.

The findings on the supervisory relationship described above also have implications for clinical psychology training courses and the content of supervisor training programmes. Courses may benefit from paying attention to the development of effective supervisory relationships by providing training for supervisors and supervisees and specifically monitoring the development of these relationships. Hopefully the developing evidence base will provide some guidance to tutors who undertake these tasks on behalf of courses.

This chapter began by suggesting that many supervisors depend on their existing and transferable relationship skills when they begin supervising. Hopefully, this chapter has provided some models and evidence to help guide supervision practice. What is encouraging about the research described, for a profession in the midst of rapid expansion, is that supervisees do not necessarily find expert supervision most effective, they perceive boundaried and collaborative supervisory relationships to be most helpful and most psychologists are good at these.

Chapter 4

Enhancing the quality and availability of clinical psychology training placements within the NHS¹

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Much of the thinking within this chapter has emerged following the Trent Region Placement Project commissioned by the Trent NHS Workforce Development Confederation. We are particularly grateful to Jane Johnson and Di Bulter from the Confederation in supporting this project and also to local clinical psychologists for co-ordinating and participating within the research. We are also grateful for permission to quote from the North & Central London NHS Workforce Development Confederation Clinical Psychology Placement Project Report.

Introduction

The last decade has witnessed major changes to the training of clinical psychologists within both the health service and higher education sectors. There has been a universal shift to three years of postgraduate training resulting in the award of a professional doctorate in clinical psychology. Both the size and number of doctoral training programmes have increased and the divide between university-based education and in-service training has disappeared, with all programmes being based within universities and supported by a system of resourcing and contracting by the NHS. The importance and sophistication of workforce planning within the NHS has also developed, evolving from educational contracts (Working Paper 10, 1989) through education consortia (NHSE, 1995) to workforce confederations (DH, 2000a, 2002).

This has all culminated in major opportunities for the profession of clinical psychology to develop and expand, and in doing so to attempt to meet the needs for psychological health care within the NHS. At the same time, the demand for psychological health care from the service has also increased, resulting in psychological care being emphasized within many recent National Service Frameworks and the National Plan (DH, 1998b). The demands have also diversified so that clinical psychology is no longer synonymous with the

provision of adult mental health services but also makes major contributions to services for children and adolescents, older people, people with a learning disability, the brain-injured, and a broad spectrum of clinical health psychology services ranging from oncology through to cardiac rehabilitation. These increased demands have consequently led to a chronic undersupply of qualified clinical psychologists to the NHS, and the resulting vacancy rates of around 25 per cent have become a long-standing feature of the profession's employment profile (MAS, 1989). Various initiatives have been suggested in the last decade (e.g. BPS, 1995c) to meet this supply problem and to expand the training capacity of programmes. Although the resources to fund these new initiatives have not always been forthcoming, developments in workforce planning within the Department of Health have led to a slow improvement in the availability of resources to support expansion. Indeed, we have now achieved a doubling of training numbers from around 180 places for England in the early 1990s to around 400 in 2001 (Turpin, 1997; EPS, 2001a). Moreover, the implementation of National Plan targets for the Allied Health Professions workforce would suggest further dramatic expansion in training places. A recent BPS consultation paper, based on discussions with the Department of Health (BPS, 2001a; Gray, 2001), suggested possible targets of between 550 and 680 training places by 2003. Similarly, the BPS (2001b) has also published general guidance on methods of workforce planning for clinical psychologists at a local level. Hopefully, the better integration of service planning with workforce development through the establishment of workforce action teams (DH, 2001a) will likely lead to increased forecasts in the demand for qualified professional psychologists.

We have arrived, therefore, at a situation whereby resources alone are not the major barrier to course expansion and professional development. As was pointed out recently by the BPS (2001a), the real obstacles to further expansion in training are placement availability and supervision resources, physical resources for programmes (e.g. teaching rooms) and scarcity of clinical academic staff. If future expansion is to go ahead as planned, it will become necessary to consider how the provision of clinical psychology training might be adapted in order to achieve these substantial increases in training numbers. Other issues may also be identified which may impact upon training programmes within the next decade. These include the development of occupational standards across the whole of applied psychology (BPS, 1998b, 2001c), developments in e-learning and continuing professional development (DH, 2001b), the shortage of clinical placements within the NHS generally (Cheesman, 2001; ENB/DH, 2001), the modernization agenda (DH, 2000b) and the increasing importance of inter-professional learning (DH, 2001b, 2001c; Miller *et al.*, 2001). The purpose of this chapter is to focus on the impact of increasing training demands on the provision of clinical placements and supervision, and to identify the barriers to placement provision and how these might be resolved in order to enhance both the availability and quality of supervised clinical placements.

Finally, we should acknowledge that whilst the reports and policy documents published by the BPS are relevant to the UK generally, differences exist in the organization of health services across the home nations. We have tended to focus on Department of Health policies and procedures, which only directly influence England.

Nevertheless, the issues discussed here have relevance across the home nations of the UK and may also be of interest to the Irish Health Boards. For psychologists working outside England, various reports and reviews have been commissioned by the Scottish and Welsh Assemblies, and these would clearly be of relevance (e.g. NHS Scotland, 2002). In particular, the recent and comprehensive *Clinical Psychology Workforce Planning Report* for the NHS in Scotland (NHS Scotland, 2002) makes a range of recommendations on how the psychology workforce can be strategically developed at both national and local levels. Various innovative initiatives have been identified and include assessing psychological need and its workforce implications at a local planning level, special circumstances of rural communities, retraining other psychologists or professions, etc., and clearly merit careful consideration outside Scotland.

Constraints on placement availability

Clinical psychology training within the UK has stressed the importance of theory-practice links, and the design of programmes has always been heavily influenced by the necessity of trainees undertaking a series of clinical placements supervised by a qualified clinical psychologist. Requirements and standards for placement experience are determined by the Committee on Training in Clinical Psychology of the BPS and are published as the Criteria for Programme Accreditation (BPS, 2002a). Prior to the widespread introduction of three-year training programmes in the early 1990s, placements within the traditional two-year M.Sc. university programme were usually around three months in duration and mandatory experience included work with adults, children and people with learning disabilities. With the standardization of training to three years and the revision of the CTCP criteria in 1989, an additional mandatory area of supervised experience working with older people was included within the criteria reinforcing the lifespan development basis around which the criteria had been originally established. Clinical placement experience was expected to constitute between 50 and 60 per cent of programme time and was usually arranged as two five-month placements each year, constituting three days a week within the NHS. Minimum criteria were also developed for placement experience within each of the 'core placement areas' (e.g. adult mental health), although it was agreed that core experience need not be obtained within a single placement but could be acquired throughout the three years of training.

Until recently, most training programmes operated a system of clinical placements constrained by the above criteria. The content of placements was frequently organized to integrate with university teaching. For example, at the

North Trent/University of Sheffield programme, trainees would undertake placements with adults and older adults in the first year, children/ adolescents and people with learning disabilities in the second year, and elective placements which they choose individually within the third year. Nearly all supervisors would be qualified (i.e. at least two years) clinical psychologists and supervision would normally be one-to-one. Placements would be identified by clinical tutors and were individually planned directly with the supervisor on a voluntary basis. The work provided by the trainee was seen as supernumerary.

What are the constraints of the present system as described above? The major problem that has arisen concerns the shortage of qualified staff within some of the specialities that are considered as mandatory or core within the criteria. Although the pattern of shortages is not universal and some courses may experience unique local shortages in some clinical specialities, the general pattern of placement provision is oversupply of adult placements, around adequate supply of child and adolescent placements, and major shortages within placements in services for either people with learning disabilities or older people. For example, as part of the BPS Options Project, courses were surveyed in 1994 about their ability to provide adequate numbers of placements, together with questions regarding how accreditation criteria might impact on availability. This work was subsequently published (Turpin, 1995). At that time programmes within England identified 1,970 potential supervisors of whom 1,310 (66 per cent) were regular supervisors. For Scotland and Wales the numbers were between 69 and 187, but the percentage uptake of supervisors was about the same. At that time, the annual intake size for programmes in England was between 189 and 224 depending on the year. It would appear, therefore, that there were around 700 trainees at any one time, and that around 1,400 placements would, therefore, be required. Assuming that supervisors might provide two placements per year, overall there was a potential supervisory resource of 3,950 placements of which 2,620 might regularly be provided. Superficially this would suggest that there was spare capacity within the supervision system and that there was potential to double the number of training commissions. Unfortunately, these figures do not take account of the availability of placements across each of the core areas of placement experience. The distribution of regular supervisors across specialities is very uneven: adults (38 per cent), children (26 per cent), learning disabilities (21 per cent) and older people (15 per cent). Despite the fact that a much higher proportion of supervisors in both older adults and learning disabilities supervise, and many offer two placements a year, the scarcity of staff and placements within these specialities constrains the overall capacity of the training system, assuming that all trainees are required to undertake mandatory placements/ experience within these clinical specialisms. Indeed, 91 per cent of courses identified placements for older adults as being the major obstacle for course expansion within the UK. A follow-up survey conducted by Gray (1997) two years later reported very similar findings with respect to overall capacity and the availability across specialisms.

Although these surveys were conducted over five years ago, the situation has changed very little. In several recent placement projects, which will be highlighted in the following section, placements working with older people represent the speciality in shortest supply. An adequate number of placements can only be realized if all supervisors provide placements, continuously and with more than one trainee being supervised. Even with this level of commitment, it is unlikely that sufficient placements would be available to meet the demand for training places identified by some work force planning models under the National Plan.

Realizing the potential

Recently the training community has been carefully exploring options whereby continuing expansion might be achieved. The process commenced in 1995 with the Options Project (BPS, 1995c), which examined different models of training and sources of funding. Among the options that were considered by the profession in 1995 were the following: in-service training, part-time modular courses, student bursaries, distance learning, assistant psychology training and accreditation, etc. Since 1995 the CTCP criteria have been amended to allow non-clinical psychologists to be involved in supervision, to allow for supervision models other than 1:1, to shorten the minimum requirement for supervision to one year post-qualification in certain circumstances, and to re-emphasize the flexibility of organizing core experience throughout training rather than restricting it to a single placement (Ashcroft and Callanan, 1997; Ashcroft *et al.*, 1998). More recently, the BPS discussion document *Expanding Clinical Psychology Training* (BPS, 2001a) identified several different strategic directions: these included expanding programmes around the existing training model, developing new courses, optimizing programmes around a new more flexible model of placement provision, and developing a second tier of professional practice. The latter solution concerns the employment and training of assistant or associate psychologists who would deliver limited psychological interventions under the supervision of a qualified psychologist.

The solution which was considered to be the most appropriate and also most likely to impact on training capacity quickly was the proposal to reorganize training around the 'competence-based' model. This model is essentially a radical approach to specifying the learning outcomes in which trainees should have demonstrated competence when graduating from a programme. This is in contrast to the current (2002) system whereby trainees 'serve their time' and are assessed as performing adequately within a particular speciality but where there is little detailed assessment of specific learning outcomes within that speciality. Such models have been around for a long time in vocational education and skills training and typify National Vocational Qualifications (Bartram, 1995) and the development of occupational standards across different professions (DH, 2001 a). This is particularly the case for generic standards for mental health workers as

represented by the work of the Sainsbury Centre for Mental Health and Healthwork UK (DH, 2001a; SCMh, 2001). These ideas have also been applied within psychology with respect to both NVQs and Occupational Standards (BPS, 1998b, 2001a), although the ease with which these concepts can be transferred to a doctoral/post graduate level professional training programmes is a source of some continuing debate (Hingley, 1995). For example, the NVQ model has really only been tried and tested against vocational skills and lacks sufficient emphasis on knowledge and the application of higher order skills involving more abstract levels of analysis and action. The use of skills assessments and competency checklists has also been considered inappropriate for the measurement of professional skills performed at a higher level of abstraction and application of knowledge. Hence, there is some scepticism within the profession as to whether these models can adequately account for professional and therapeutic skills and roles.

At the same time as 'competence-models' were being entertained as a better basis for organizing and assessing clinical experience, a growing dissatisfaction with the traditional 'four core placements model' was growing. Programmes were keen to remove the CTCP constraints, which limited the size of intakes by the minimum availability of core placements, usually placements working with either older people or people with learning disabilities. Staff in newly emergent specialisms such as clinical health psychology or psychosocial rehabilitation (Ledwith and Stowers, 2001) questioned whether they should also be involved in providing compulsory core experience alongside the existing four. Even within core specialisms, supervisors were finding it increasingly difficult to provide the minimum core experiences since their jobs had become more specialized and clinically focused. Indeed, there was a sense that core experiences were forcing the profession to adopt a model of placement experience that was constrained and based upon job descriptions designed some 20 years ago. Moreover, the ever-increasing diversity of clinical psychology services led some to question whether core experience in particular specialisms was any longer feasible. Instead, it has been suggested that there should be an emphasis on the application of psychological skills and knowledge generically to clinical problems and not constrained directly by different clinical specialities. Trainees would be required to apply their knowledge across ranges of ages, disabilities and service models, rather than to serve their time within a fixed number of core placements.

The desire to overhaul the accreditation criteria surrounding placement experience led to the establishment of a BPS Working Group, chaired by Malcolm Adams (Adams, 2001), with the task of re-examining the criteria around a competence-based framework and to consult widely within the profession about the acceptability of any changes. A final set of criteria have recently been endorsed by the Society (BPS, 2002a). As a result of some of the criticisms of competence-based models, the newly proposed criteria were formulated around a matrix of learning outcomes which specify the knowledge and skills to be acquired by a trainee in order to meet, on graduation, the

occupational standards for the profession. The new criteria describe a framework for various pathways through training, delineating client populations, clinical contexts and learning outcomes which contribute to a generic training in Clinical Psychology. A flavour of this framework is provided by the following selective quotation from the criteria:

Clinical experience will be gained in service delivery systems that offer a coherent clinical context. This will usually be a setting oriented towards a population defined by age (e.g. child, adult, older people) by special needs (e.g. learning disabilities, serious mental health problems, health-related problems, substance abuse) or by a service delivery focus (e.g. psychological therapy). In addition, clinical experience will be gained in a range of service contexts (primary, secondary and tertiary care, in-patient, out-patient, community), with service delivery models ranging from independently organised work through to integrated inter-professional working.

(BPS, 2002a:7)

There have also been some doubts about the appropriateness of the new criteria and how they might work in practice. The major concern has been from the Older People and Learning Disabilities Special Interest Groups who are determined to preserve compulsory training experiences with these often poorly resourced client groups. Concerns have also been raised about moving away from generic training, difficulties recruiting trainees to these under-represented and staffed specialities within the NHS, and the organizational and practical difficulties that might be encountered if formal placements were disbanded (see Adams, 2001).

A compromise solution has been carefully negotiated which seeks to maintain the usage of all 'core placements' and to ensure that placements in either learning disabilities or older adults are not under-used. It is likely that individual programmes will have sufficient leeway to determine the extent to which they wish to embrace the 'competence-based model'. Different courses might evolve different approaches, some relying on detailed schemes of competence-based placements and assessments, others perhaps just extending their definitions of core placements to also include health psychology, neuropsychology, forensic, psychosocial rehabilitation, etc.

It needs to be emphasized that the adoption of a 'competence-based model' for clinical placements may also have a profound effect on how trainees are assessed and on the structure of the curriculum. The present traditional system of fixed mandatory placements possessed the advantage that teaching usually preceded placement experience and hence was oriented at preparing trainees for work with specific client groups. Greater flexibility of placement provision will mean that programmes will have greater difficulty providing a uniform curriculum in order to prepare trainees for their forthcoming placements. Courses that are

considering fully embracing the ‘competence-based model’ are likely to have to introduce major changes in the design of their curriculum.

We hope that we have introduced the background underlying placement availability issues and some of the more recently discussed solutions. Before suggesting which of these might be usefully developed within training courses, we would like to report the results of some studies which have empirically investigated these issues further. From the data that has already been presented, it is clear that just above 60 per cent of the profession are engaged in supervision. This raises the question as to why the remaining 40 per cent are not so engaged. Is this lack of involvement due to lack of placement resources, lack of training, incompatible job roles, negative attitudes, poor management practices, etc? In order to maximize our supervisory potential, not only do we need to free up flexibility around core placements but we must also ensure that we maximize the involvement of the qualified clinical psychology workforce. Moreover, we need to consider not only the quantity of available supervision resources but also its quality! What resources and training are required to provide good quality and effective supervision to trainee psychologists? Are these quality standards being met within the NHS and, if not, what management practices might be preventing their attainment? Questions such as these have been addressed in a number of local research projects designed to look at factors surrounding placement provision. The following section will summarize some of the themes emerging from this work; finally we will examine the recommendations for good practice emerging from this work.

Lessons from the placement projects

With the planned expansion of clinical psychology training resulting from the NHS National Plan (BPS, 2001a), the training community within England began to consider how it might achieve a significant increase in training numbers. During 2000/01 a number of projects were developed and funded by the NHS Workforce Confederations to consider methods for expanding training whilst maintaining or improving quality by identifying obstacles to developing placement capacity and methods for resolving them.

In this section we will outline some of the issues highlighted by two such projects: the Trent Clinical Psychology Placement Project (Rajan *et al.*, 2002), hereafter called the Trent Project, and The North & Central London Workforce Confederation Clinical Psychology Placement Project (Dooley *et al.*, 2002), hereafter called the London Project (covering the London region, Kent, Surrey and part of Sussex). Although the two projects adopted differing methodologies, both included university and service staff on their project teams, emphasizing the collaborative nature of clinical psychology training. They both sought to identify the placement resource available to the several programmes, which provided training within the Workforce Confederation areas under consideration, and surveyed supervisors concerned, in order to identify obstacles to expanding

placement provision. Additionally both projects sought the views of managers and clinical psychologists with regard to possible ways in which placement availability might be enhanced.

The Trent Project initially utilized questionnaires asking all clinical psychologists identified on a pre-existing database maintained within the region about their availability to provide placements in the next academic year. Respondents were also asked to identify their perceived barriers to placement provision. The survey was able to account for 95 per cent of the 347 clinical psychologists registered on the database. A second phase of the project employed local clinical psychologists to interview supervisors and managers about their attitudes towards and knowledge of clinical psychology training using a semi-structured interview. The London Project, covering seven confederation areas, intended to make telephone contact with all potential supervisors. This method proved unworkable because staff couldn't be recruited to do this work, so postal contact was used to supplement the data collection. Both projects included services which vary considerably in size, which emphasizes the fact that there is no standardized unit of clinical psychology service organization. This may give rise not only to a methodological consideration for the studies but also indicates that many clinical psychology services have recently been or are in the process of reorganization. This is partly due to the development of new provider organizations such as Primary Care Trusts and specialist Mental Health Trusts. The days of the 'District Department' are now gone, and thus there is no simple process by which programmes are able to access high-quality information regarding the workforce and available supervisors.

Availability of core placement experience

The London Project identified whole-time equivalents in their area (see [Table 4.1](#)). These data mirror the national picture in as much as there are many more clinical psychologists potentially available to provide adult and child core placement experience than is the case for older adult and learning disability placements. Similar findings were gathered in the Trent Project

Table 4.1 The London Project: whole-time equivalents

<i>Speciality</i>	<i>Adult*</i>	<i>Child and adolescent</i>	<i>Older adult</i>	<i>Learning disability</i>
Whole-time equiv.	398	266	112	105

Note: * The category 'Adult' refers generally to adult mental health work but might include some specialist work (e.g. HIV) if supervisors worked within a large adult speciality but excluded specialist areas in larger trusts where these were in a different unit/directorate. Hence the figures might be an underestimate depending on the definition of 'adult'.

confirming that with the usual model of core placement experience and one-to-one supervision, the availability of older adult and learning disability supervisors is a major limiting factor. Both projects also identified that these supervisors provide almost twice as many placements per supervisor than their colleagues in other specialities. This is due to supervisors in older adults and learning disabilities frequently supervising 'back-to-back' and sometimes taking more than one trainee at a time.

Attrition

The theoretical size of the supervisor pool does not in practice match the availability of placements. In the London Project, across all NHS trusts and specialities, 54 per cent of the potential supervisor pool is lost due to a combination of factors, including vacancies (15 per cent), clinical psychology posts filled by non-qualified or non-fully qualified staff (14 per cent), staff not yet eligible to supervise (11 per cent), and other factors such as sickness and staff holding managerial posts (14 per cent). The Trent Project revealed a similar finding of 45 per cent, and this was made up of staff who had left the service or were absent through ill health (9 per cent), those unavailable for supervision (31 per cent) and non-responders (5 per cent). The reasons for the lack of availability of supervisors identified within the Trent Project will be discussed later. Interestingly, the London Project did not attempt to estimate the numbers of potential supervisors who in practice refused to supervise.

In addition, the Trent Project assessed attrition by following up those supervisors who had said that they would be available to provide placements, but subsequently withdrew the offer, and found a loss of between 15–20 per cent of potential supervisors. All in all it seems that potential placement availability is compromised by a range of factors and there is no simple relationship between number of potential supervisors and the availability of placements. Indeed, it would appear that we can predict that around 50 per cent of supervisors, due to various reasons, are unavailable to provide placements at any one time.

Barriers to placements

The Trent Project asked potential supervisors who said they were unavailable to provide placements to indicate the factors that prevented them from doing so. They were provided with three categories (i.e. practical, personal and organizational) and asked to indicate which of these were relevant. Organizational issues such as job descriptions, managerial roles and/or work pressures provided relatively few barriers. Personal factors such as lack of years' service for eligibility to supervise, lack of supervision training and/or personal plans provided additional barriers. However, out of the three categories it was practical problems such as lack of office and clinical space that figured most highly. Supervisors who were able to offer placements also indicated barriers to

effective placement provision, and when these two groups were combined, a total of 27 per cent of respondents cited lack of office space, 17 per cent a lack of clinical space and 9 per cent a lack of clerical support. Similarly the London Project cited lack of accommodation as a 'serious impediment', resulting in an estimated loss of 10–20 per cent of potential placements in the adult speciality.

Attitudes to training

Both projects considered the views of clinical psychologists and managers towards training and any potential expansion. Within Trent these views were identified by a stakeholders' conference, followed by semi-structured interviews with a sample of managers (including chief executives) and a sample of clinicians. These interviews were carried out by local clinicians who were recruited to link to local services in order to promote the identification of the project with their services. In the London Project telephone interviews were held with professional heads of psychology services representing 41 NHS trusts.

In Central & North London 78 per cent of services were going through or had just experienced major organizational change. Within Trent, it was felt that the reorganization of trusts, together with the implementation of the various National Service Frameworks, was dominating senior managers' thinking, and although these managers had some knowledge of the general move to modernize clinical psychology training it did not figure very highly on their agendas. Although general managers expressed support for clinical psychology as a profession, they seemed to have little specific knowledge of the size of the workforce they employed or issues relating specifically to clinical psychology training. Within Trent, some psychologists were concerned that changing from the current core experience model with one-to-one placements would lead to a loss of quality in training, although there was some support for the notion of redefining what constitutes core placement experience, especially the possibility of using specialist supervisors to provide 'core placements'. Both projects identified the need for NHS management to consider the impact of training on resources such as accommodation and clerical support. They also identified the need for both psychology and general managers to find ways for supervisors to accommodate the additional workload of trainee supervision within their workplans. This might require consideration of reducing the clinical caseloads of supervisors taking trainees on placement.

The projects highlighted the need to formalize the procedures for planning and utilising the placement resource. Suggestions included service level agreements, better co-ordination by having confederation-wide placement planning in order to avoid competition for placements between programmes, employing local training co-ordinators within NHS trusts, more use of part-time staff not currently used by having one main supervisor working alongside other supplementary supervisors to provide a component of the experience. Within

Trent the potential for the development of 'accredited training units' formed from several small or a single larger department(s) was also raised.

Quality

A concern for quality was also indicated by clinicians who recommended, for example, more supervisor training, using group supervision in addition to but not instead of one-to-one supervision, and a desire to take change one step at a time and evaluate what works. Both projects considered developing standards for placements, and the London Project specifically built upon the BPS accreditation criteria, together with recommendations from an earlier study conducted by the Salomons Clinical Psychology Training Programme. The following criteria were recommended to be adopted within the London region:

- 1 Access to (at least) a shared office space (i.e. use of a shared desk and telephone).
- 2 Provision of local, accessible and lockable storage space, e.g. one drawer of a filing cabinet in which to keep client records (when appropriate) and other clinical or placement material.
- 3 Access to a computer for word processing as required for writing reports, letters, etc. This may be shared with others and may need to be booked.
- 4 Clinical rooms for client work that can be booked on a regular basis. These should be adequately furnished, safe, private and with a suitable reception facility. The amount of time needed will vary between specialities and placements.
- 5 Secretarial/administrative support for work not done on word processing; e.g. appointment letters, urgent client matters, booking of rooms and other administrative activities linked to the placement activity.

Although establishing standards for placements was an objective of the Trent Project, consultation with supervisors indicated that although there was agreement that this was needed there was some reluctance to take this forward at this point in time. This was due to concern that at a time of potential expansion, placement capacity could be lost rather than gained if significant numbers of placements could not fulfil these standards. Rather, staff recognised the existence of the BPS standards, which could be referred to as necessary.

Summary

It is clear from these projects that resolving one issue alone will not be sufficient to solve placement availability problems. There are a set of interconnected issues that need to be dealt with adequately. These include:

- Revising the model of core placement experiences and the competence framework.
- Perceived location of responsibility for placement provision.
- Arrangements for placement planning and co-ordination.
- Agreements between universities and the service regarding placements.
- Practical resources to support trainees and departments whilst trainees are on placement.

Whilst the profession has responsibility to develop best-practice training models, the Workforce Development Confederations (WDCs) within the NHS have the responsibility to provide support and resources in a number of key areas. The major recommendations reached by the Trent Project were that WDCs might:

- Raise awareness about clinical psychology training issues for managers of NHS trusts and Primary Care trusts.
- Establish confederation-wide structures for the planning and coordination of placements. Supra-confederation structures might be necessary for co-ordinating placements within small professions such as clinical psychology.
- To provide resources targeted at supervisors to support placements (i.e. a non-medical equivalent of SIFT whereby NHS trusts and hospitals providing resources for medical education were funded specifically for taking on these additional responsibilities).
- To make resources available to local Special Interest Groups to work with programmes on developing and revising core placements in order to facilitate more placements alongside the proposed revision of the curriculum.

Conclusions and recommendations

What can be done to maximize supervisory resources?

The studies described above identify a number of key issues that are crucial to the development and expansion of supervisory resources for clinical psychology training in the UK. Some require a more radical approach than others and all rely on the co-operation of the stakeholders in the training process. Purchasers need to identify additional resources in order to facilitate the provision of placements in NHS trusts; programmes need to be prepared to restructure not only placement organization but the nature of the curriculum and the way in which it is taught. NHS clinical psychology departments and supervisors need to acknowledge the central role that they play in training and that they are the ultimate beneficiaries in having a well-trained workforce from which to recruit.

Keeping track of potential placement supervisors

With the expansion in numbers of qualified clinical psychologists working within the NHS, repeated reorganization of NHS trusts and their arrangements for employing staff, plus changes in regional boundaries, it has become increasingly difficult for programmes to keep up to date with staff who constitute the potential supervisory resource. The University of Sheffield maintains a database on behalf of the former Trent region, funded by the Trent NHS Workforce Development Confederation and accessible by local clinicians, the Confederation, trainees and the regional DCP. It is updated on an *ad hoc* basis and from information provided by programme administrators, trust departmental secretaries and local representatives on programme training committees and special interest groups. It is invaluable in helping programmes to plan placements. Confederations elsewhere could be encouraged to fund the establishment and maintenance of such a resource.

Future developments in the profession of clinical psychology

The expansion of clinical psychology, both in terms of the numbers of people entering the profession and in the roles and tasks that its members undertake, has meant that there is now a great diversity of specialism and role. New applications of psychology in health care settings continue to evolve and even without the impetus to expand training numbers, congruent models of training need to be developed to ensure that recruits fit professional requirements.

The traditional core specialisms of the profession have become multiple specialisms. For example, a child placement could now be with a CAFTS team, in a Child Development Centre, in a Home Start programme, working with looked-after children, or in a tier 4 specialist in-patient unit. Each of these involves significantly different work, and a trainee in one setting will gain a very different experience and learn some different skills from a trainee working in another. The number of people in post working with physical health problems may well exceed those in some of the traditional core specialisms, and these changes need to be reflected in the manner in which practice placements are provided for new recruits. An advantage of the 'competencebased model' is that it emphasizes commonalities in the skills and knowledge required to practise both across and within particular specialisms rather than a progressive differentiation of skills for particular client groups. It is hoped that this approach might give rise to a less fractionated and more integrated curriculum, which might facilitate trainees extending knowledge acquired in one service context and with a particular client group to a new client group or emerging service demand (e.g. asylum seekers) not previously anticipated.

Finally, clinical psychologists also need to be mindful of more general developments in applied psychology and particularly how professional psychology practice is emerging within the European Union. Within the UK, the

increasing numbers of other applied psychologists (e.g. counselling and health psychologists) working within the NHS will provide opportunities for supervision across the family of applied psychologists but may also give rise to greater pressures due to competition between training these other applied psychologists and the existing demands of the supervision system. Within Europe, the distinction between different types of applied psychologist is less prominent and there is a pressure to harmonize higher education qualifications around five years of training, resulting in a masters level of qualification. Such a trend would raise fundamental problems with the UK system of differential applied psychologists, many of whom are now trained to doctoral level.

The importance of overseas developments, particularly within the European Union, should not be underestimated. The NHS progressively looks to recruitment from other countries in order to resolve its workforce supply problems (DH, 2001a). Traditionally, many overseas clinical psychologists have been trained for the NHS via the BPS Statement of Equivalence route. This route to qualification is particularly important in areas of the UK with major staffing shortages and also specialisms such as learning disabilities that have experienced difficulties in recruitment. Within both placement projects, but particularly the London Project, the provision of placements for Statement of Equivalence candidates, or qualified posts filled with overseas-qualified staff not eligible to supervise, has had a significant impact on the overall availability of placements.

The presence of overseas-qualified staff within the NHS places particular pressures on training and placement provision. However, it should be emphasized that the employment of clinical psychologists trained and qualified abroad also enhances the diversity of the profession and the NHS and offers a wider range of experiences and models of psychology relevant to health care. It also deserves recognition that the Statement of Equivalence route to qualification is exacting in its BPS requirements and is often completed without the usual academic input and support for someone training via a university programme. Indeed, concerns have been expressed about viability and quality assurance methods of the BPS Statement of Equivalence route (Wilner and Napier, 2001). Accordingly, several programmes (e.g. University of Leeds and Salomons, Canterbury Christchurch University College) have organized formal courses for these candidates (McGuire *et al.*, 2001; Whittington and Burns, 2001). Ongoing developments within the BPS will also allow university programmes to assess the training requirements for the Statement of Equivalence as laid down by the BPS Committee for the Scrutiny of Individual Clinical Qualifications (CSICQ). Any overall plan for placement supervision should take into account the needs and opportunities afforded by overseas-qualified psychologists.

Attitudes and values of supervisors and psychology departments

Who has responsibility for providing placements for clinical psychologists in training? We would contend that this is shared between universities, clinical psychology departments in NHS Trusts and the purchasers of the programmes. Whilst there may be little contention in this assertion, in practice it has been the programmes that have carried out the task of finding sufficient placements for the agreed number of training commissions. This process has relied on good will, of which there has been plenty, and it worked well when the profession was small. With expansion in the workforce it is much more difficult to maintain the personal knowledge of each other that is required in order for the goodwill model to work. In the absence of well-developed personal relationships it is much easier for a busy clinician to turn down a request for a placement, and programme team staff have no managerial responsibility for the supervisors on whom training relies.

Under the conditions in which the profession now functions, the responsibility for finding placements must shift, with a greater emphasis on shared responsibilities between the major stakeholders. It may also be necessary for more formal arrangements to give structural support to the placement planning process. There are a number of models through which this might be encouraged. These range from the incorporation of supervision responsibilities within job descriptions, the creation of Service Level Agreements between service providers, and courses to ensure a minimum supply of placements, the creation of accredited Training Units through to a radical internship model recently proposed by Kinderman (2001). However, it is unlikely that organizational and structural changes will be sufficient by themselves to bring about changes in the attitudes and aspirations of individual supervisors.

One of the striking findings of the placement projects described above was that the ratio of placements provided to number of staff in post varied significantly according to the particular specialism and by individual department. Clinicians working with people with a learning disability and with older adults provided, on average, a greater number of placements than those working in adult mental health and child and family services. Traditionally, posts in learning disability and older adult services have been harder to fill. With unfilled posts, these clinical psychology departments have used their funding creatively, employing assistant psychologists who have been factored in to the ongoing service provision. Qualified clinicians have become used to supervising a continuous supply of junior staff and these skills readily translate to the supervision of trainees. In contrast, the lone psychologist in a multidisciplinary team may feel less skilled and experienced in the supervision and management of junior staff, and hence less willing to volunteer placements.

The data from the Trent Project also showed great disparity between departments in number of placements offered, irrespective of speciality. Those

that provided large numbers of placements to staff in post were characterized by heads of department who were themselves enthusiastic about training and supervision, often taking trainees back to back on placement themselves and modelling enthusiasm about the role to other staff in the department. This enthusiasm was in some cases also in evidence where departments or specialities within departments were particularly engaged in the process of supervision for qualified staff, seeing it as an entitlement rather than an imposition.

It has been suggested (Dooley *et al.*, 2002) that professional heads of service ensure the formalization of supervision as a role in jobs through internal structures and procedures. This should ensure acknowledgement of the demands of the role, the provision of supervision time and an appropriate reduction in other activity. On its own, however, it would not ensure that less willing staff undertook the role. Positive approaches to changing attitudes and values are likely to be more productive, and the single most important factor associated with successful supervision has been identified as the interest of the supervisor in the task (Nelson, 1978; Engel *et al.*, 1998).

These findings suggest a number of approaches which might encourage a change of attitudes and values within the profession leading to an expansion in the placement resource:

- The encouragement of a greater sense of responsibility for placement provision within psychology departments in NHS trusts. This can be achieved through a number of measures such as placement projects which involve stakeholders in ongoing discussion and debate about training and the practice components.
- This sense of responsibility can also be formalized by the recruitment of staff in NHS trusts to posts attached part time to the university on a substantive or honorary basis with a brief to take some responsibility for placement provision and co-ordination within the trust. These may be designated honorary clinical tutors or associate tutors.
- Clinical psychologists can be encouraged to value the process of supervision more highly through the notion of career-long supervision as an entitlement in post-qualification training. The clinical governance agenda requires such mechanisms to be in place. An aspiration would be that supervision of trainees becomes an expected component of a clinical psychologist's role. Only in certain circumstances (e.g. newly qualified, very part-time working, managerial post, specialist research post) would a qualified psychologist not have or expect to have a trainee.
- Programmes could introduce training in supervision as a core skill throughout the three-year doctoral training, giving new qualifiers welldeveloped skills and positive expectations in their role as a supervisor.
- As the knowledge and skill base of supervision has developed apace, this could be reflected in the development of more formal post-qualification

training programmes for supervisors. Well-trained and qualified staff are more likely to feel confident in the role of supervisor and to enjoy the role.

- Programme staff could develop supervisor training programmes that encourage a positive attitude to the role. These could be individually designed for particular departments and specialisms, and targeted at those who have traditionally offered a low ratio of placements to qualified staff. (See Scaife, 2001a, for key topics that might contribute to the curriculum for such a programme.)

Core experience and flexibility

The recent review of the accreditation criteria for clinical psychology programmes (Adams, 2001) frees core experience from core placements. Under the new proposals, each trainee could have an individualized training programme within parameters that ensure that they gain experience in work across the age span, with people with chronic and enduring health needs and with people with a disability. These proposals have been generally welcomed within the profession with the proviso that the strengths of the current training model should not be lost.

With this increase in flexibility it will be possible to include placements traditionally designated as 'specialist' as suitable for trainees in the first two years of their training. Such a move would also reflect the changes that have taken place in the profession as it has expanded into increasingly diverse health and social care settings. Implementation of this change will take time. It requires programmes and supervisors to review the manner in which skills, knowledge and experience are designated core. It will also be crucial to ensure the full involvement of local clinical psychology special interest groups in this process.

Alongside this review will be the need to redesign formal recording methods of placement experience, assessments of clinical competence and aims and activities plans. Where the programme curriculum is designed around core placements, a major reorganization and review will be required. A number of options are possible. Core teaching at the university site would need to be relevant across specialisms in modules such as assessment, formulation, working with difference, interviewing skills, psychological therapies, research skills, etc. Indeed, continued work undertaken by the BPS on occupational standards might help further to shape a revised curriculum. The redesign of the curriculum would allow for the development of module options, possibly undertaken by distance learning in order that trainees could study individual topics best fitted to their current placement experience. It would be essential to retain the sense of a learning community and systems of support were trainees to be in less frequent contact with the university base.

Resources

The third general area in which there were identified constraints to the expansion of the placement resource was that of inadequate resources. These were largely in regard to clinic space, office space and administrative and clerical support. This inadequacy meant that in many cases clinicians who were willing and able to supervise were unable to offer placements.

The problem is by no means confined to the profession of clinical psychology or to the issue of training. It has resulted from the drive towards greater efficiency and the widespread reduction in hospital beds and accommodation that took place in the latter part of the twentieth century. It has left staff in substantive posts with inadequate resources for the job. In such a context it is difficult to make a case for resources for trainees, particularly if they are not seen as making a substantial and ongoing service contribution. Attempts to deal with these problems have also been identified in various interdisciplinary reports (ENB/DH, 2001; Cheesman, 2001).

The Trent study showed that many general managers have a very inadequate knowledge of the profession of clinical psychology, and in a climate of recurrent reorganizations and resource shortfall they are unable to prioritize the provision of resources to support training placements. Since general managers are unlikely to seek knowledge of the profession themselves, members of the profession need a strategy to educate and inform. Such a strategy can be undertaken at the level of the workforce confederations and by local service heads.

Workforce confederations have a major role to play here within their brief to provide a well-trained workforce to meet the projected requirements of the NHS. The trusts are represented on confederation boards and are the route for a wider dissemination of the blocks to placement provision that currently exist and of the potential solutions. Confederations need to stress the interdependence between service size and development, provision of training, and staff recruitment and retention. Programmes can facilitate this process by making available the data and the studies that demonstrate the major constraining factor that a lack of resources present.

Recent reviews of funding policy for training in the health professions may suggest a way forward as regards resourcing placements (NAO, 2001; DH, 2002). For many years medical training has been supported by the SIFT system. In order to reflect the need for additional resourcing for placement provision across all forms of health professional (HP) training, and also to ensure equality in the way that resources are distributed, a recent consultation document (Universities UK/DH, 2002) has recommended the merging of all levies and the use of such funds to support placement provision across all health care professions.

It is also likely that the differences in both the organizing and funding of training across the different health care professions will be radically diminished. The NAO report (NAO, 2001), together with the recent universities UK/DH

(2002) consultation document, points to a system of standardized fees nationally agreed but locally implemented at the institutional level. Such a system would reduce the need for an administrative infrastructure whereby each individual HP training programme has to engage in protracted contract negotiations. At the same time, there are also major developments in the systems of quality assurance for the health professions. The recent establishment of common benchmarks for undergraduate courses by the QAA and Health Professions Council further underscores the joint working across professional bodies (QAA, 2001a). Similarly, the QAA has also established standards for work experience and placements (QAA, 2001b). It is likely that contract monitoring and quality assurance might take place at an institutional level across a range of health professions. The quality of placement experience, the availability of resources on placement, and the accountability of any 'SIFT-like' support to NHS trusts or training units, would all come under scrutiny. Clinical psychology programmes need to monitor these important policy changes both nationally and locally, and will need to establish good working relationships with the training bodies of the medical and allied health professions. Indeed, not only is greater co-operation required between professional bodies but the current NHS agenda is generally to encourage shared learning within the education of health professionals. At the undergraduate level, several innovative schemes are being established to support inter-professional learning across medical, allied health care professions and social work education.

Although the focus of this chapter has been on placement provision, the continuing development of clinical psychology training requires that adequate resourcing of the training system be achieved across the board. The shortage of clinical academic staff to run clinical psychology programmes based within universities and to supervise the research projects of clinical psychologists in training is recently being acknowledged (Davey, 2002; Thomas *et al.*, 2002; Turpin, 2002) as a critical problem. Similarly many courses based in universities are limited and constrained by teaching accommodation established for small group teaching rather than accommodating the increased numbers being demanded of the service. The provision of capital costs for new buildings and teaching resources will be critical for the future expansion of clinical psychology programmes.

In conclusion, universities and clinical psychology training programmes, together with WDCs, need to consider the following developments:

- A model of accredited training units akin to those adopted by the medical profession would allow departments providing placements to benefit from additional resources and to obtain recognition for their efforts. Such units might be accredited and provided with additional training funds.
- Transferring training from the university to placements, especially for specialist skills or client/services knowledge, would encourage supervisors to

be more directly involved in training and for their skills to be more positively valued.

- Ensuring that adequate teaching accommodation exists for universitybased programmes.
- Ensuring that support and remuneration exists to attract clinical academic staff into programme teams.
- Opportunities for interdisciplinary learning would allow the profession to draw upon the knowledge and skills of staff in other disciplines where this was considered relevant and appropriate in the training of clinical psychologists.

Conclusion

The expansion in the number of substantive posts and training places, and the increasing diversity of work carried out by the profession, is testament to the success of clinical psychology during the latter part of the twentieth century. Current indicators suggest that the profession will continue its successful development into the foreseeable future. This development is contingent on a continuing supply of adequate numbers of good-quality placements. This chapter has reported on studies of blocks to such placement provision and makes suggestions as to the measures that would facilitate an expansion in the placement resource. The commitment of all stakeholders in the training process is a necessary condition. There is every indication that the resourcefulness of the stakeholders, the willingness of the profession to seek flexible solutions, and the ongoing goodwill of supervisors will secure such an optimistic future.

Note

- 1 To Mr Jinks for 18 years of non-judgemental feline supervision.

Chapter 5

Training clinical psychologists as supervisors

Ian Fleming

As few clinicians undertake any formal training in supervision prior to assuming the role, considerable variation may be expected, and is often found, between supervisors concerning the ways in which they function and perceive their role... In practice, supervisors often function within the same professional discipline or organisation, in very different ways.

(Edwards, 1997:14)

There are those who have natural ability to supervise productively, and there are those who make a pig's ear out of it, no matter how many books they read or courses they go on.

(Laing, 1965, quoted in Fowler, 1998:82)

What can we deduce from these selected quotations? What is the role of training in the acquisition and assurance of high-quality supervision? Can it make a difference to supervisory practice? This chapter will attempt to shed some light on these issues through an examination of the current training of clinical psychology supervisors in the UK.

Earlier chapters in this book have addressed the functions of supervision both in general and within clinical psychology in particular. In this chapter we wish to report on the current situation with regard to clinical psychology in Britain concerning the training of clinical psychologists as supervisors, and to discuss the data collected in a survey with respect to the current state of knowledge about supervision. The data concern supervision of pre-qualification practice (i.e. of trainee clinical psychologists), although the relationship that this may have with post-qualification supervision will be discussed.

Although there are a variety of courses in the UK providing training in supervision, the focus will be on the supervisor training that is provided by doctoral clinical psychology training programmes. The information derives from a survey of UK clinical psychology training programmes carried out in the summer of 2001. Before reporting and discussing these data it will be helpful to consider the professional and service contexts in which supervision operates.

Turpin *et al.* in [Chapter 4](#) of this book have described the service context that has seen, and will continue to see, significant growth in the numbers of clinical psychologists being trained in the UK. Green in [Chapter 6](#) reports on a study that described the content of supervisor training that clinical psychologists want to see. This chapter will make links with both of these contributions.

The historical importance of supervision in clinical psychology

Clinical psychology is a small but rapidly growing profession in the UK (see data in [Chapter 1](#)). The National Health Service (NHS, the state health care provider in the UK) is the major employer of clinical psychologists and commissions and pays for their training via workforce planning (see [Chapter 4](#) for more details). There is currently an excess (estimated at 25 per cent) of vacant clinical psychology posts, and there are continuing difficulties in filling posts in particular clinical and geographical areas.

In an attempt to meet this shortfall there has been an expansion in the number of training places in England from 189 in 1993 to 390 in 2000. In Scotland, Wales and Northern Ireland this rise has been less pronounced. (In Eire the expansion has also been less pronounced.) The expansion is influenced by the explicit and positive references to the role of clinical psychologists and psychological approaches in different aspects of health care, such as the National Service Frameworks published in 1998.

At the time of writing (October 2002), there are 29 clinical psychology training programmes in the UK (compared to 24 in 1990), and two in Eire. All UK programmes are required to achieve accredited status from the British Psychological Society's Committee on Training in Clinical Psychology (CTCP). There are explicit criteria that must be met to achieve accreditation, and this is awarded for a maximum of five years. Accreditation can be withdrawn, and awarded for a period of less than five years subject to interim review.

During training, clinical psychologists are required to undertake extended periods of supervised practice. The current accreditation criteria (BPS, 2002a) reflect the move away from an earlier requirement for trainees to complete placements in specialist client areas towards the more flexible gaining of specified experience and competencies. The necessity to identify these, organize them and evaluate a trainee's performance may result in additional and more detailed input from those clinical psychologists who are supervising trainees.

Although the majority of clinical psychologists in the UK are actively involved in supervising trainees, a sizeable minority do not supervise at all regularly (some of the reasons for this have been discussed earlier in [Chapter 4](#)). Currently there are no mandatory requirements on qualified clinical psychologists to act as supervisors.

It can be argued that the profession of clinical psychology in the UK has only recently become concerned with the role of the supervisor and the practice of

supervision (e.g. Fleming and Steen, 2001). Although individuals have attended to supervisory skills, there is little evidence of clinical psychology defining, developing or evaluating supervisory practice, especially when compared with allied professions such as counselling and psychotherapy. This is illustrated in recent surveys of placements and supervisors as training resources (Turpin, 1995; Gray, 1997). In these the emphasis was on placement capacity, rather than the competencies of supervisors or their training in supervisory skills. The more recent attention paid to these issues is reflected in [Chapter 4](#) of this volume.

One reason for this lies in the historically dominant therapeutic models in British clinical psychology (e.g. Newnes, 1996), and their lack of emphasis on supervisory relationships and processes. The origins of supervision can be traced to the training process in psychoanalysis (e.g. Page and Wosket, 1994), and, although supervision is well established in social work (e.g. Kadushin, 1992), counselling (e.g. Carroll, 1996; Lawton and Feltham, 2000), psychoanalytic psychotherapy (see Shipton, 1997), and beginning to develop in nursing (e.g. Butterworth and Faugier, 1992), it is less well rooted in clinical psychology in the UK (Gabbay *et al.*, 1999).

This has been accompanied by a historical lack of attention to the training of supervisors in clinical psychology, although the situation is now changing. Increased attention is being paid to the tasks and competencies of supervision, and the training of people in supervisory skills. Consideration is also being given to quality issues and the accreditation of supervisors—although this does *not* exist currently. These changes have been accompanied by a small literature describing supervision in clinical psychology and supervisor training (e.g. Alien and Brazier, 1996; Bacon, 1992; Gabbay *et al.*, 1999; Hitchen *et al.*, 1997; Milne, 1994; Milne and Britton, 1994).

The impetus for this change in emphasis comes from both general health care systems and the clinical psychology profession. One reason is a general concern with the quality of health care. There were a number of clear failures of the health care system in the UK in the 1990s, and one conclusion from the resulting inquiries was that there should be improved vigilance of clinical practice with supervision at the core of this.

Clinical governance (e.g. DH, 1998a; Hall and Firth-Cozens, 2000) is another tool for promoting the development of the highest practice through increased accountability. It can be argued that good-quality supervision can provide some of the means by which clinical governance is implemented.

Another driver for an increased emphasis on supervision comes from continuing professional development (CPD) (e.g. Green, 1995). It will soon be a requirement for clinical psychologists to demonstrate their CPD activity, and it is very likely within a few years that the demonstration of suitable CPD will be requirement for professional registration (BPS, 2001a; DCP, 2001a).

There is also an increasing trend towards self-regulation within the profession of clinical psychology that contributes to the focus on most effective practice.

What does the clinical psychology profession currently require of supervisors?

The changing emphasis on supervision has been accompanied by more consideration of the training clinicians require to practise as supervisors. As mentioned previously, the CTCP is the body within the British Psychological Society that has the responsibility for awarding accreditation to clinical psychology training programmes. Guidance from the CTCP has, in general, focused more on the activities of clinical psychology training programmes than on the practice of individual supervisors, and contained little in the way of detail. Thus, although there has been increased emphasis on the need for supervisors to receive 'training', the form and content remain unspecified.

The NHS and the profession have assumed and expected that clinical psychology (pre-qualification) training programmes would be the providers of this particular form of post-qualification training, and in general this has been the case. Indeed, the BPS *Guidelines for Continuing Professional Development* (BPS, 1998a) refer to this being an obligation placed on training programmes by the CTCP (section 5.1). Some clinical psychologists attend independent courses of training in supervision skills, but the numbers seem to be small and participants are more likely to work in particular specialities. It is not inconceivable that other providers could appear in future if training in supervision skills became an identifiable component of continuing professional development (CPD), and if and when there is a requirement for the quality control of supervisory practice (perhaps via accreditation). These latter issues will be discussed later.

Fleming and Steen (2001) described the developments in supervisor training in one doctoral training programme, in which there was an attempt to increase the amount and range of training in supervision tasks that was made available to clinical psychologists who supervised trainees from that programme. Current guidance states:

8.7 Regular workshops on supervisory skills and other teaching events for supervisors must be organised by the Programme to ensure a high standard of supervision. Supervisors should be encouraged to attend workshops and teaching events.

(BPS, 2002a:15)

This is a minor improvement on the previous guidance dating from 1996 that required programmes to demonstrate training for supervisors, and said that 'supervisors are expected to attend workshops on supervision' (BPS, 1996: appendix 3).

Neither the number nor content of these workshops are specified. The accreditation criteria refer to (undefined) 'good quality supervisory resources'. Clinical psychology training programmes are accredited, but not individual

supervisors, and data are not available to determine the extent to which this guidance is followed. BPS/DCP guidelines on supervision are, at the time of writing (autumn 2002), expected to be published soon.

The BPS *Division of Clinical Psychology Professional Practice Guidelines* (BPS, 1995b) state that ‘relevant workshops’ should be attended prior to undertaking supervision. Time should be allowed for supervisors to attend appropriate supervisor groups and newly qualified supervisors should be enabled to enhance their competency in supervision (section 4.3) Subsequently, the *DCP Guidelines for Clinical Psychology Services* (BPS, 1998c) state that supervisors ‘will have attended at least one workshop on supervision prior to taking on a trainee’ (section 1.5.2.8).

In future the development of national occupational standards (NOS) for applied psychology may include specific data about core competencies for supervision and, in turn, this may have implications for supervisor training. Requirements in future for multi-professional training (NHSE, 1995; DH, 2001c) and supervision are also likely to have a significant impact on the training of supervisors.

In view of the absence of specific guidance about training of supervisors it was decided to conduct a survey of clinical psychology training programmes to gain data about their current practices.

Data from the 2001 survey

In August 2001 the author sent a survey form to all existing doctoral clinical psychology programmes in the UK and Ireland. The survey comprised 29 questions divided into areas of organization, content, costs, evaluation, and links with CPD. By December 2001, a total of 27 programmes had returned completed survey forms, a response rate of 87 per cent.

Analysis of results

Organization

1 All 27 doctoral training programmes provided training for supervisors of trainees from their programme. Of these 19 (70.4 per cent) organized programmes of training; a minority described their training events as ‘*ad hoc*’. Within these programmes the number of separate training events varied considerably from 1–10, with a mode number of 3. On average 4.6 training events had been put on during the previous 12 months, with a range of 1–9 and a mode of 3.

The average number of training events in the previous 12 months was similar, both for those organizations arranging programmes and those organizing *ad hoc*

events, although there was a greater range in the number organized by the former.

There was variation in how often training was organized and repeated. The largest number of training programmes (12) indicated that the frequency was annually; other significant proportions were every six months and 'as necessary' (8). Some programmes indicated that the frequency of events varied according to content, with, for example, 'introductory' training being provided on a more regular basis.

2 The most common duration for training events was one day (16 training programmes). Five programmes organized mainly two-day events, and four mainly residential events. Those training programmes with programmes of supervisor training organized more residential and two-day events than those that organized more *ad hoc* training.

Only seven (26 per cent) programmes routinely organized events for both trainees and supervisors, although another four programmes did so on an occasional basis.

3 Twelve (44 per cent) programmes used only staff from their own programme to deliver the training. Very few training programmes used outside speakers/facilitators solely, although 12 indicated that they used both, according to the content of the training event. Clinical training programmes that organized their supervisor training on an *ad hoc* basis were more likely to utilize trainers from outside the programme team. It is not clear if there was a relationship between clinical training programmes that delivered more training for supervisors and the available internal resources (e.g. staff time, perceived competencies of staff) for the delivery of this training. Cost issues of training are discussed later.

4 Many training programmes are geographically close to others, with the result that individual clinicians may regularly supervise trainees from more than one programme. Sixteen (59 per cent) programmes organized supervisor training with other local programmes on a regular basis and only five (18.5 per cent) reported that they did not organize training events with other programmes. Some programmes indicated that this depended on the content of the training event, and that some events were organized in conjunction with other programmes but others were not. Six programmes organized with others on an infrequent basis and six did so in addition to their own training for supervisors.

Table 5.1 Content of supervisor training events using categories supplied in the survey questionnaire

<i>Content of training event</i>	<i>No. of programmes organizing such training events</i>
Supervision and learning processes	23 (85%)
Different theoretical models of supervision	22 (81.5%)
Failing trainees/placements	19 (70%)

<i>Content of training event</i>	<i>No. of programmes organizing such training events</i>
'Race', culture and gender issues in supervision	14 (52%)
Team supervision	8 (30%)

Table 5.2 Content of supervisor training events based on respondents' own reports

<i>Content of training event</i>	<i>No. of programmes organizing training events with this content</i>
Supervising research	9
Dealing with dilemmas, conflicts and challenges in supervision	8
Teaching clinical skills in supervision (e.g. cognitive behavioural therapy, formulation)	7
Supervision contracts; setting-up and managing placements	5
Supervising other professions, consultation skills	4
Group supervision	3
Gatekeeping	2
Dynamics of supervisory relationships	2
Taping live supervision	2
Personal and professional development	2
Trainee-facilitated workshop	1
Ethics/boundary issues	1
Developing trainees self-appraisals	1

Content

5 Programmes were asked about the content of their training events. [Table 5.1](#) contains the responses to titles provided, and [Table 5.2](#) their own descriptions of the content of their training events.

Attendance

6 Attendance at training events varied according to content. The majority of programmes reported average attendances of over 20, and the largest attendance was reported as 'up to 50'. Most training is organized in a workshop format with an emphasis on enactive teaching using exercises, role-play and small group work. This mode of training has implications for resources (e.g. teaching rooms

in a venue, numbers of facilitators) and the number attending. From our personal experience in Manchester, as in Newcastle (Milne and Howard, 2000), supervisors regularly attest to the value of role-play in reflection and learning during training workshops.

7 Programmes were asked what they knew about the individuals who attended their training events. Seventeen of the clinical training programmes (63 per cent) reported that they informally monitored attendance of supervisors at training events. Twenty-two (81 per cent) reported that they knew of active supervisors who rarely attended supervision training events, and 15 (55.5 per cent) programmes ‘targeted’ these individuals and encouraged them to attend. One programme reported that they did so ‘sometimes’ and, although this was not specifically asked, another programme reported that it intentionally identified newly qualified clinicians ready to become supervisors. (This is probably an underestimate of this practice across training programmes.) Of those that monitored attendance, 13 (76 per cent) considered that this targeting was generally successful, with increased attendance and participation in training.

Attempts to monitor attendance need to acknowledge that individuals may attend supervisor training events organized by neighbouring training programmes, especially where this is geographically more likely (see p. 77). In the north-west of England, for example, the Manchester, Lancaster and Liverpool clinical training programmes are in a region approximately 80 miles long and 45 wide, and a number of individual clinicians supervise trainees from more than one programme.

This situation is likely to increase in accordance with the expansion in the number of training programmes. Individual supervisors could use logbooks to monitor their attendance and participation at training events and as a tool for personal development. This is discussed on pp. 212–213.

8 Sixteen clinical training programmes (59 per cent) did *not* have a specific budget for training. Despite this, only two levied a charge for attendance at training events, and this was for residential events only.

Audit

9 Most programmes made attempts to evaluate the training for supervisors, although it was generally recognized that this was carried out in a limited way. Twenty-three (85 per cent) programmes made regular attempts to evaluate these training events and another did so ‘sometimes’. Twenty-three employed written feedback from those attending the workshops. A further three used observation of supervision and another two asked supervisors to monitor their subsequent practice in supervision or use learning logs. No programmes sought reports from clinical psychology trainees.

Table 5.3 Details of the relationship between supervisor training and continuing professional development

When asked to enlarge on this relationship, the following were included:

- The situation may change in the near future as a result of increased interest locally (three programmes).
 - Some supervisors' individual performance reviews take account of supervision skills (two programmes).
 - The regional Post-Qualification Training Consortium organizes a CPD programme that includes supervision (two programmes).
 - There is locally a 0.5wte* Regional CPD Co-ordinator, but that person is not involved with supervisor training (one programme).
 - There is a requirement for supervisors to attend a three-day training event prior to supervising, and a 'refresher' event every three years (one programme).
 - Supervisor training has been 'marketed' as fulfilling CPD requirements, and accreditation certificates are being sought from the university (one programme).
-

Note: * wte = whole time equivalent

Table 5.4 Organization of continuing professional development in the localities of Clin.Psy.D. training programmes

- Events are organized mainly by local Special Interest Groups and DCP branches. (5 programmes)
 - There is a regional Post-Qualification Training Committee or an 'active' CPD committee that organizes events. (4 programmes)
 - There is a less-active CPD committee that organizes some events. (3 programmes)
 - Arrangements are 'ad hoc', 'variable', left to individual trusts. (3 programmes)
 - A post-qualification doctorate. (2 programmes)
 - Mainly organized by the DCP but plans for future joint organization with the University. (1 programme)
 - CPD tutor recently appointed/survey carried out. (2 programmes)
-

Continuing professional development

10 Programmes were asked if there was a specific link between continuing professional development (CPD) initiatives locally and supervision training events that they organized. Only five (18.5 per cent) programmes affirmed this link and 17 (63 per cent) indicated no link. One was unsure. Programmes were asked to elaborate on this relationship and their responses are contained in [Table 5.3](#).

11 Three (11 per cent) training programmes reported that they have responsibilities for post- as well as pre-qualification training; 19 (70.4 per cent) indicated that they did not. [Table 5.4](#) contains the programmes' descriptions of the arrangements for CPD in their localities.

Accreditation

12 Only one programme reported that it accredited supervisors in any way on the basis of competence. The vast majority of programmes (25) did not do so. In this single instance accreditation was given for attendance at supervisor training events.

Three programmes reported that they had plans to employ accreditation in the near future. Another reported that it 'would like to', and one thought that these plans were a possibility. Twenty-two programmes indicated that they had no plans to do so, however.

Despite this four (15 per cent) programmes (with another 'possible') have plans to use supervisor training to identify the competence of supervisors.

Discussion: what does this tell us about training people to supervise in clinical psychology?

Data have been presented that describe the current provision by clinical psychology training programmes of training for clinical psychology supervisors in the UK. Experience from attending 'external' courses in supervision is not discussed here.

The following discussion will consider aspects of the organization of training for supervisors, the content of the training provided and its perceived relevance to the tasks of supervision, and future developments of supervisor training within the changing context facing the profession of clinical psychology. It will enquire how well the profession is providing training for supervisors and what can be learned and taken forward from experience.

Why train supervisors?

The value of training for supervisors has been questioned, for instance, by Bramley (1996):

No doubt supervision too is about to come under inspection in this regard and therapists will flock to 'recognised' training courses that will spring up all over the country to meet the demands. While welcoming any move to keep up standards and protect the public, I am worried about too much standardisation; too much concern about career prospects and making sure one is part of the professional 'in crowd' at the expense of the patient, who would benefit much more from his therapist's supervisor if she had been allowed to develop the art of supervision gradually, as her own expertise and knowledge as a practitioner increased rather than in a rushed once and for all qualifying course.

(Bramley, 1996:182)

In contrast to this there is a *prima facie* case made for all aspects of training to improve performance, although the empirical evidence available to support this has been subject to criticism (see [Chapter 6](#)). Other reasons for training supervisors include an increasing concern generally with the quality of supervision (as well as the quantity of supervisors); supervisors' own requests for more training; and the identification of the lack of training experience as a (lesser) barrier to individual clinical psychologists offering to supervise trainees. A further impetus may come with the European Union directives related to the qualifications and employment of applied psychologists (see [Chapter 4](#)).

What happens in supervision in the absence of training in supervision skills? If the profession of clinical psychology has underemphasized the practice of supervision in the past, has this affected what takes place?

A general argument in the literature is that in the absence of specific training, supervisors tend to apply their clinical skills to supervision. For example, Carroll (1996) says:

Often the decision about which tasks to employ in supervision, made either consciously or unconsciously, accords with the theoretical orientation, and/or is due to the limited training and competences of supervisors.

(Carroll, 1996:52)

There is also a general presumption that training in supervisory skills is desirable, if only to impose a minimum standard. For example, Page and Wosket state: 'If supervisor training were to accomplish nothing beyond eradicating previous bad habits, it might serve some useful purpose' (1994:174).

Blocher, with reference to counselling, identified some potential problems that could develop for untrained supervisors:

The supervisory relationship is by its nature one in which the counsellor begins, at least, by feeling inadequate and vulnerable. The possibility always exists that an immature, inadequate, and insensitive supervisor may intimidate, bully, and even damage a supervisee. No theoretical model of supervision is idiot proof and bastard resistant. When such destructive events occur in supervision it is more likely to be due to the personal inadequacies of the supervisor than to the deficiencies in any well-thought through theoretical model.

(Blocher, 1983:30)

It is interesting to consider whether these experiences apply to clinical psychologists in the UK. Introductory supervisor training sessions in Manchester ask individuals to identify unhelpful personal experiences of being supervised. The ease with which participants can complete this exercise suggests that Blocher's remarks may not be too exaggerated.

The general view in the literature is of training being able to provide supervisors with the different skills necessary for the task, irrespective of the different supervision models (see Chapters 2 and 3).

Training provides supervisors with a grounding in the particular skills and duties involved in supervision. It can build confidence, promote enthusiasm for the task of supervising, provide skills for supervision that are additional to therapeutic clinical skills, and rid supervision of the worst forms of bad practice. Across the different models of supervision, there appears to be agreement about the importance of the relationship within supervision. Training in this area thus seems very important, and the content of training for supervisors can benefit from considering the research carried out into the supervisee's experience of supervision. The prominence given to elements of the supervisory relationship is congruent with comments made elsewhere in this volume by Beinart, Wheeler, and Matthews and Treacher.

The content of supervisor training

The survey demonstrates that the majority of clinical psychology training programmes organize training for psychologists who supervise trainees from their programmes. It is unclear, however, how the content of supervisor training has been developed, and whether it is designed explicitly to meet the tasks of supervision. There is little evidence for clinical psychology having a particular model of supervision (cf. BPS guidance referred to in [Chapter 1](#)), and this absence may have led to a more pragmatic and idiosyncratic content developing.

While this survey provides data about the content and organization of supervisor training, it fails to convey much of the detail. There are a limited number of published examples of training workshops (e.g. Alien and Brazier, 1996; Milne and Howard, 2000).

The survey data do suggest that there is a shared view about the core issues for supervision training, and therefore by extension for what constitutes effective supervisory skills, although this will reflect to some degree clinical training programmes' sharing of experience. The most prevalent training provides supervisors with an introduction to the tasks of supervision and to the particular requirements of that clinical psychology training programme. In view of the very real importance of the *evaluative* function of the supervisor this 'administrative' training is crucially important. In light of the earlier comments concerning different theoretical models of supervision it is interesting to read that this is the second most frequent area of content in training. The importance to supervisors and to training programmes, of correctly evaluating performance, and the necessity of professional gatekeeping tasks is shown in the third most frequent training content. The increasing recognition of societal factors in all aspects of clinical psychology practice is demonstrated by the organization of training for supervisors in issues of 'race', culture and gender. A simple, if slight majority, of

training programmes organize such training. This issue is discussed later in Chapters 7 and 8.

These data (what is currently provided) have much in common with those discussed in Green's Chapter 6 (what it is desirable to provide). A question remains about the relevance of both of these to the tasks of supervision. Milne and James (2002) argue that research is able to help determine relevant content for the training of clinical psychology supervisors. The training should help supervisors to facilitate supervisees in experiential learning (Kolb, 1984). Taken together this information could help the CTCP to provide more detail about supervisor training in future revisions of the accreditation criteria. An implication of this might be that the profession of clinical psychology should recommend or require that supervisors be trained to competence in a specified content.

The general literature on supervision discusses the issues that training should include and is referred to by Wheeler in an earlier chapter. It is acknowledged (e.g. Lawton and Feltham, 2000) that there remains a lack of detail about the practice of supervision even in these other professions with reportedly more advanced considerations of supervision. One outcome can be the compilation of large lists of content areas, and in clinical psychology the increased emphasis on the development of competencies might be matched by a similar development of the competencies of supervisors. Clarkson and Gilbert (1991), for instance, have compiled a list of 17 topics 'essential to supervisor training'. Carroll (1996) describes six elements of a 'model curriculum' for counsellor supervisor training. Some of these are common to the supervisor training programmes surveyed here:

- 1 Knowledge of supervision including different models.
- 2 Reviewing issues to do with power, including gender.
- 3 Isolating and practising supervision skills.
- 4 Understanding and implementing tasks of supervision.
- 5 Being supervised for supervision.
- 6 Knowledge of the stages that supervisors go through.

How much can clinical psychology learn about training content from other professions? (It may be sensible to limit our focus to professions in the UK, although North American literature describes a richly varied picture of the practice and content of training provided for supervisors.) There is not a clear answer to this question. Although other professions have introduced standards for the training of supervisors the content and practice in such training is not always clear. In the UK the British Association for Counselling and Psychotherapy (BACP) has requirements for 'supervisors to engage in specific training in the development of supervision skills', and its ethical codes have consistently emphasized the importance of training in supervision-relevant practice.

In nursing, the requirement for clinical supervision was formally introduced in 1992 and expanded in 1996. The UKCC wrote a position paper that identified six statements to assist the development of clinical supervision at local levels. Education for supervisors is identified within these statements. Although not a statutory requirement (unlike for midwives) supervision for nurses is recommended.

It is very important that issues of diversity are being attended to within supervisor training (see Chapters 7 and 8). These reflect the explicit moves in the profession as a whole to embrace these issues (e.g. Patel *et al.*, 2000). The data from the survey stand up well to Carroll's critique (1996) of the lack of emphasis on culture and diversity in recent UK (counselling) texts on supervision.

The general literature often talks of supervision and training in broad terms. Is the training for post-qualification supervisors the same as that for supervisors of people who are completing their qualification into the profession? It can be argued that there are real differences—in the evaluative component for example. A further complication is presented if inter-professional supervision is considered. Many clinical psychologists supervise members of other professions or receive supervision from them in their general clinical practice. Are these requirements different to those of supervising trainee (or even qualified) clinical psychologists, and if so, how? Are we talking of generic or particular skills in supervision?

Within the clinical psychology training organizations, experiential and reflective models of learning such as that developed by Kolb (1984) are often utilized. Milne and James describe using experiential learning within supervision and their assessment of the effectiveness of training a supervisor to 'move...(a learner)...around the experiential learning cycle' (2002:59). It is not possible from this survey to know how general is such an attempt to develop supervisor training within this model of learning

*Developing standards and the accreditation of training for
supervisors*

How should training for supervisors be evaluated? Should the profession set standards for the training of supervisors? What is the relationship between the content of training and these standards? Should training be linked to a form of accreditation by which the quality can be controlled?

Although it is often presumed that different training programmes reflect the different therapeutic models within clinical psychology, there is little evidence of this from the survey of the content of supervisor training. This would indicate that it may be less difficult to identify a common core of content for the training of supervisors. By extension it may be possible to develop some standards for the training and the subsequent performance of supervisors.

Despite the apparent homogeneity in the content of supervisor training, it is not clear whether there is agreement about the skills required of a supervisor.

The more pragmatic approach referred to above may enable clinical psychology to sidestep some of the discussions about model-specific standards. Concerns about a lack of theory can be assuaged by reference to developments within experiential learning (e.g. Milne and James, 1999, 2002) and cognitive-behavioural psychotherapy.

Examination of the general literature suggests that it is possible to draw on this in developing standards, although attention also needs to be given to any particular requirements of clinical psychologists. An example of difference in emphasis is the supervisory relationship. Considered crucial in much of the literature, in training clinical psychologist supervisors it is considered more obliquely; for example, in training about managing dilemmas and challenges in supervision (see Tables 5.1 and 5.2). In Manchester, for example, supervisor training also draws on developmental models of supervision because there is recognition of the different demands in supervision of neophyte and third year trainee clinical psychologists. Drawing on different models in this way would also have the benefit of not discomfiting any particular constituencies within the profession, and introducing possibly unhelpful allegiances to a particular training programme.

In developing standards for training of supervisors and the resulting supervisory activity it will be helpful to retain a sense of what is 'good enough' in practice. Kadushin (1992) has commented that supervision is about 'motivating towards excellence' rather than 'merely protecting against incompetence', and Wheeler, earlier in this book, referred to the difference between 'bad' and 'harmful' supervision.

The development of standards for supervisor training leads logically towards a discussion of accreditation, either of supervisory practice or supervisor training, although it is clearly preferable for the two to be related.

Accreditation of supervisors has been under discussion in recent years for a number of reasons. First, it is seen as an element of professional governance and a means of assuring the quality of supervision within clinical training. Second, within discussions about increasing the number of available training placements, the introduction of accreditation (for individual supervisors, or for supervising departments) has been seen considered as an incentive to increase clinicians' commitment to supervising trainees. Third, it is suggested that a commitment to supervision could constitute a legitimate CPD activity, thus providing mutual benefits to individuals and their profession.

As stated earlier, from the survey, only one training programme uses accreditation, and that is linked to attendance at training events. It would be useful to know more about this experience from both the point of view of the programme and from the supervisors involved.

CPD may play a critical role in linking up these different professional activities. Some of the competing pressures on clinicians' time, the requirement for clinical governance, and establishing a linkage between supervisory and

clinical practice could be assured through supervision and supervisor training being established as legitimate activities to be assessed through CPD.

These issues are discussed further in [Chapter 11](#).

In Manchester, clinical psychology supervisors often talk of a need for supervision for supervisors. As an informal method of upholding quality and sharing learning this arrangement may have much to offer. Consideration should be given to ‘surgeries’ at which a member of the programme team examines issues that have arisen in supervision, and the form of specific consultancy described by Milne and James (2002).

It is hoped that the enhancement of supervisory skills will have generalized effects on the therapeutic practice of supervisors. In this way supervisor training can facilitate the introduction of the governance-based measures discussed earlier. Whilst there is a *prima facie* case for this (improvements in, for example, skills of listening, reflecting, evaluating, giving clear feedback are consistent with professional practice), there is a lack of empirical support.

Currently, supervisors generally welcome training, although participation and attendance is voluntary. A minority of supervisors do not attend even when given particular invitations from programme staff. Some of these individuals may not supervise on a regular basis; others may be regular supervisors; occasionally they may be senior, regular supervisors. Linking supervisory activity to CPD is likely to have a significant effect on the attendance at supervisor training, is likely to change significantly if accreditation is linked to supervisory status, and if supervising is, in turn, linked to promotion and CPD.

Different clinical training programmes reflect different emphases in professional practice (for example, on therapeutic models). Although there has been a concern that supervisors who offer placements to more than one programme may experience problems in working across the ‘cultures’ of different training programmes, there is no evidence to support this—nor that the training of supervisors differs significantly in different programmes. Rather, supervisors have reported frustrations with the different assessment protocols than with varying demands within the supervisory process.

The profession may be only a short distance from a position where supervisor training can be clearly linked to an explicit form of quality control via clear standards, and possibly through accreditation. For that to occur there would need to be clear statements about the exact purposes and objectives for supervisor training, and its content, along with an agreed form of evaluation of its effectiveness. This could be organized within the general accreditation exercise that clinical psychology training programmes undergo, or within the educational establishment that hosts the training programme, although there remains the issue of whose responsibility it is for accreditation.

Organizing and providing supervisor training

All this is consistent with increased importance for supervisor training. Any move from voluntary to mandatory will have implications for resources. At present, the majority of training is delivered by (pre-qualification) training programmes, using programme staff mainly and free of charge to those attending, although most programmes have no dedicated budget for this activity. Any move towards accreditation, or any form of training linked to identified standards, has financial and organizational implications for clinical training programmes.

Reference was made earlier for supervisors' request for their own supervision of their own supervisory skills. Milne and James (2002) have described the benefits of a consultancy model for the quality of supervision and its maintenance. Establishing these will have implications for the clinical training programmes.

Would accreditation be transferable? If awarded by a training programme in the south of England would its legitimacy extend to Scotland? Or, if awarded by a training programme with a reputation of strength in cognitive-behavioural therapy would the supervisors' accreditation still hold after a move to a region where the training programmes had an explicit emphasis on person-centred therapy? One answer to this, of course, is a nationally administered accreditation. An additional advantage could be that the resource implications are then transferred from training programmes to the profession.

The issue of the *costing* of supervisor training will increase in importance as numbers increase and supervisor training becomes more established. If supervisor training is to be linked with CPD and clinical governance then the financial provision may need to be more formalized within the profession or the Health Service. There are parallels with the issue of whose responsibility it is to seek and provide training placements (see [Chapter 4](#)).

Evaluation

All of the above is based on the assumption that training has a beneficial effect on supervision. Notice the noun *supervision*; there are different views within the literature as to what should be the demonstrable results of supervisor training. A clearly logical model suggests (rather like the staff training models of the 1980s) that supervisor training will only be effective if demonstrable change can be identified in *both* supervisee performance and in the outcome of the therapy carried out by the supervisee.

Is this increased attention to supervisor training effective? An answer should consider two issues. First, is the training of supervisors able to improve their performance and make supervision more effective? Second, is supervision *per se* effective in enabling beneficial change in supervisee behaviour and in client outcome? The literature suggests that there is evidence for the former, though less for the latter (see [Chapter 6](#)). No one doubts the complexities inherent in

evaluating supervision, given the many different characteristics of the supervisory dyad alone (Wampold and Holloway, 1997). Holloway (1997) concludes that there is little research that examines client change as an outcome of the supervision process. In general, although there is research that demonstrates the effects of training and supervision on the development of particular skills relevant to therapy, there is less evidence for overall effects.

Clinical psychologists in the UK (e.g. Milne and James, 1999, 2002) have reviewed the research into the effectiveness of supervision. They conclude that an evidence base for clinical supervision that can be used to promote good practice does exist. They have argued that research on supervision within counselling and psychotherapy has lacked empiricism, and that clinical psychology approaches research differently. Milne and James argue that learning and changes in supervisee behaviour can be legitimate goals of supervisor training and that an insistence on seeing therapeutic changes as well can place an unjustifiable demand on research that paradoxically makes it almost impossible to carry out because of the numerous variables that would have to be controlled. In their research various measures were used to evaluate training.

In practice the situation is rather different. From the survey it is clear that the forms of evaluation used by trainers are quite limited. Although more useful evaluation would require resources beyond those available to programme teams, it is important that more research into supervisor training is carried out.

It is noticeable that supervisor training appears to be positively welcomed by supervisors, particularly by individuals who have qualified recently. This finding is reinforced in Green's report ([Chapter 6](#)). Attendance figures are high in general, and in Manchester only two workshops in six years have had to be cancelled because of inadequate interest. This finding offers a more optimistic view of supervisors' perceptions of training than that of others in the literature (e.g. Bernard and Goodyear, 1998).

In the light of this generally favourable view of supervisor training in clinical psychology, combined with the fact that individuals are now eligible to supervise trainees one year after qualification rather than two years (which was the previous requirement), it is appropriate that more attention is devoted to using supervision in pre-qualification teaching (as recommended in [Chapter 4](#)). It is noticeable that a number of programmes organize training in supervision for supervisors and supervisees together. Clinical psychology programmes generally teach trainees to play an active role in the supervision process (for instance via negotiating placement contracts). Hitchen *et al.* (1997) describe an innovative workshop for Oxfordshire clinical psychology supervisors put on by supervisees. Despite this it is interesting to ponder Carroll's remark below, especially given the finding from the survey that clinical psychology trainees' views about the effectiveness of supervisor training are not sought generally:

It would seem that supervisees are passive *vis-à-vis* supervision, have few expectations from which to negotiate with supervisors, and are prepared to 'fall in' with supervisor ways of setting up and engaging in supervision.

(Carroll, 1996:92)

Conclusions

If we return to the remarks quoted at the beginning of this chapter how do we assess them with regard to clinical psychology in the UK? On balance, it is difficult to deny the situation described by Edwards because there are many active supervisors who have not received any specific training in supervisory skills, and because there is a paucity of data about current practice with which to discuss variability. For a number of reasons discussed earlier this situation is changing and will continue to do so in the near future. Laing's remarks will remind us that training is only a start to change in practice and no guarantor of it. As psychologists we need to learn from the extensive literature on behaviour change, and its maintenance, if supervisor training is to have its intended effect.

Clinical psychology is a rapidly developing profession in the UK. Prequalification training involves spending at least 50 per cent of the training period learning clinical skills on placement and receiving supervision from a qualified practitioner.

Until recently little attention has been paid, in general, to the tasks and skills of these supervisors. Previously an apprenticeship model was used that had developed largely independently of the supervisory developments in related professions such as counselling and psychotherapy.

Possible reasons for this include a lack of attention to the therapeutic relationship and process, and an emphasis on more 'technical' therapeutic skills. In the wider supervisory literature debate continues as to whether there needs to be congruence between supervisory style and therapeutic approach (e.g. Kadushin, 1992; Lawton and Feltham, 2000). In clinical psychology, any such agnosticism to the importance of supervisory processes may have been underlined by the lack of consensus on the definition of supervision and the array of different models of supervision (e.g. the estimated 25 different developmental models alone; Carroll, 1996). An additional, contributory factor may have been that the emphasis on a scientist-practitioner model within clinical psychology rendered it difficult to assimilate some of the complexities of supervision.

There have been significant changes in many aspects of clinical psychology training in the last decade and more attention is now being directed at supervision, although this improvement may not be generalized and many clinical psychology supervisors may have received no specific training (see [Chapter 10](#)). Some of the factors associated with this include increased training numbers to accommodate the expansion of the profession, an emphasis on clinical governance, and continuing professional development. Alongside this change it is noticeable that the majority of research and literature concerning

supervision derives from psychoanalysis, counselling or social work. There is a smaller, but growing, literature about clinical psychology.

The survey of UK clinical psychology training programmes reported in this chapter provides useful data about the state of supervisor training. Training is being provided on an increasingly systematic basis within an enactive framework. There is a good uptake of training by supervisors generally, although there may remain exceptions in the absence of accreditation status for supervisors.

Programme team members deliver most of the training and are well placed to do so, but would probably benefit from using the research literature to develop the most effective training and to evaluate this. Professional developments are likely to lead to the development and sharing of highquality training materials, and the relevant professional body (the Group of Trainers in Clinical Psychology) has an active interest in these areas combined with an active spirit of co-operative enquiry. So, although it is not clear whether there exists a uniform view about the tasks and process of supervision, there is a sharing of knowledge and developments across training programmes. Whilst this might exaggerate the impression of an agreed model for training, and there is very little about this in the accreditation criteria, there appears to be a common core of issues that are deemed important for supervisor training.

It would appear that some if not most of the content of supervisor training originates in work from counselling and other disciplines. Indeed, very little has been written about supervision from the perspective of functional analysis or cognitive-behavioural therapy (Liese and Beck, 1997; Padesky, 1996; Liese and Alford, 1998; Ricketts and Donohoe, 2000). Since cognitivebehavioural therapy is a popular theoretical model within UK clinical psychology currently, this lends support for the view that supervisory models are generalizable (Holloway, 1997), and that there need not be a contradiction between supervisory and therapeutic practices. Since studies have reported that supervisors will adopt their preferred clinical approach in supervision, the important component of supervisor training may be that to do with making the learning processes most effective.

With reference to counselling in the UK Carroll makes the claim,

The various codes of ethics for supervisors emphasise the need for supervisors to be alert to their own competency and involved in their ongoing training. This training is fast becoming a requirement for supervisors, rather than an optional extra. The days of inheriting the supervisory mantle, and requiring no initial and ongoing training in supervision, are disappearing.

(Carroll, 1996:159)

It is clear that this description may also describe clinical psychology in the UK in the first years of the twenty-first century.

What this survey does not tell us of course is much about the actual practice of supervision in clinical psychology in the UK. That research remains to be carried out. Other areas to research include the content of training, the effectiveness of training and whether training can generalize to supervisors' therapy skills. It will be interesting to investigate further whether there is a benefit in developing a cognitive-behavioural approach to both supervisor training and to supervision, and whether congruence between supervision and therapeutic models is beneficial. However, in light of the discussion of the training offered to supervisors it is hoped that the practice is effective and coherent, and yet able to accommodate differences in formulation and intervention.

Finally, the profession should use these data to develop guidance about the training of clinical psychology supervisors. It seems likely that such training will be the responsibility of clinical psychology training programmes based in universities. Development of supervisor training will benefit from further research. The degree to which learning from other professional contexts can be utilized will need evaluation. The links between supervisor training, accreditation and CPD, and the extension of training for entry to the profession to post-qualification responsibilities will need to be carefully considered, and programme teams will need the resources and confidence of the profession to carry this out.

Chapter 6

Organizing and evaluating supervisor training

David Green

Introduction

Supervision in the mental health professions is an expanding market. Therapists are increasingly expected to seek out some systematic oversight of their work as a hallmark of good practice. Those searching for a reliable supervisor to take on this critical role would be well advised to shop carefully. The wrong choice could prove expensive or worse. When faced with important decisions of this order most of us cautious consumers might like to check out the qualifications of the several potential providers that people this particular marketplace. Where was she educated? What psycho therapeutic training has he received? With what professional associations is she registered? And so on. Sooner or later we should also be asking the question which is the focus of this chapter. What specific preparation for the task of clinical supervision has he undertaken? In all probability the honest answer is likely to be remarkably little. A brief historical overview may perhaps explain how this surprising state of affairs has come to pass.

History of supervisor training

In the final chapter of *The Handbook of Psychotherapy Supervision*, the magnum opus which he edited in 1997, Watkins (1997a) expressed open puzzlement at the sorry lack of recognition of the importance of supervisor training in the available research literature in the field. Trainee psychotherapists are expensively and intensively trained. A core plank of their education is the monitoring and guiding of performance that is provided by their clinical supervisors. But these supervisors themselves typically receive little or no training in how to supervise. As Watkins candidly observed: ‘Something does not compute.’

On reflection this apparently illogical commitment of resources makes some sense if seen in a historical context. The practice of psychological therapy has been given a rough ride by its critics. Eysenck (1952) famously asked whether the passage of time might be as effective a healer as an

experienced psychotherapist in treating emotional disturbance, and triggered an immense investment in large-scale scientific outcome research. This battle could not be postponed. 'But does it work?' is a question that cannot be ducked. The emphasis on the efficacy of our collective product (i.e. the brand of therapy) has been at the cost of chronic inattention having been paid to the efficiency of our means of production (i.e. the 'traditional' structures of professional training). Many of our assumptions about what are the essential ingredients in the peculiar broth that we feed novice therapists remain gloriously untested (Alberts and Edelstein, 1990; Binder, 1993; Stein and Lambert, 1995). Could it be that our faith in the centrality of clinical supervision is no more than a widely held psychologists' myth (Bickman, 1999)?

There are certainly good intellectual reasons for doubting another prevalent lazy assumption—namely, that 'good therapists automatically make good supervisors', so investing in further training is a waste of everyone's time and effort. Just let them get on with it... There is an allied line of argument that accompanies this assertion. Psychological therapies are founded on well-articulated and researched theories of how to help human beings change and grow. This hard-won expertise should surely be made available to a psychologist's students as well as her patients. There is some merit in these arguments. One mechanism whereby professional skills and standards are passed from one generation to the next is undoubtedly modelling (Bandura, 1965). Trainees respect, identify with, and ultimately copy the ways of supervisors whose work they admire. Conversely it is very hard for a supervisor to be taken seriously as a constructive critic of another's performance if they themselves do not 'cut the mustard' in the therapy room (D.R.Green, 1998).

It would also be a poor comment on our faith in the benefits of psychotherapy if we were only prepared to apply our psychological models to other people's problems but refuse to see their reflexive possibilities in better understanding ourselves. There are transferable skills that the able therapist can surely use in supervision (rapport building, empathic listening, summarizing, and so forth), but their effective application demands that he does not confuse the different goals of supervision and psychotherapy. Micro-analytic research has also indicated that clinicians tend to hold significantly different conversations with their supervisees from those they have with their patients (Holloway, 1995). Supervisor training can and should alert new supervisors to the dissimilarities as well as the similarities between psychological treatment and clinical supervision.

It would be easier to persuade sceptics that educational theory was a sounder basis for the practice of clinical supervision than psychotherapeutic models of change if the research evidence supporting its application were more convincing. Unfortunately, though there is a substantial amount of published work on the practice of clinical supervision its quality has rarely matched its quantity (Ellis and Ladany, 1997). When Ellis and his colleagues reviewed 12 years of published empirical studies in clinical supervision from 1981 to 1993 and evaluated them against a series of established scientific criteria that could

threaten the validity of each experiment's findings, they were palpably unimpressed by the results (Ellis *et al.*, 1996). They concluded that the vast majority of published research that they had analysed failed to meet necessarily rigorous academic standards. Subsequently the authors concluded that there currently exists no worthwhile scientific evidence base on which the assiduous supervisor could found her practice. By the same token those presuming to train supervisors for their role cannot point to an established body of empirical knowledge to support their educational programming. If we cannot say with confidence what works in supervision, how dare we imagine we know how to prepare clinical supervisors for their responsibilities?

While other researchers (Milne and James, 2000) have found more encouragement in the available literature than Ellis and his colleagues, there remain substantial obstacles to a truly evidence-based curriculum for supervisor training. 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. This is the whole point of the exercise. However, the number of causal links and intervening variables that must be accounted for in testing this hypothesis is formidable. We would expect the clinical outcome of any psychological intervention to be affected by factors such as the personal characteristics of the therapist; the nature of the problem for which the client has sought help; the brand of therapy employed; the setting within which the work was conducted; extra-therapeutic life events; and so on. Unsurprisingly, therefore, no published research yet appears to have established a secure relationship between supervisor conduct and patient outcome (Holloway and Neufeldt, 1995). What chance, then, of adding yet another link to this lengthy causal chain by asking what form of specialist training would best equip the supervisor to set in train the beneficial sequence of events that would result in life getting better for the client/consumer at the end of the line? Furthermore, there are problems for any UK clinical psychologists who might wish to draw even tentative clues for good practice from the extant body of research evidence on clinical supervision for it is overwhelmingly American and conducted with counsellors, counselling psychologists and psychotherapists. Differences in professional training structures, as well as in service delivery systems, mean that we should be tentative about generalizing findings from even the best-conducted studies across very varying contexts (Carroll, 1988).

This fleeting review goes some way to explaining why supervisor training appears to have been largely overlooked as both a professional development activity and a research enterprise. It is evidently not going to be straightforward either to design a credible training programme for supervisors or to evaluate its effectiveness. Why bother?

Rationale for supervisor training

The primary justification for formalizing supervisor training lies not in its scientific foundations but in the pivotal role supervision plays in the scrutiny of trainees' evolving clinical competence. Clinical supervision is the means by which trainee clinical psychologists gain the practical skills required to deliver the therapeutic service for which most will subsequently be employed. They can learn 'about' psychotherapeutic theory and research findings in university lecture theatres and libraries (so called 'declarative knowledge'). However, the capacity to translate this book-based wisdom into effective practice requires a well-developed sense of 'how' and 'when' to intervene during a therapeutic session that requires 'procedural' and 'conditional' knowledge. These skills are acquired through experiential learning that cannot just involve exposure to more and more hapless clients until our trainee finally somehow gets the hang of it. Clinical supervisors have a responsibility to both supervisees and their patients to ensure that this educational venture proceeds as efficiently and safely as possible. Clinical work must be planned. Therapeutic sessions need to be systematically reviewed, for it is this process of considered reflection that transforms exposure into meaningful experience (Boud, 1985). Sometimes crises will have to be managed. Finally the clinical supervisor plays a crucial professional gatekeeping role in determining whether supervisees are safe to practise. Of course it is possible to fail a clinical psychology training programme on academic grounds by, for example, submitting a sub-standard research thesis. However, it is clinical supervisors alone who directly sample the quality of the face-to-face contacts that trainees have with clients. Indeed, any direct access to a novice therapist's work with clients is likely to be infrequent as we continue to rely heavily (and some would say naively) on the supervisee's self-report in clinical supervision. When qualified clinical psychologists are professionally reprimanded it is rarely because of their inadequate essay technique. In the hierarchy of competences of our profession appropriate and effective care of patients should surely top the list. Clinical supervisors are pivotal members of the training community who must both energetically promote best practice and maintain safe professional standards. Can we seriously argue that clinical psychologists do not need to be properly prepared for this essential role? Quite how they should be prepared is another question entirely.

The content of supervisor training

In the UK clinical psychology training programmes have been obliged since 1989 to provide some form of supervisor training as a condition of their continued accreditation by the British Psychological Society. However, these conditions do not stipulate either the minimum dosage or the curriculum that should be followed. Nonetheless even this level of professional guidance is more stringent than that applying to contemporary US clinical psychology training

programmes (Knapp and Vandecreek, 1997). As a consequence the British training community has considerable collective experience in organizing educational modules for clinical psychologists who are about to take on supervisory responsibilities for the first time. Typically, the consumers of this training are recently qualified clinicians who are just becoming eligible for the supervisor role. Is there a way of distilling the understanding that has been acquired through the development of these modules so that a consensus on good practice might be achieved?

The movement towards competence-based training in the health professions has prompted a number of researchers to experiment with novel ways of investigating what exactly a capable clinical psychologist, speech therapist, dietician, etc. should be able to do (Caves, 1988). A popular vehicle for dissecting a large body of opinion is the 'Delphi approach' (Clayton, 1997; Stonefish and Busby, 1996). This methodology aims to consult the views of a representative panel of judges who are considered expert in a given field. It seeks to promote consensus decision-taking in two ways. Firstly, the technique involves an iterative sequence of consultations through which panel members receive written feedback, not only on their own views but also on those of all their fellow judges. Having digested this information, each panel member is invited to reconsider his or her opinion. Secondly, the Delphi process is traditionally organized using postal questionnaires. It has hence been characterized as 'how to hold a meeting with no one there'. Even if it were possible to gather hordes of experts together in a single room the developers of the Delphi approach reckoned that the resulting large group dynamics would be inimical to reflective participatory discussion. On the contrary they predicted that some voices would be dominant while others might be scarcely heard. They also feared that public debate might entrench opposing views rather than promote the gradual emergence of an agreed group position which consensus policy-making requires. Although Delphi methodology was initially developed by the US defence industry as a predictive tool, it has subsequently found ready application in the field of professional education (Green and Gledhill, 1993; Williams and Webb, 1994; White and Russell, 1995). The approach therefore might enable us to satisfy our curiosity about the collective opinion of those currently running supervisor training modules for UK clinical psychologists.

The Delphi survey

While fuller descriptions of the Delphi technique are available elsewhere for the interested reader to consult (Jones and Hunter, 1995), the simple mechanics of this particular experiment warrant a brief explanation. The goal of the project was to see if an adequate consensus on the most useful format for the basic training of clinical supervisors in clinical psychology could be constructed. The panel of 50 'experts' represented the primary stakeholders in the professional training of clinical psychologists in the UK: ten clinical tutors (who routinely

organized placement rotas and supervisor training modules); ten programme directors (who had ultimate oversight of the postgraduate clinical training programmes); ten heads of department (who both employed the would-be supervisors and routinely recruited newly qualified clinical psychologists into the NHS workforce); ten experienced supervisors (who had all been providing placements for their local university training course for a minimum of five years); and finally ten novice supervisors (who were attending an introductory series of supervisor training workshops and so offered a consumers' perspective). The task set for this august set of judges was to complete a postal questionnaire by rating the importance of 45 potential elements of a basic training package for new clinical supervisors on a seven-point scale, and whenever possible write a few words to explain their thinking. The 45 items had been culled from a range of relevant sources such as professional guidelines, the curricula of specialist diploma courses in clinical supervision, and published research papers. This constituted Round One of the Delphi procedure. For Round Two panel members received both quantitative and qualitative feedback on the full range of replies given to each item during Round One. They were then asked to re-rate the initial 45 items, plus offer their opinions on five further items added as a result of Round One recommendations. All 50 of the panel completed Round One and 47 managed to last through to the end of Round Two!

The full results of this survey are available from the author, but a few essential 'headline findings' will suffice for the purposes of this chapter. Firstly, the consensus building claims of the Delphi methodology received some support. In Round Two the variance of replies was significantly less than in Round One for 26 of the 45 items. Of the remaining 19 items, 18 showed no significant difference and on one item Round Two variance was higher than in Round One. Of more practical import, the second round of consultation served to remove some troubling inter-group disagreements that emerged in the analysis of Round One replies. At this stage the novice supervisors appeared out of kilter with their more senior colleagues. Analysis of variance showed they had rated nine items as significantly less important than any of the other subgroups of judges. This pattern of scores suggested a possible mismatch between what our youthful consumers wanted from a supervisor training module and what their 'elders and betters' thought they needed! However, all these significant inter-group differences of opinion disappeared after the analysis of the Round Two questionnaires.

Overall the results of this consultative exercise indicated that there may well be a working consensus on a standard curriculum for the basic training needs of new supervisors in clinical psychology. In Round Two the mean score of the lowest rated item was 4.58 on a seven-point scale, so there was nothing here that could be classified as unimportant or irrelevant. However, even in this top-heavy distribution of scores a definite sense of priority could be detected. The most valued component was 'considering when and how to fail a placement' with a mean rating of 6.76. The next three most important elements were 'legal

responsibilities of supervisors' (6.54), 'the need to ensure that the supervisee's client receives appropriate care' (6.52) and 'how to negotiate a placement contract' (6.52). The message here seems to be that novice supervisors need to be ethically sensitive and procedurally well-informed (Russell and Petrie, 1994) before assuming their new responsibilities. The lowest-rated items provide an intriguing insight into what is unlikely to get new supervisors excited. 'Bottom of the Pops' was 'require that supervisor provide audio or video recordings of actual supervision sessions' with a mean score of 4.58. This lack of enthusiasm for systematic scrutiny of the supervisor's own performance was echoed in the third-lowest scoring item 'provide formal supervision for the trainee supervisors' (4.94). The other undervalued components falling in the bottom four of the elements surveyed were 'the use of non-traditional formats, e.g. group, peer' (4.72) and 'providing specific instructions for trainees' (4.96). At first sight the identification of these possible elements of supervisor training as relatively unimportant is somewhat worrying. Unless a serious effort is made to ensure that lessons learned on training ventures are transferred into everyday practice, any commitment to continued professional development in health care can easily be presented as a waste of scarce resources (Davis *et al.*, 1992). Education should make a noticeable difference. However, an alternative interpretation of these results is that the panel members have a keen understanding of the anxieties and priorities of novice supervisors. They have articulated a 'hierarchy of need' (Maslow, 1943) in which safe practice and professional survival assume immediate prominence. Perhaps new supervisors will not be ready to seek out external feedback or experiment with a range of supervisory approaches until they have established a necessary level of role security. It is not therefore a question of irrelevance as much as one of timing—an argument made in a number of qualitative comments suggesting that some educational initiatives would be more appropriate for experienced rather than novice supervisors. We shall return later to the theme of the continued training needs of experienced clinical supervisors.

Evaluating supervisor training modules

If the promise suggested by our Delphi survey were to be translated into a more standardized set of guidelines for those organizing basic supervisor training modules, this would not, of itself, guarantee any improvement in the manner in which novice supervisors go about their task. Continued professional development is not an act of faith. The outcomes of CPD programmes need to be carefully monitored. As indicated in the introductory literature review, it will be beyond the capacity of module organizers to trace the impact of their efforts right through to possible symptomatic improvements in clients seen by the supervisees of those attending supervisor training workshops. How far can we reasonably expect responsible educators to travel along this causal chain (Holloway, 1984)?

Most current courses probably elicit ‘how was it for you?’ consumer satisfaction feedback from module attenders. This approach has its merits because introductory training courses for clinical supervisors are likely to be repeated at regular intervals and their character can be shaped by user preferences (for example employing more small group discussion rather than a formal lecture format). Be warned, however, that the road to hell is paved with clinical psychology training programme organizers desperately trying to placate last year’s students! A more serious concern about relying on consumer satisfaction measures to evaluate the effectiveness of these CPD modules is their failure to investigate what supervisors have learned from their study and whether any new learning will find ready application in their day-to-day working lives. It is these kinds of questions that the systematic evaluation of ‘learning outcomes’ tries to answer (Shillitoe *et al.*, 2002).

What sort of a difference should effective supervisor training make? Certainly we would anticipate some changes in attitude—for example, novice supervisors should feel a little more confident in their new role. They should probably have acquired some fresh factual knowledge such as an understanding of the protocol for mid-placement visits. Finally we would hope that they might actually behave differently—for example, by putting into practice their good intentions to safeguard supervision slots against competing clinical priorities. Evaluation strategies can be developed to monitor each of these categories of learning outcome.

Psychologists have traditionally used a simple scaling technique termed the ‘semantic differential’ (Osgood *et al.*, 1957) to track shifts in their patients’ attitudes. Why not use similar methods on each other? For example, the following statement could be rated on a seven-point scale from totally disagree (1) to totally agree (7):

It is imperative that supervisors complete all course paperwork thoroughly and on time

This measure could be taken at the beginning and end of a training module for supervisors, and would test whether opinions had shifted on this issue during the course of the workshop.

The brief review of the extant research literature in the field of clinical supervision might suggest that there may not be much strictly factual knowledge to convey to would-be supervisors. However, there are some aspects of the supervisor’s role for which accurate information is crucial; for example, regarding the legal responsibilities of the supervisor. Multiple choice questionnaires (MCQs) can be a useful way to check factual knowledge, especially if questions developed for one cohort of learners can be repeated with subsequent classes (Lowe, 1991). Formats vary and the approach lends itself easily to computer marking and feedback where appropriate. An example of a

multiple-choice question that might grab the attention of our fellow psychologists is:

The proportion of US graduate students in psychology who have had some form of sexual relationship with one of their professional educators has been estimated as:

- (a) <5 per cent
- (b) between 5 per cent and 10 per cent
- (c) between 10 per cent and 15 per cent
- (d) between 15 per cent and 20 per cent
- (e) >20 per cent

According to Glaser and Thorpe (1986) the figure is 17 per cent so (d) is the correct answer. In fact, earlier US research (Pope *et al.*, 1979) reported that 1 in 4 women who received their doctoral degree in psychology had had past sexual contact with a supervisor.

The ultimate effectiveness of supervisor training modules depends on the lessons learned in the rarified atmosphere of a specialist workshop being transferred to the much messier and demanding setting of 'NHS world'. Although the Delphi survey suggested new supervisors might not be enthusiastic about having their practice closely scrutinized, some can be persuaded to opt into a voluntary scheme that monitors their performance during placements (Green, 1997). This arrangement suits the use of goalattainment scaling (GAS) as a means of checking whether supervisors can meet their own individually determined expectations. GAS has been employed in a range of therapeutic settings (Kiresuk *et al.*, 1994), but has also worked well in an educational context in general and the field of clinical supervision in particular (Green and Sherrard, 1999). The approach asks the individual to specify broadly what she wishes to achieve and then decide for herself what would constitute a reasonable outcome of her efforts. Once this performance indicator has been operationally defined, she must determine what would constitute both 'better than' and 'worse than' expected outcomes. So, for example, a novice supervisor might construct the goal-attainment scale indicated in [Table 6.1](#) to map her intentions of establishing a negotiated placement contract with the trainee clinical psychologist whom she will be supervising on a forthcoming placement.

Table 6.1 Goals to be achieved within two weeks of start of placement

+2	much better than expected outcome	Full written contract negotiated with trainee meeting all placement guidelines and trainee preferences
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+1	better than expected outcome	Full written contract that incorporates some of the trainee's preferences
0	expected outcome	Placement contract agreed and written up in note form; meets most placement guidelines
-1	worse than expected outcome	Verbal contract only; trainee knows what to expect from this placement
-2	much worse than expected outcome	Haven't got round to any sort of contractual discussions

The experienced supervisor

In 2000 81 per cent of trainees entering training in clinical psychology within the UK were less than 29 years old. With luck, therefore, the average qualified practitioner will be able to offer some 30 years of service to the Health Service. Our discussion thus far has centred on the training needs of new supervisors, the bulk of whom will probably have been working as autonomous professionals for only a couple of years. Even if the introductory module that we have envisaged becomes increasingly well standardized and evaluated in the future, it is doubtful whether an improved initial programme of supervisor training could serve as an effective 'once and forever' preparation (like the UK driving test). Part of the argument for regular updating of senior clinical supervisors (DCP, 2001a) relates to the inevitable organizational changes that structures of professional education undergo from time to time at both a local and national level. However, a more fundamental training concern is how best to make the expertise of experienced clinicians available to their supervisees. This is not primarily a question of keeping senior supervisors 'on the books' as it were, but more the familiar challenge of facilitating communication across generations.

The natural history of professional expertise

Researchers into expert performance across a range of professions have indicated that the more established an individual becomes in their own career the more they tend to rely on implicit understandings of their craft that have evolved as a result of accumulated experience rather than bookbased knowledge (Eraut, 1994). This often makes for swift and skilful performance when the professional is able to respond intuitively to the immediate demands of any particular situation (for example, the moment-to-moment interpersonal dynamics of a psychotherapy consultation). However, there is a downside to this almost automatic application of tacit knowledge. At a time when the Health Service is heavily investing in evidence-based medicine and consumers of clinical psychology are themselves becoming increasingly well-informed, it is something of a liability if senior practitioners cannot give an articulate account of why they do what they do. As many a golfer will attest, the charm of not knowing quite how you hit the ball down the proverbial middle palls considerably when you are

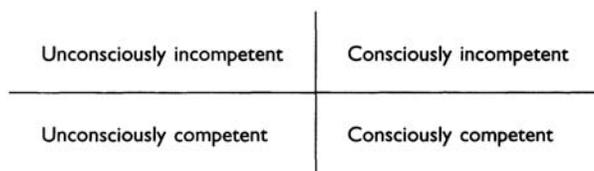


Figure 6.1 Sequence of skill acquisition

trying to correct a virulent hook that is wrecking your scorecard. It can be very difficult to correct performance that is under the control of implicit learning (Tomlinson, 1999). Furthermore, if experienced supervisors are unable to find a way to convey their understanding to trainees and share the lessons they have learned over years of practice, their wisdom may well end up being wastefully underused and, worse still, carelessly undervalued.

It has been suggested that as we acquire skills we characteristically move through a series of levels from an initial reliance on rules and external direction, on to a more flexible and responsive style, to a final intuitive grasp of situations that is founded on a deep tacit understanding (Dreyfus and Dreyfus, 1986). This sequence is simply summarized in Figure 6.1.

The notional journey that the learner undertakes passes from a blissful ignorance about the complexity of the job at hand through an uncomfortable recognition of his relative incompetence via a deliberate attempt to ‘do it right’, then on to the apparently effortless enactment that is the hallmark of truly skilled performance (Clarkson and Gilbert, 1991). Many of the conversations that occur between experienced supervisors and trainees on clinical psychology training courses can be typified as attempts made by the consciously incompetent to learn from the unconsciously competent. We should not therefore be surprised if these discussions sometimes turn out to be rather frustrating for the two participants! Equally, we should not underestimate their educational potential for both parties.

Knowing more than we can easily say^{1/4}

The professional training of clinical psychologists is heavily loaded towards the acquisition of ‘codified knowledge’ (Eraut, 2000)—that is to say, knowledge that is public, explicit and therefore examinable. The smart trainee knows this and prioritizes her learning accordingly (i.e. ‘if it’s not coming up in the exam I’m not interested’). The effective practice of clinical psychology, however, relies much more heavily on accumulated ‘personal knowledge’ of individuals, contexts and indeed the psychologist herself. Personal knowledge takes time to acquire and has a strong tacit dimension. Successful theory/practice integration requires the creative synthesis of codified and personal knowledge. Our students are not always convinced that the current structure of clinical psychology training courses best promotes this combined model of learning. Could

developments in supervisor training do something to correct this perceived imbalance?

It should not be easy to produce an explanation for behaviour that relies on implicit learning. Indeed one school of thought argues that the defining characteristic of tacit knowledge is its very inaccessibility. If you can talk about it, it's not tacit (Polanyi, 1967). An alternative reading of the literature (Eraut, 2000) encourages us to view all professional knowledge as lying on an implicit—explicit continuum, and suggests that conscious deliberation can allow individuals to work out for themselves the reasoning behind some of their seemingly intuitive therapeutic work. If we wish to exhort our more experienced supervisors to 'account for themselves' in this exploratory fashion, we need to establish a safe climate for experiment. Otherwise the likely outcome will be the shallow explanations and expedient self-justifications that are our defensive stock-in-trade (Wilson and Keil, 2000). Envisage a workshop where certainty is banned and doubt admired, in which supervisors give 'thick' descriptive accounts (Pidgeon *et al.*, 1991) of a piece of therapeutic work in which they had impressed themselves but weren't sure why. As each detailed story develops more contextual information is supplied—the setting; the bodily feelings of the therapist; previous exchanges with this client, etc. Fellow supervisors are encouraged to use their own professional curiosity to support the speaker's sense of inquiry, not by offering 'ready-made' theoretical interpretations (a cardinal weakness of clinical psychologists) but by asking intriguing questions (Ravenette, 1997). 'How come you chose to make that comment when you did and not earlier?' 'Do you recall ever feeling like this before?' And so on. I've tried just this sort of experiment on several occasions and the results have always been interesting. Some conversations 'took off more than others and it would be naive to think that this spot of reflexive psychology allowed participants to unearth all the mysteries of their implicit decision-making processes (Nisbet and Wilson, 1977). However, the exercise prompted truly constructive discussions as small groups of psychologists struggled to make sense of incidents that would not usually be subjected to such a level of sensitive scrutiny. Feedback from supervisors suggested that these 'learning conversations' (Thomas and Harri-Augstein, 1985) can provide an educational pay-off for both the 'teller' and the 'enquirer'. The enquirer gets a privileged access to the thinking processes that inform apparently automatic professional competence. The teller is helped to reflect on a noteworthy clinical episode and systematically think it through so as to complete the experiential learning cycle (Kolb, 1984). In each case there is movement along the continuum from implicit to explicit understanding. All we need now is to get the supervisees involved.

Before ending discussion of the training needs of experienced supervisors a particularly painful nettle needs to be grasped. While attendance at supervisor workshops is ever an occasional venture accidentally triggered by the passing interest of individual practitioners, those whom we might consider most in need of developing their supervisory skills may well prove to be the least likely to take

up the learning opportunities at hand. This is probably not a consequence of wilful neglect of a key professional responsibility. One of the saddest handicaps of incompetence is that a lot of the time we just do not realize quite how poorly we are performing (Kruger and Dunning, 1999). Nearly everybody reckons they are a better-than-average car driver, and this 'above average' effect seems to occur across a range of skills and populations (Alicke *et al.*, 1995). Furthermore, the tendency to inflate our appraisal of our own capability seems to be strongest when our performance is, relatively speaking, at its weakest. There is also some suggestion that this mismatch between confidence (how well we subjectively think we're doing) and competence (how well we actually perform according to objective criteria) tends to be more marked in experienced as opposed to novice health professionals (Marteau *et al.*, 1989). On a more positive note it appears that even these most self-serving of attributions may be open to revision if people engage seriously in skill development through training. Basically once we realize what competent performance in any particular domain entails, we can acknowledge (and therefore remedy) our past limitations.

These findings have implications for supervisor training. There is no reason to assume that clinical supervisors will be uniformly competent in their role. Those who are least well regarded may well consider their own performance perfectly adequate. Training experiences can prove an effective counter to unrealistically positive self-appraisal. The message seems clear. Develop 'advanced' training modules that all senior supervisors must attend on a regular basis. The practicalities of pursuing this policy will undoubtedly prove complex but the logic of the proposal remains compelling.

Why not have supervisee training as well?

The emphasis thus far in this chapter has been exclusively on supervisor training. The unwary reader might therefore assume that supervision is something that the supervisor does to the supervisee rather in the manner that a cook might fry an egg. The quality of your breakfast depends on the skilfulness of the chef (though it is acknowledged in culinary circles that some eggs are more co-operative than others). In fact, as the expanding research literature on the importance of the supervisory alliance demonstrates (Beinart, 2002), successful supervision is a collaborative process in which both parties must master their reciprocal roles. Why put all our efforts into training up one half of a dancing partnership?

In the UK nurses have been slower to embrace the culture of clinical supervision than their colleagues in the mental health professions such as counselling and psychotherapy. Since nursing is the largest subgroup of employees within the NHS, the task of establishing a profession-wide commitment to maintaining competence through supervision is considerable. While the intellectual arguments to support this shift in culture can be made quite persuasively (Bond and Holland, 1998), any rapid expansion in numbers of skilled supervisors presents severe practical problems. The generation of senior

practitioners who are the natural resource to tap for this new role have themselves had little prior experience of the benefits of clinical supervision on which to draw. Furthermore, nursing, much like clinical psychology, has yet to establish a standardized structure for preparing clinical supervisors for their extra responsibilities. Add the suspicion that many qualified nurses may remain unenthusiastic about embracing the culture of clinical supervision (Bishop, 1994) and the challenge facing advocates of change starts to look increasingly formidable.

Cutcliffe (2001) has therefore advocated the novel strategy of committing resources to supervisee rather than supervisor training. He suggests that this initiative can have a number of both short- and long-term benefits. In the immediate future nursing students will enter placements with a more sophisticated awareness of the part they can play in making the supervisory relationship work. At a later date when these students themselves begin to take on supervisory responsibilities (in the first year after qualification in some nursing specialities) they would already be committed to the supervisory cause and so enter the new role with confidence and enthusiasm. Ultimately Cutcliffe hopes to change the professional culture of nursing in the UK by this 'bottom-up' revolution.

Within clinical psychology in Britain we do not need to be so pessimistic about the effectiveness of supervisor training. We are a smaller trade than nursing with an established commitment to supervision at both pre- and post-qualification levels. Nonetheless there is a sound case to be made for introducing teaching on supervision into the professional issues curriculum of our doctoral training programmes. For example, trainees can be inducted into the difficult art of providing a frank and thorough report of a therapeutic session, or set an essay to review the research literature on cultural factors in clinical supervision (Lopez, 1997). It is interesting, too, that our experience in Leeds of successfully running supervision workshops attended by both supervisors and final-year trainees has been repeated elsewhere (Hitchen *et al.*, 1997). Supervisee training could yet be the 'coming thing' in clinical psychology as well as nursing.

Final thoughts

The focus of this chapter has been on the nature of clinical supervision provided for trainee clinical psychologists as a core component of their professional training. Clinical psychologists in the UK are now required to organize continued supervision of their practice throughout their careers (DCP, 2001a). While there are probably fundamental supervisory skills that apply across all supervision relationships, there is also a credible argument that supervisory style should be consciously matched with the developmental stage of the supervisee (Stoltenberg *et al.*, 1998). For example, an as yet unqualified assistant psychologist will need a level of direction that would be inappropriate for an established autonomous senior clinician. To date, the empirical evidence on which specialist

developmentally sensitive supervisor training can be founded is sparse (Skovholt and Ronnestad, 1995). In particular the longitudinal studies that are necessary properly to test the theory that therapists progress through predictable developmental stages in the course of their careers have not yet been conducted (Watkins, 1995). It is a moot question whether the pressures to offer support to supervisors asked to expand their training repertoires will await the completion of lengthy prospective research programmes.

Although there have been several references in the chapter thus far to the study of clinical supervision in other professions such as nursing and counselling, the provision of supervisor training for clinical psychologists in the UK is predominantly unidisciplinary. Members of fellow mental health professions both provide supervision for some clinical psychologists and receive supervision from them. Why therefore have we so infrequently organized supervisor training on a multidisciplinary basis? The ideology of 'shared learning' raises some educators' hackles at the pre-qualification stage (Forman and Nyatanga, 1999), but surely established supervisors are secure enough in their professional identities to gain from the melting pot of interdisciplinary training. There is an irresistible logic in the argument that the best way to prepare psychologists for inter-professional supervision is to run interdisciplinary training workshops (Leathard, 1994).

Conclusion

The prevailing *Zeitgeist* within both clinical psychology in the UK and the National Health Service supports investment in developing supervision skills as an important quality assurance measure. This sense that the time is right compensates somewhat for the tangible lack of a firm evidence base on which our training efforts can be founded. We are, however, far from clueless and can do better than sit on our hands waiting for the ultimate study in supervisor training to be published. There is probably enough professional consensus and research expertise within the clinical psychology training community in the UK to mount larger-scale and more formally evaluated programmes than have as yet been reported. This quite achievable goal would add significantly to the pool of practical and intellectual knowledge on which fellow trainers in our own and other professions can draw in the future.

Chapter 7

Difference and power in supervision

The case of culture and racism

Nimisha Patel

Introduction

The centrality of power relations in the supervisory process is the main theme within this chapter. A specific focus on the case of culture and racism is intended to provide an example of how power relations can manifest and how they can be constructively addressed to enhance the effectiveness of supervision and psychological practice.

This chapter attempts to address three main questions:

- 1 Why address power and difference in supervision, specifically in relation to ethnicity, racism and culture?
- 2 What are the key issues with regards to culture and racism and how might they become salient in the different aspects of supervision and supervisory tasks?
- 3 How could supervisors in particular, and supervisees, enhance the quality and effectiveness of supervision by incorporating understanding of power relations and the issues of culture and racism?

Some of the implications for supervisors, supervisees, the profession of clinical psychology, and psychological services are also considered.

Power and supervision

Supervision can be described as a process characterized by a collaboration between the supervisor and the supervisee, with the explicit task of ensuring ethical and professional therapeutic practice aimed at improving the client's psychological and social quality of life. Taylor (1994) identifies three purposes in terms of the 'overseeing therapy' aspect of supervision: transmitting the values and ethics of the profession, controlling and protecting services provided by the supervisee, and helping the supervisee to develop a conceptual framework. These purposes highlight the role of the supervisor as the educator, endowed with the responsibility towards the supervisee of both imparting knowledge and

facilitating intellectual and practical skills. The role of the supervisor as an evaluator, assessor, gatekeeper and transmitter of values for the profession points to their responsibilities to the profession, whilst the role of the supervisor in controlling and protecting services provided emphasizes the responsibility of the supervisor towards the client.

The responsibilities of the supervisor, as mentioned above, thus illustrate the centrality of power relations in the supervisory process, yet the infrequent mention of power relations in literature in this field exposes one of the many 'givens' in our professional practice. The tacit acceptance and therefore the invisibility of the role of power in supervision can inadvertently lead to a misuse of power relations and often give rise to a supervisory process characterized not by collaboration but by coercion, however subtle and unintentional. In this regard, collaboration is then seen as a key principle in developing a supervisory relationship where both the supervisor and the supervisee are engaged in a learning process and where responsibility and accountability are more equally shared (Orlans and Edwards, 2001).

The notion of collaboration necessitates some exploration of common interpretations and manifestations of power in the supervisory context. Power has been described and theorized about in many ways, but in relation to supervision few meanings have been offered in the literature. Taylor (1994) suggests that a feminist emphasis in both counselling and supervision involves the sharing of power in an effort to establish a mutual, reciprocal and non-authoritarian relationship to facilitate optimal therapeutic outcomes. In this context, she focuses on the social history, the socialization and the relatively powerless structural position women face, and what she refers to as the general lack of 'real' power. Here, power is used to refer to the unequal distribution and access to resources and privileges which impact differentially on the life experiences of women, often in disadvantageous ways. In relation to supervision, Taylor (1994) thus argues that power and gender feature strongly in any therapeutic and supervisory relationship, particularly where clients seeking help themselves feel powerless in many ways, and that supervision has a responsibility to challenge inequalities in power (e.g. gender bias) implicit in our culture. The concept of social power (Cooke and Kipnis, 1986) has also been used in a similar way in relation to supervisory interactions to describe the differential distribution of and claim on power men and women have and assume in their interactions. Miller (1991) has argued that traditional constructions of power can inhibit women to assume greater power in interactions for fear of losing or jeopardizing the relationship with their interactional partner. She further proposes a model of shared power where individuals can be empowered within a connected relationship—what has also been described as relational power (Surrey, 1991). Based on this concept of relational power, Nelson (1997) posits that the supervisor (through the use of their expert power) can enable a supervisee in assuming greater power over time, and expressing their personal power within their interactions. Thus, power is conceptualized not simply as a

commodity that one has and the other does not, but a feature reflecting a social reality which becomes manifest in the interactions within a relationship such as a supervisory or therapeutic relationship.

Others have conceptualized power in relation to ethnicity in similar ways; for example, describing power as ‘the crucial variable in minority-majority relations and [which] affects the ability of individuals or groups to realise their goals and interests, even in the face of resistance to the power’ (Kavanaugh and Kennedy, 1992:17). In addressing the complex power relations present in cross-cultural supervision, Ryde (2000) introduces the concept of role power, which she asserts points to the power inherent in the role of the supervisor, cultural power, which refers to the power of the dominant ethnic grouping, and individual power, which points to the particular power of the individual’s personality. Ryde’s contributions enable a more sophisticated analysis of the many ways in which power relations become manifest, and the ways in which they may change depending on who the supervisor is, who the supervisee is and who the client is. For example, a supervisor may be white, male and from a working-class background, a client may be white, female, working class and able-bodied, and the supervisee may be black, male, middle class and gay.

Social inequalities are therefore complex and multilayered with any person in the supervisory triad, the supervisor, supervisee or the client, reflecting differing power relations, differing social positions and experiences of both privilege and disadvantage, simultaneously but on different axes. In supervision, power then becomes a complex reality requiring a sustained, committed and sophisticated social, political and psychological analysis rather than a one-off acknowledgement as a token gesture in the supervisory process. The recognition of power relations and the social and political inequalities experienced by clients, supervisees and supervisors in itself is inadequate. Here it is argued that it is both the supervisor’s and the supervisee’s ethical responsibility to ensure that the supervisory process attends to social inequalities and their impact on all those in the supervisory triad and, most importantly, on the client.

However, integrating this perspective into training in clinical psychology and into the training and the practice of supervisors within the profession remains a matter of choice in Britain, rather than an ethical and professional obligation. In considering how inequalities and difference in relation to ‘race’, culture and ethnicity can be integrated into training, supervision and continuing professional development, some attempts have been made in Britain in clinical psychology (for example, Dennis, 2001; Patel *et al.*, 2000) and in counselling (Lago and Thompson, 1997). In the United States there is far more literature in this field and one predominant theme is the focus on describing ‘multicultural supervision’ and ‘cross-cultural supervision’. Leong and Wagner (1994) suggest that multicultural supervision refers to those supervisory and (or counselling) situations which are affected by multiple cultural factors—for example, in relation to the client, supervisee and supervisor. Cross-cultural supervision is defined as a supervisory relationship in which the supervisor and the supervisee

are from different cultural groups. Both terms have been used to refer to supervision which considers issues of culture and ethnicity, such as differing life experiences, values, beliefs, world views and ethnic identity development in relation to counselling and psychotherapy assessment, intervention, knowledge base and the supervisory and the therapeutic relationships (for example, D'Andrea and Daniels, 1997; Constantine, 1997; Priest, 1994; Brown and Landrum-Brown, 1995; GopaulNicol and Brice-Baker, 1998). In addition, there have been some studies examining cultural and racial issues in supervision (for a brief review see Helms and Cook, 1999).

However, both in Britain and in the United States, there is a paucity of related literature focusing particularly on clinical psychology supervision and, more poignantly, there is little in the way of guidance on how to incorporate current understandings of power relations, social inequalities and issues of cultural difference and of racism into the supervision of clinical psychologists. In addition, as described in [Chapter 3](#), current supervision models are based on specific psychological or psychotherapy theories or developed specifically for supervision, commonly referred to as developmental models.

Indeed, Banks (2001) argues that the use of supervision models based on specific theories or therapeutic models must be questioned, given that the cultural biases within those theories are inevitably reflected in supervision. Developmental models of supervision also need to be questioned as they are often presented as being universally applicable and devoid of any biases.

Before proceeding to address the second and third questions stated in the introduction, I shall return briefly to the notion of power and empowerment and the implications for integrating this into supervision.

Foucault's understanding of power (see Foucault, 1977, 1988) has been influential in the development of various theoretical, therapeutic and research practices, and perhaps it is of some relevance to the subject of supervision. Foucault's conceptualization of power pointed to the interactional nature and the constitutive force of power whereby power manifests and shares itself through everyday interactions, language, discourses, social practices, knowledges and the ways in which we come to know of and understand personhood. The notion of resistance is an important ingredient in his theorizing of power relations, the idea that resistance can manifest itself within interactions, discourses and in people's attempts to challenge particular definitions of subjectivity, and, as such, power is neither seen as lineal nor static but as relational and as being culturally, socially and historically situated. Thus, Foucauldian analysis of power can enable us to study everyday interactions and institutional practices which can sustain regulatory systems of control.

Given that supervision is one of the main sites in which particular knowledge is transmitted and perpetrated at the expense of other knowledge, where certain skills are fostered as institutionalized social practices (e.g. note keeping, research activities, therapeutic interventions) and where power relations permeate every aspect of the supervisory relationship and process, it is perhaps an appropriate

place to focus on how issues of difference, inequality and oppression become manifest and how supervision can facilitate and nurture resistance in the struggle against oppression. However, one of the main criticisms of Foucault's analysis and theory of power is that he offered little in the way of encouragement or direction in challenging oppression and illustrating how resistance could be fostered (for example, Taylor, 1984). Furthermore, Foucauldian understandings of power neglect the material reality of power relations and their impact on people's lives, and their resistance to change. To focus only on power as it operates in everyday interactions, discourses and in regulatory systems actually serves to disguise the reality of actual material inequalities, thereby leaving the social order, and power, relatively unchanged.

Practice implications of an approach to supervision which attempts to address both interpretations of power include first, the necessity of including a social, cultural, historical and political analysis into every aspect of supervision; second, the importance of developing an awareness of how the client, the supervisee and the supervisor have been both privileged and oppressed and the impact on their lives and the significance of this in therapy and in supervision; and third, active exploration of the different levels and ways in which a clinical psychologist could intervene in negotiation with the client to create maximum change for the client in a way that would enhance their emotional, social and political well-being. These practices can be seen as opportunities for resistance in the Foucauldian sense, and, hopefully, for change in the political and personal sense. The underlying assumption is that the ultimate and desirable goal of supervision is to empower the client through the process of empowering supervision.

The following sections focus on four main aspects of supervision. For each of these, some of the key issues with regards to culture, racism and ethnicity are identified and, also, some guidance is provided on how supervision can integrate and facilitate an understanding of power relations and of issues of culture, ethnicity and racism in empowering practice. The four main aspects of supervision to be addressed are (1) the process of supervision, (2) developing knowledge, (3) developing skills, and (4) personal-professional development. In order to develop confidence and competence in addressing these issues in supervision both supervisors and supervisees would need to accept that learning to think and to question in a particular way are vital prerequisites to learning how to practise.

The process of supervision

As discussed earlier, the roles of the supervisor as educators, mentors, evaluators and trainers all accentuate the power imbalance between the supervisor and the supervisee. A supervisee from a black and minority ethnic background being supervised by say, a white majority ethnic supervisor inevitably amplifies this power imbalance by virtue of the differing histories, experiences, privileges and oppression experienced by both parties. Of course, even where both supervisee

and supervisor share the same ethnic or cultural background, other variables, such as gender, age, and class will determine the nature of power relations in the process of supervision. Likewise, where both supervisee and supervisor share similar ethnicities, say white majority ethnic backgrounds, but where the client being discussed is from a minority ethnic background, power relations remain an issue for analysis and discussion.

Due to limitations on space, the focus in this chapter will be mainly on the experiences of black and minority ethnic supervisees being supervised by white majority ethnic supervisors, where clients may be from any majority or minority ethnic backgrounds. Numerous barriers exist in supervision to prevent an analysis and an exploration of the significance and effects of power relations and difference in terms of culture, ethnicity and racism. These barriers are important to understand if we are to begin changing supervisory practice to become more empowering for supervisees and for clients. Some of the common barriers include:

Colour blindness

Statements such as ‘I treat all trainees in the same way, regardless of their ethnicity or colour’ exemplify the commonest barrier to discussing power relations and their effects on the supervisee and the client. It is as if all supervisees are seen as colourless, culture-less and denuded of social and political contexts, as if the fact of racism and the reality of its impact on people’s lives is not worthy of acknowledgement, let alone of discussion, in supervision. Ridley (1995) suggests that colour blindness can result from counsellors’ (or supervisors’ in this context) need to appear impartial, or from fears that they may actually be, or be thought of as, racist, or from fear of appearing ignorant or incompetent.

Colour consciousness

Ridley (1995) defines colour consciousness as the opposite of colour blindness, based on the belief that perhaps all of the client’s (and the supervisee’s) difficulties stem from their being a minority ethnic person. He suggests that ‘white guilt’ is a common cause. In supervision this can manifest itself in attributing all difficulties to being black with an implicit message that a detailed exploration of relevant issues in the supervisory relationship or the supervisory process cannot take place. Thus, the responsibility for change, if any is thought possible or desirable, rests with the supervisee, not the supervisor. Supervisees may themselves avoid raising issues of culture or oppression for fear of being themselves positioned as being overly preoccupied with such issues and with their own personal difficulties in relation to their ethnic identity or experiences of racism.

Pathologizing the supervisee or the client

Similarly to colour consciousness, supervisees often describe the process in supervision whereby they come to be held responsible for any difficulties in the client-supervisee or supervisee-supervisor difficulties, or where a supervisee fails to meet the expectations or standards set by the supervisor. Little space is allowed for a discussion of, say, the cultural biases inherent in the expectations or standards set by the supervisor, or of the cultural norms against which the supervisor may be judging the supervisee's competencies, knowledge and learning styles, or of the biases and oppressive functions of certain therapeutic models and interventions espoused by the supervisor. Supervisees, including trainees, thus can easily be labelled as perhaps 'lacking in an adequate level of competence', as 'being defensive and inflexible', as being 'resistant to feedback or reflexivity', or as 'requiring a greater level of instruction, guidance, monitoring or supervision'.

Discussion of power relations, cultural and racial oppression, the Eurocentricity of values in supervision or in the models or styles of interviewing remain absent, the supervisee carries both the blame as the perceived site of the problem and the responsibility for change.

Denying the importance of discussing power, culture and racism

Supervisors may never mention or invite or encourage any discussion at all about power relations or cultural differences. They may, if challenged or asked tentatively by a supervisee, respond that 'it's not an issue here, most, if not all our clients here are white', or 'we never see any black or minority ethnic people in this particular service/area'. The message to the supervisee is that culture, ethnicity and racism are not worthy of mention, discussion or understanding, regardless of the possible differences and inherent power relation between supervisee and supervisor. Exploration of the social, historical and political factors in why services are geared towards a relatively majority ethnic, homogeneous client population, and the implications of this for the minority ethnic population, or for the planning, design and delivery of psychological services, or for the minority ethnic supervisee working with an entirely majority ethnic client caseload, is absent.

Fukuyama's (1994) analysis of critical incidents also suggests that supervisors may tend to minimize supervisee's efforts to attend to their client's racial concerns. Helms and Cook (1999) give examples of 'supervisor minimisation strategies', including insisting that such matters are superficial and not (germane) in the client's 'real' problem; or refusing to discuss such issues, or devaluing the supervisee's competence if they choose to include such factors in their therapeutic endeavours. They suggest that in response to such strategies, supervisees may feel discouraged and reluctant to explore issues of culture or

racism for fear of being negatively evaluated by the supervisor. Others have pointed out that the real fear of being scapegoated, marginalized (for example, amongst peers) and of being failed, if a trainee, can act as a major deterrent to voicing issues of discrimination even amongst peers (Patel *et al.*, 2000).

Expressing dissatisfaction with demands to integrate 'new material' into clinical and supervisory practice

Supervisors may often feel dissatisfied, pressured, misunderstood, undervalued and burdened with the increasing demands placed on them to provide a range of experience, to facilitate the development of a range of competencies and to ensure a scholarly and critical approach to the development of knowledge within supervision. Reactions include anger, irritation and outright dismissal of any suggestions or requests that supervision should include discussion and exploration of issues of culture, racism and power relations, perhaps because it is experienced as a demand, and one which arises out of an explicit criticism of the profession and clinical psychology practice (Patel *et al.*, 2000). Unfortunately, supervisees often bear the brunt and may be left feeling that they are making unreasonable demands, that they themselves or their training needs are an excessive and an unreasonable burden to the supervisor or that these issues are simply unimportant or unworthy of acknowledgement within the profession and supervision.

Not surprisingly, the supervisory relationship is fraught with complexities, anxieties, differences in expectations and perhaps mutual mistrust or suspiciousness when the supervisee and the supervisor are from different ethnic backgrounds, bringing differing histories, experiences, values, beliefs and hopes to the supervisory process. The majority ethnic supervisor's anxieties about their level of expertise or competence in understanding and addressing issues of power, culture, ethnicity and racism may be compounded by the minority ethnic supervisee's anxieties about how they will be judged, negatively evaluated and misunderstood or not understood at all by the supervisor because of their minority ethnic status. Gopaul-Nicol and Brice-Baker (1998) argue that such levels of anxiety in some minority ethnic supervisees might inhibit them from revealing difficulties in their work or weaknesses, and manifest in their reluctance to play videotapes or audiotapes, or discuss problematic aspects of a therapy session.

Crucial to any effective supervision is unquestionably the quality of the supervisory relationship. In relation to addressing power relations and their effects on the supervisor, supervisee and the client, the supervisory relationship must be prioritized as the primary area to be nurtured and developed. Martinez and Holloway (1997) suggest that both power and involvement are crucial to the development of trust and mutuality in the 'multicultural supervisory relationship'. Power is seen as a vehicle in constructing a mutually empowering relationship, and involvement is seen as referring to intimacy that includes

'attachments'; that is, the degree to which each person uses the other as a source of self-confirmation (Miller and Rogers, 1976). According to Holloway (1995) the supervisory relationship is the container of the process in which supervisee and supervisor negotiate a personal way of utilizing a structure of power and involvement that facilitates learning. But for both supervisor and supervisee to learn from one another through the process of supervision, both need to feel safe. Gatmon *et al.*'s (2001) study also highlights the importance of providing an atmosphere of safety, combined with a depth of dialogue and frequent opportunities to discuss cultural variables in the supervisory relationship, all of which were found to significantly contribute to building supervisory alliances and increasing supervisee satisfaction.

Improving supervisory practice

The question addressed in this section is how can supervisory practice be improved to facilitate the process of empowering supervision?

1 Safety and trust have been previously identified as key factors in supervision and their establishment and nurturance is arguably the most crucial goals within the supervisory relationship. The issue of feeling safe raises further questions such as: What does it mean to feel safe? Does it hold different meanings for supervisees and supervisors? How can safety and trust be achieved? Whose responsibility is it to make the supervisory relationship and process safe?

Feeling safe can mean essentially the same for both supervisee and supervisor: being able to be open, honest and reflective; being able to take risks in sharing one's concerns and doubts and being able to take risks in revealing one's own limitations in terms of knowledge and skills in relation to addressing issues of power, culture, ethnicity and racism. Feeling safe can mean being able to do the above within a trusting, honest, mutually respectful supervisory relationship where both parties are also explicit about their differing roles and tasks and the implicit power relations embedded in the relationship. Thus, feeling safe does not mean giving false reassurances that the supervisee (who may be a trainee) is not being evaluated; or that the supervisor will not be challenged if they make biased assumptions, racist comments or advocate a Eurocentric perspective. For the supervisor the challenge is learning how to model openness and learning about potentially deeply sensitive, often controversial and complex issues of cultural difference and racial oppression spanning the personal, professional and theoretical realms. For the supervisee the challenge is learning to take considered risks in being open, thoughtful, reflexive and challenging within the process of supervision.

Ultimately, and primarily, it is the supervisor's responsibility and obligation to create an atmosphere of safety and to develop a trusting relationship with the supervisee. To simply expect that the supervisee should feel safe and trust the supervisor is not enough, trust needs to be earned, safety needs to be

demonstrated and the process of building a relationship conducive to mutual learning can thus be facilitated.

2 Developing a language to talk about power relations, culture, ethnicity, 'race', racism and oppression in supervision is a crucial step towards enhancing the supervisory relationship and process. Learning to talk about power and racism, for example, is often extremely difficult and anxiety-provoking. Supervisors can give permission to discuss such emotive, sensitive and complex issues and demonstrate a willingness to talk about them without being dismissive or attacking, to perhaps expose their uncertainties about the language to use or their limitations in knowledge about these concepts and issues, and to grapple with the implications for their own practice, for the services within which they work and for the profession.

3 Reflexivity on part of both the supervisor and the supervisee is a key ingredient in minimizing anxiety and in developing a supervisory relationship and a process conducive to mutual learning. Reflexivity in this context can mean the supervisor examining and reflecting on (a) their own ethnicity and culture and their ethnic identity, (b) their own experiences of power and powerlessness in their personal and professional lives and in their own supervision, (c) their theoretical models and clinical practice and inherent biases within them, (d) their assumptions, beliefs, values, biases and racism which inevitably influence their practice, their supervision and their relationship with the supervisee, (e) their stage in development as a supervisor and the related anxieties, expectations or attitudes to supervisees or to supervision, or to the demand to include newer and challenging approaches into their supervision, and (f) their own anxieties, fears, doubts, limitations, abilities and strengths in thinking about and addressing issues of power, culture and racism. The implications for how and where supervisors might do this will be addressed later in this chapter.

Reflexivity extends to the actual supervisory relationship too. Supervisors can ensure that reflection and discussion about the supervisory relationship itself is permissible, welcomed and a necessary part of the process of learning. This can include exploring cultural differences between supervisor and supervisee and their effects on each person's interactions, thinking and practice in supervision and in clinical work.

4 Establishing the parameters of who can raise the aforementioned issues, and how and when or what action might follow if such issues are raised, is essential to discuss and to negotiate in the supervisory relationship. The contracting process may begin at the point of establishing the supervisory relationship, but it is an ongoing process where the initial agreement is reviewed regularly (Scaife, 2001b). Supervisees should be given ongoing opportunities and also be actively facilitated in contributing to the contracting process and its ongoing review. The temptation for both parties may be to avoid discussion of issues which understandably cause anxiety, discomfort and sometimes which can be very painful to acknowledge and explore. Both may collude to deny the significance of these issues and to avoid exploration of the implications, until maybe a crisis or

problem arises, by which time there is already an impasse in the supervisory relationship and possibly in the clinical work. Crises in these situations typically escalate, reflexivity, discussion and analysis cease, the supervisory relationship deteriorates and is characterized by distance, misunderstandings, mistrust, fear and a lack of respect and, not surprisingly, learning comes to a halt for both supervisor and supervisee with inevitable implications for clinical work and clients.

Ideally, developing a supervisory contract which encompasses all the issues raised above, and which is conducted in an open, honest and collaborative way, will facilitate the development of a quality supervisory relationship where mutual learning can flourish.

Developing knowledge

An important function of supervision in clinical psychology is to facilitate awareness, understanding and skills in the application of a knowledge base which draws on psychological theories, research and practice-based evidence. The development of competence in this area within supervision is traditionally thought of only in relation to the supervisee's learning. Questions which arise include:

- who has the responsibility to impart knowledge to whom?
- whose knowledge is being imparted?
- what is the basis of that knowledge and how has it come to be produced?
- which knowledge is being privileged?
- which knowledge is absent or suppressed?

In clinical psychology training, supervision and practice the belief that all psychological theories are universally applicable, politically neutral and potentially beneficial, as opposed to being potentially toxic and oppressive, remains largely uncontested. Psychology's approach to 'race', racism and cultural difference in its knowledge base has historically been to either render the subject and reality totally invisible, or to focus on 'race' in an exploitative and abusive way (e.g. in examining 'race' and IQ), or to depoliticize it and to strip it of its social historical and political context (e.g. in discussing cultural difference as if it constituted nuances and idiosyncrasies which are located in the 'other'). However, some developments in psychology have contributed to a better understanding of power and racism in psychology's knowledgeproduction (see Henwood and Phoenix, 1999, for a summary), although this seems to have had little effect as yet on academic teaching in clinical psychology or on the content and process of supervision in clinical psychology.

The Eurocentric nature of psychology's knowledge base points to the inherent limitations of this knowledge and to the potential for perpetrating oppression in theory production, and in supervisory and clinical practice. The blanket use of

and the unquestioning approach to applying such knowledge to black and minority ethnic clients can be seen as amateurish at best or as abusive, or as 'secondary colonisation' at worst (Patel and Fatimilehin, 1999). In discussing the nature of unintentional racism in the use of psychological theories, Ridley (1995) describes four prominent categories of models of mental health—the deficit, medical, conformity and biopsychosocial models—in an effort to expose their limitations and their potential to perpetrate racism. If supervision is to be able to address the nature and function of power relations in psychology then it is incumbent upon supervisors to integrate an analysis and a critique of psychological knowledge, particularly in relation to their own field or speciality.

Improving supervisory practice

Supervisors can address issues of power, ideology, culture, racism and oppression in facilitating the supervisee's general competence in the understanding and application of psychological knowledge. The following includes suggestions that might aid this process:

- 1 Supervisors need to be committed to examining and critiquing their own knowledge base and their own previous trainings from a historical, cultural and political analysis in relation to identifying cultural biases, racist assumptions and oppressive functions of this knowledge. This can be done in private, in their own supervision, with colleagues or in their own training and services.
- 2 Supervisors need actively to engage in and facilitate ongoing reflection and critical discussions in supervision about commonly used theories and concepts in their field in relation to cultural biases and racism. (For guidance and suggestions for particular clinical specialities see Patel *et al.*, 2000.)
- 3 Supervisors can encourage discussions in supervision on identifying the merits and the potential benefits of certain theories and philosophical approaches, as well as the limitations in their application to black and minority ethnic people, or in enabling a sophisticated understanding of power relations, oppression and empowerment.
- 4 Supervisors can encourage exploration and discussion in supervision of alternative useful models and theories not necessarily based on psychological models founded on Western philosophies, values and understandings. For example, contributions from the fields of black psychology, Chinese medicine, Ayurveda, yoga, Buddhism, sociology, etc.
- 5 Supervisors can guide supervisees in developing critical thinking skills in relation to knowledge development by modelling a reflective, questioning approach. They can pose challenging questions that invite reflection on the origins and production of psychological theories, on the role, uses and misuses of research in perpetuating biased and racist theories, on the benefits and limitations of research-based and practice-based

evidence in clinical psychology, on the application of biased and racist concepts and theories in clinical practice and in service design and delivery.

Developing skills

The current focus in clinical psychology training is on developing a range of competencies with a range of clients and across a range of settings. The development of specific skills is seen as an indicator of the level of attainment of essential competencies in relation to psychological assessment, formulation, intervention, evaluation, research, service delivery, teaching and professional practice. The role of supervision both pre- and post-qualification is central in facilitating the development of such skills and competencies. However, essential ingredients in the development of competencies are the capacity, ability and commitment to developing thinking skills. As such, for supervision to facilitate an understanding and competence in addressing power relations and oppression in clients' lives, in therapeutic encounters, in research practice, in psychological services or in the supervisory relationship supervisees and supervisors have to strive to establish an essential foundation in the development of skills in critical thinking.

In relation to multicultural counselling competence, Helms and Richardson (1997) believe that it is not a unique set of skills *per se* that is required, but a particular type of philosophical orientation characterized by a responsiveness to the relevant socio-political dynamics of 'race' and to principles of cultural socialization in all interactions with clients. Of course, such responsiveness and a philosophical orientation have to go beyond simply an 'awareness' of and a 'sensitivity to' relevant issues. To develop and to demonstrate competence in empowerment clinical psychologists need to be able to operationalize a social and political analysis of cultural and racial oppression in their psychological thinking skills, as well as in their assessment, intervention, training and research skills. It is argued here that clinical psychology supervision is one of the most important sites where learning how to translate that philosophical understanding and commitment into clinical practice, or perhaps, more appropriately, into both resistance and into social action, can be fostered.

Improving supervisory practice

The following provides some suggestions regarding what supervisors can do to encourage reflection, discussion, debate and skills development within supervision. The main areas considered are assessment, formulation, intervention and organizational skills. For guidance related to particular clinical specialities see Patel *et al.* (2000).

Assessment

Critical to the development of appropriate assessment skills is, firstly, the ability to evaluate the validity and the appropriateness of the theoretical basis of assessment methods used; secondly, the ability to critically analyse how difference has been constructed within that theoretical approach and within the entire process by which a client has come to be referred to a clinical psychologist; thirdly, the ability to evaluate the role and function of power within the entire process of referring, assessment and the process of establishing theory-practice links during the assessment. **Box 7.1** highlights a few questions which may be useful in supervision.

Box 7.1 The referral process and assessment

- 1 What aspects of your 'self' (culture, ethnicity, heritage, gender, age, class, etc.) could be influencing your understanding of the client referred, of the referral request and of the assessment process?
- 2 Who is the referrer? What might be their personal and professional understanding of the client referred to you? Could their ethnicity (or gender etc.) or their professional context have influenced how they have described the client in the referral letter, or how they construct the client's present difficulties, or possible solutions? Which theoretical constructs are used in the referral letter (e.g. 'separation problems' or 'somatization')? To what extent are those constructs Eurocentric? What are the implications?
- 3 In the referral process who else or which other services influenced the referral being made to you in particular (or to clinical psychology)? Which assumptions, values, stereotypes and personal/professional beliefs might have influenced the referral route? Have these influences been made explicit to the client? If so, who explained this to the client, and how? What might be the client's fears, suspicions, expectations or understanding of what a clinical psychologist does, how and why?
- 4 What might be some of the implications of the way in which a referral letter constructs, say, culture (for example, culture as the only central construct, or as invisible and unimportant; that is, with the dominant professional understanding which promotes assumptions of universality in psychological responses)? What are the implications for the client and for the type of service or interventions offered to the client (or withheld from them)?
- 5 Who might you need to consult to enable you to conduct an appropriate assessment (e.g. which family members, which colleagues or community organizations or religious practitioners, etc.)?

- 6 Which language is the most appropriate for conducting the assessment? Do you need to find a bilingual therapist or co-worker, or an interpreter? What do you need to know in order to decide or to find an appropriate interpreter (e.g. language or dialect spoken or preferred by the client, gender of interpreter, etc.)?
- 7 What are you and the client bringing to the assessment in terms of your own cultural understandings, your values, stereotypes, histories and experiences of privilege and oppression and your expectations? How might this influence the client's experience of the assessment process? How might this influence the process of trying to establish a therapeutic alliance? How can this be addressed within the context of an empowering assessment?
- 8 Have you made transparent and explicit to the client how and why they have been referred to you? Have you explained the 'professional' and the 'organizational/service' rationale for the referral? Have you sought their understanding of the referral process and its implications? Have you discussed the possible limitations or inherent biases in the process of psychological assessment and in the therapy you might be offering to them? Examples include: have you explained and discussed with the client how psychological therapies used have commonly been developed in the West and rest on the assumption that 'talking' helps? Or have you explained and discussed the construct of confidentiality as it is meant in the Western professional context or in other cultural contexts?
- 9 If you have chosen to use formal assessment tools (standardized tests, or measures) can you justify their use and their validity for the client in question? What might be the inherent biases (e.g. cultural), limitations and the potential for abuse in these assessment tools? What are the ethical implications of using assessment methods and tools which are not reliable or valid for the client in question?
- 10 What is the significance of power in the assessment process? For example, as a white, male, trainee clinical psychologist how is your ethnicity, gender and position as a trainee professional significant in relation to a black, male, older client referred to you for a cognitive assessment whilst under section? What are the implications for the process of assessment or of the possible outcomes of the assessment?
- 11 What are the contexts central to talking with and understanding the client and their presenting difficulties? For example, what is the economic context, their familial context or the reality and the impact

of poverty and racism in their lives? How can an awareness of these contexts be translated into an assessment that seeks to understand the client's difficulties, the obstacles and oppressions they may experience and possible opportunities available to them? In seeking to understand these issues, how can an assessment be conducted in a way that does not unquestioningly mirror and reinforce power relations experienced by the client in their own lives?

Formulations

The development of formulation skills is often a focus in clinical supervision. However, almost all forms of psychological formulation are derived from particular theoretical approaches, models which themselves are invariably Eurocentric and often decontextualized, depoliticized and sanitized of understandings of power. As such, psychological formulations rarely encompass more than a cursory glance at power relations and their impact on people's lives and not surprisingly suggest little in the way of direction in terms of empowerment or social action. However, useful contributions in clinical psychology can be found in the work of Hagan and Smail (1997), who advocate power-mapping as a methodology, and Holland (1990, 1992b), who illustrates the use of a material understanding of power and its impact in her model of social action psychotherapy.

The processes of assessment and formulating inevitably develop simultaneously, and the skills in effectively and meaningfully integrating the understanding of cultural difference, cultural socialization, racial oppression and racism in this process can be facilitated in supervision. The wheel of assessment and formulation (Figure 7.1) brings into focus the ongoing and cyclical nature of this process and the different arenas in which the practitioner can integrate understandings of culture and racism. The suggested questions in Box 7.2 correspond to the different segments in the wheel and may facilitate supervision.

Interventions

The ability to continually explain and to negotiate and renegotiate with the client an appropriate and relevant approach to intervention, based on the evolving formulation, encompasses many skills. Supervision can be a forum where such skills can be formulated, articulated, rehearsed and debated in the context of mutual learning for both supervisee and supervisor. Perhaps the most challenging aspect of actually facilitating this process in supervision is how both supervisor and supervisee can demonstrate reflexivity, critical thinking, and the capacity to

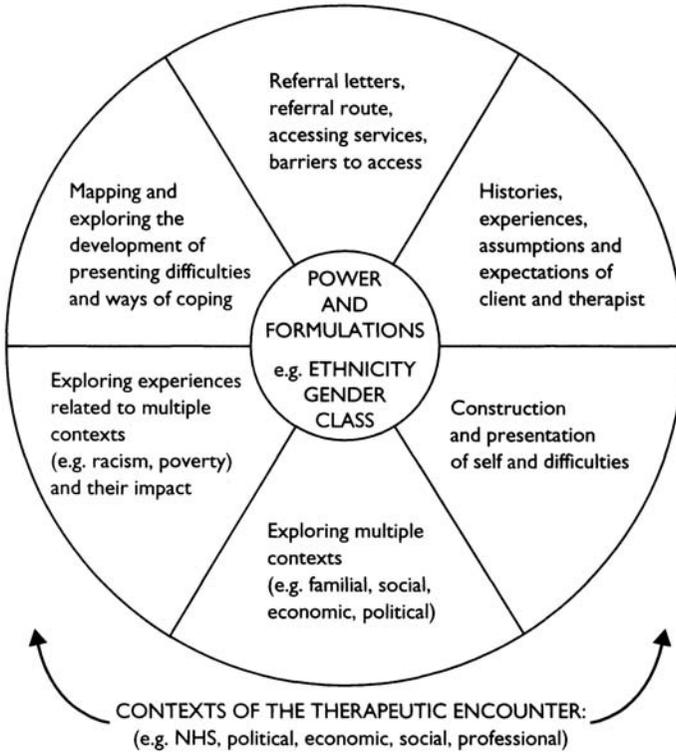


Figure 7.1 Assessments and formulations: integrating issues of difference and power

re-evaluate the potential for abuse and oppression in using existing theoretical models and interventions and, perhaps most importantly, the willingness and commitment to re-visioning therapeutic philosophies and interventions and reconfiguring professional roles and responsibilities in order to practise a just psychology.

Box 7.2 The process of assessment and formulation

1 How are referral letters written and by whom? What has the referral route been for the client and what assumptions on the part of the referrer have influenced the referrer? Which services are made available and accessible to the client by the referral and which have been excluded or withheld? What might be culturally biased assumptions, stereotypes or values which have operated in this process? How transparent are these in the referral or to the client? What are the implications for the client (e.g. in terms of informed consent, informed choice versus coercion in the referral process)?

Would the client be able to request a particular therapeutic approach or a therapist from a black or minority ethnic background? Would the client have been given an opportunity to discuss their preferences in terms of health care approaches (e.g. traditional to the client rather than traditional Western approaches offered within the NHS)?

- 2 What are the histories (personal and political) that clients and practitioners bring to the assessment? How might we explore and understand the client's expectations and assumptions of who the practitioner is, what they will do, what will their position be on the client's situation and presenting difficulties (e.g. black and minority ethnic clients may have many assumptions about a white

practitioner and they may utilize effective survival strategies of adopting a distant, questioning and mistrusting stance towards them)? Similarly, what are the assumptions, stereotypes, values, biases and expectations of the practitioner in relation to the client? How might these assumptions, biases and expectations be converging to impact on the process of the assessment and formulation, and what are the implications for the validity and utility of the emerging formulation? How might such formulations influence the interventions (and their related models) chosen, offered or imposed on the client? What is likely to be the enabling or disabling and oppressive outcome of this for the client?

- 3 How does the client talk about and construct their sense of self? To what extent does the assessment and formulation explore the significance of the points of convergence or of divergence in the client's and the practitioner's understanding of the 'self'? Does the client talk of their self-identity as a racialized, gendered identity, or in terms of an individual, autonomous identity or a collective identity (e.g. in relation to their family, or in terms of 'the black community')? What is your understanding of the 'self'? To what extent is that influenced by your own personal, cultural history, or perhaps by your professional and academic training in psychology (e.g. the dominance of the dualist notion of self in psychological theorizing)? What are the implications for the choice of interventions or of psychological models for interventions? How can that be discussed with and negotiated with the client?
- 4 How does the client talk about and explain their difficulties? Which meaning-making systems (e.g. religious, political, cultural) do they employ? To what extent are these ways of understanding their

distress respected, explored and privileged or superficially acknowledged or integrated into the psychological meaning-making systems (e.g. psychological models) that you might be using in the assessment and formulation?

- 5 How does the client present themselves and their difficulties to you? How do these ways of presenting make sense to the client in terms of their own cultural etiquette (e.g. how to respond to elders, to men or to professionals) or in terms of their own histories of oppression (e.g. how to talk or protect yourself with those in authority, or with white people in 'white institutions')? Clients present themselves and their difficulties often in ways that make sense to them; which feel safe for them; and which may determine what they are offered. How can a formulation take these factors into account?
- 6 What are the multiple contexts influencing the client and their difficulties? How might these influences be crucial in understanding

which resources and opportunities clients have for change, and what are the impasses to change? For example, what is the significance and the impact of the marital or familial context for the client and the related cultural factors? What are the influences and immovable forces of power in the client's economic and political context and how might that be linked to the history of racism for black and minority ethnic people in Britain, and specifically for the client? For example, is there likely to be an opportunity and any choice for a client to be able to move out of accommodation where they and their children have experienced racism from neighbours and in the area despite the impact on their well-being? To what extent might the reality of poverty and institutional racism be factors for consideration, engagement or neglect within an assessment and formulation? Does feeling powerless as a practitioner to do something about such disadvantage and oppression justify not addressing these issues in a formulation? What might be the ethical and practical implications for intervention and for the evaluation of such interventions or for the absence of any interventions addressing these material realities?

- 7 What are the client's experiences in relation to the multiple contexts identified in the assessment? For example, which opportunities in life have they been afforded, or denied, because of who they are as, say, a white, middle-class male, or a young, black, gay male? Which negative experiences have they had (e.g. racism at work, racist

attacks, or racist, verbal abuse on the streets, or homophobia within their own family and religious community as well as within the majority white gay community)? What might be the impact and influences of these experiences on the client, their life, their relationships, their view of the world or their interactions with you? What are the implications for the models that you employ, the interventions that are planned, the appropriateness of the practitioner themselves or for the configuration, or re-configuration, of the roles of a clinical psychologist?

- 8 The process of mapping and exploring the development of presenting difficulties and ways of coping is one which forms the backbone of traditional psychological approaches to assessment and formulation. How does the experience of racism in the client's life, in education, employment, in the lack of opportunities, etc. manifest in and account for the presenting difficulties or for the way in which the client (or their family) attempted to manage/ cope to date? How can a formulation effectively address the aforementioned questions and suggest an ethical and just approach to interventions?

It is precisely the contention here that no single Western psychological approach currently exists which can adequately address the reality of both material and relational power and powerlessness and the impact on people's lives and distress. However, contributions from narrative approaches to therapy (White and Epston, 1991) and social action approaches to therapy (e.g. Holland, 1990, 1992b) provide both hope and indication that perhaps psychological approaches can contribute to social change in differing degrees and address the issues and reality of power. However, the paramount question remains: is psychology and psychological interventions as currently configured in the West the only, or indeed the most effective, way to address social inequalities and their impact on people's well-being?

[Box 7.3](#) highlights questions which might stimulate relevant discussion and facilitate the development of intervention skills within supervision.

Understanding organizational contexts

Another important area of competency in clinical psychology is the ability to understand the organizational contexts which encapsulate and shape service design and delivery and the ability to develop ethical, professional and just psychological practice within those contexts. Central to this competency is the unequivocal commitment to developing services which best serve clients from all sections of the population.

Supervision can provide a space to reflect on the way power operates within the organizational context, including within the legislative context as it relates to health care; within the profession, its espoused ethics, code of conduct and practice guidelines; within the particular NHS trust; within the psychological services or within the local, team context. Part of understanding the operation, functions and outcomes of power within these contexts is the opportunity to examine the role of clinical psychologists in challenging discriminatory and oppressive structures and practices which exclude and

Box 7.3 Interventions

- 1 Given your formulation, which psychological models or specific interventions might most effectively address the varying layers of experience and meaning contributing to the client's distress? For example, is there a particular approach that might be appropriate for the client in question and their difficulties, which may be a product of racism, marginalization and oppression? How might your planned intervention address the reality of, say, racism and poverty in a client's life? How would you carry out this intervention, with whom, when, and who else would you need to consult

other than the client? How will this be explained and negotiated with the client?

For example, if a client who did not speak English was assessed by a colleague without an interpreter and subsequently denied a service which you believed would be crucial or preferred by the client, how would you proceed? Would you simply organize a referral or access to the denied service in question? Would you also challenge the colleague who conducted the initial assessment, or would you alert the client to their rights and enable them to lodge a complaint or make a formal complaint yourself? How far would you be prepared to proceed, for whom, with whom and why?

- 2 What are the possible assumptions, values and cultural biases inherent in the interventions you have planned and in the models from which they are derived? What might be the implications of using such interventions with the client?
- 3 How will you explain to the client the rationale for the type of model and interventions you plan to implement? How will you facilitate the ability and create genuine opportunities for the client to question the utility, validity or appropriateness of your planned

interventions? For example, how would you respond to a client who says ‘How will talking help...we don’t/I don’t believe that just talking will change anything in my life?’ How might you explain the culturally bound belief that talking is helpful in Western therapeutic practice and how might you facilitate the client in making an informed choice about whether to consent to whatever you are offering or to request alternatives?

- 4 What might be possible parallel processes in the therapeutic process and relationship which mirror, replicate and perpetrate experiences of discrimination that the client has had in their life? How can these processes be identified, and both acknowledged and explored with the client?
- 5 How might you reflect on and challenge your own prejudices and racism, however unintentional, in the therapeutic process? How would you know when your interventions were oppressive or racist in their outcome? How would you know when you or your therapeutic style or approach was experienced by the client as blaming or as being totally blind to or dismissive of the client’s cultural beliefs, ways of living or practices? How would you enable and facilitate an exploration of these issues during therapy? Where and with whom might you want to reflect on these issues in safety?
- 6 To what extent do your interventions focus on the problems, weaknesses and vulnerability of the client in a way that might be experienced as pathologizing or blaming the client—for example, for their experiences of racist abuse in their workplace? Could

strategies for helping the client to be ‘more assertive’, or to reevaluate their perception that ‘everyone is out to get me at work ... they’re constantly watching and waiting to pick on me’, or to explore the reasons why they perhaps repeatedly find themselves in situations or relationships, both personally and at work, where they are victimized, be experienced as and function as being oppressive and racist in themselves?

- 7 How could you assess the impact of racism on a client’s life and formulate effective intervention strategies? How could your interventions challenge racism in the client’s life, as well as in the therapeutic relationship, in the therapeutic work and in the related professional network/team? Which personal and professional resources would enable you to challenge such racism effectively? What would ‘challenging racism’ look like in practice?

- 8 To what extent are your interventions or your therapeutic approach designed, adapted or chosen specifically for the client in question, or to what extent is the client expected to fit into and respond to your own preferred approach, or into the dominant model within your service, regardless of the client's cultural background, or specific experiences and issues around oppression? What are the implications of this for the client? What is the implication of this in terms of power and its abuses within the model used, within the service, within the profession and within your own clinical practice?
- 9 To what extent do your interventions assume that all of the client's presenting difficulties can be attributed to their culture, or to experiences of racism, or, conversely, that culture and racism are irrelevant factors? What are the implications of this for the client?
- 10 When might you choose to and how might you work with a bilingual co-worker or an interpreter in therapeutic practice? What are your beliefs about the value of working with such colleagues in therapeutic practice? To what extent do your own anxieties or possible lack of experience and skills in working with interpreters influence your choice to either deny some clients psychological therapy, or deny them a right to a professional interpreter? What might this illuminate about power relations and unintentional racism? What might be the implications for clients or 'potential' clients (those who cannot access our services)?
- 11 What are the range of ways in which your therapeutic interventions could be evaluated, particularly with regard to their validity and their effectiveness in addressing issues of culture and/or racism significant to the client? What role might the client themselves be entitled to and be allowed to use in enabling an honest and just evaluation to take place?

abuse, amongst others, black and minority ethnic people. The role of psychologists as potential change agents in developing more equitable and appropriate services for black and minority ethnic people is advocated by Nadirshaw (2000) and by the Division of Clinical Psychology in their Briefing paper on services to black and minority ethnic people (DCP, 1998).

Questions which could contribute to relevant discussions and to the development of organizational skills within supervision can be found in [Box 7.4](#).

Box 7.4 Understanding organizational contexts

- 1 What were the historical, social, legal and cultural contexts within which the service you work in was first conceived and developed? How did these contexts and related motives operate in a way that some sections of the population were excluded, marginalized or ill-served?
- 2 What is the composition of the local population which your organization serves? What are the numbers of black and minority ethnic people in your area; what are their backgrounds, histories and differing needs? Are they aware of the availability (or not) of local psychological services, statutory and voluntary? What is the range of perceptions, assumptions, fears and expectations of these services or those that work within them? What evidence exists to reveal their use of, or avoidance of, or exclusion by these services? In the absence of such evidence what would we need to do to find out and to develop more appropriate services?
- 3 What is the composition of the client population referred to and seen by clinical psychologists? How does this compare with the composition of the local population? How is this monitored within your service, or your team, or by yourself in your own caseload? How does such monitoring impact on the design and ongoing development of services and clinical practice? If service design and delivery is changed in response to monitoring exercises then how is this change evaluated, and by whom?
- 4 What might be some of the reasons for an absence of or relatively very low numbers of black and minority ethnic people within your service? What are the issues of accessibility of psychological services? Or, conversely, what might be some of the reasons for an over-representation or disproportionately high number of black and minority ethnic people in certain parts of the service, such as in acute mental health wards or in forensic settings? What are the implications of this for clients, or for the local black and minority ethnic populations, or for the service? What are the roles and the ethical responsibilities of clinical psychologists in addressing these

factors? What would it mean for psychologists to remain curious bystanders or to remain disinterested or comfortably blind to the contributory processes and functions of power, and to exclusion and oppression?

- 5 How might clients who do not speak English be able to access and to utilize psychological services? Which services are made available

to them or denied them, and on what grounds? For example, particular psychological services may be denied to people who do not speak English because of practitioners' beliefs that psychological therapy is compromised, impossible or rendered ineffective with the use of interpreters or bilingual co-workers. Such practitioners may deny their own lack of competence and experience in working with interpreters or attempt to obscure their lack of commitment to providing appropriate services equitably to all those in their local population. What are the implications for would-be clients of such practices and defences offered? What might be some of the ethical, professional and legal obligations of clinical psychologists to address these issues effectively? Which policies might need to be implemented within the organization? Which resources would be needed and how could psychological services be developed to be able to serve all those in the local population?

- 6 Which policies exist within the organization and within psychological services to ensure equal opportunity to access health care services? How are such policies operationalized within your own service or team? How are these measures monitored and evaluated? What is the role of clinical psychologists in this process? What steps are taken when such policies are breached? What might be your own professional and legal obligations in such situations?
- 7 What is the make-up of the profession, the British Psychological Society and clinical psychology training courses in terms of the proportion of black and minority ethnic people? To what extent does this reflect the composition of the national population? What might be some of the reasons for the overall under-representation of black and minority ethnic clinical psychologists in the profession and the particularly low numbers of those from specific ethnic backgrounds, and the under-representation of black and minority ethnic clinical psychologists in academia and in senior positions within the profession and in the NHS? What might be the implications of this for the profession, for psychological services and for clients?
- 8 How might we effectively translate our awareness and understanding of the aforementioned issues into the development of the profession and into the design and delivery of appropriate and just psychological services?

Personal and professional development

In learning how to understand and manage the dynamics related to culture and 'race' Helms and Cook (1999) argue that supervision is indeed the most logical and primary vehicle for influencing personal and professional growth and development for both supervisee and supervisor. Scaife and Walsh (2001) describe personal and professional development as an ongoing learning process about aspects of the self in relation to others. They identify three categories of aspects of self: acknowledging the personal impact of client work; the influence of events outside work on relationships at work; and the influence of personal life history, values, beliefs and personal characteristics on relationships at work. The primary and most crucial aim is to focus on professional practice that is of benefit to the client. It is also important to acknowledge that if supervision is to facilitate personal and professional development effectively then it is an obligation for both supervisees and supervisors to learn about aspects of self as it applies to the supervisory relationship and to the process of supervision itself.

Who we are, how we experience and see the world, how we relate to one another, how we practise in a professional context and the baggage and resources we bring to supervision and to our overall work are all areas for concern in personal and professional development. Learning to be a clinical psychologist is thus more than just learning about clinical psychology, it is about learning how to integrate our personal and professional identities in their totality; that is, as constituting our identities in terms of our gender, ethnicity, age, sexuality, class, etc. In supervision that can mean, for example, a supervisee being encouraged and facilitated in learning what it means to be a black, female clinical psychologist; learning how it impacts on both her professional relationships and on her clinical work; how to make oneself safe as a black professional at work where subtle and perhaps unintentional institutional discrimination is pervasive; or how to recognize, challenge and manage racism when encountered within a clinical session, within clinical supervision or within management supervision.

D'Andrea and Daniels (1997) emphasize that both ethnic and racial identity development—that is, 'the way individuals view themselves as cultural/ethnic/racial beings'—represent important considerations requiring discussion in supervision. They describe the range of ethnic identity development models which currently exist, such as Cross's (1971, 1995) model of black racial identity development, the minority identity development model (MID) (Atkinson *et al.*, 1993), white identity development models (Helms, 1995; Ponterotto and Pedersen, 1993), and assert that assessing at which stage(s) of ethnic-racial identity development supervisors and supervisees are likely to be functioning is of critical importance in understanding the process of what they call multicultural supervision. Thus, the essence of supervision which addresses personal and professional development is the ability and willingness for both supervisee and supervisor to reflect on their own, and perhaps each other's, ethnic-identity development stages in relation to clinical practice.

Improving supervisory practice

Supervision that values and actively facilitates personal and professional development is one where safety is fostered, reflection is encouraged and modelled, permission is given to explore the personal-professional interface, and where related uncertainty, confusion, anxiety, fears and ambivalence are normalized, accepted and not judged. Such supervision also requires that both the supervisor and the supervisee are committed to ongoing learning and to their own ongoing personal and professional development. The suggestions below identify some ways in which personal and professional development in relation to considering issues of culture, racism and power can be pursued:

- 1 Supervisors and supervisees can examine their own values and beliefs as they manifest in the supervisory relationship and in the supervisory process itself. Scaife and Walsh (2001) provide excellent examples of how supervision can be used in this way—for example, by audiotaping a supervision session with a view to reviewing it specifically to identify the values and beliefs of both supervisor and supervisee.
- 2 Supervisors and supervisees can reflect privately or with colleagues and perhaps discuss models of ethnic and racial identity development and how they may apply to their own supervisory relationship and to the supervision of clinical work.
- 3 Supervisors might seek further training in the form of seminars, workshops, conferences and courses to develop their knowledge, understanding and skills related to working with black and minority ethnic clients, and to providing supervision to supervisees from a range of minority ethnic (or majority ethnic) backgrounds.
- 4 Supervisors and supervisees could seek out and consult black user groups, minority ethnic community groups and black and minority ethnic colleagues to enhance their own knowledge and understanding of issues related to culture and to individual and institutional racism, etc.
- 5 Supervisors and supervisees could identify and reflect on their own experiences of inequality, racism, disadvantage and privilege and of being marginalized in their personal and professional lives. They could consider how this might influence their identities, values and expectations; their relationships at work; their professional activities—especially their work with clients. This might be an ongoing theme for discussion during supervision sessions.
- 6 Supervisors and supervisees may need to identify and use existing or potential sources of support for themselves, particularly sources which would facilitate their confidence and competence in addressing issues of culture, racism and power in all areas of their professional practice. Sources of support could include professional relationships, personal relationships

(such as friends, partners and family), professional networks and user networks.

In conclusion, this chapter has attempted to explore key issues and some of the ways of improving supervisory practice in clinical psychology to enable us to develop greater understanding, confidence and competence in addressing power, cultural differences and racism. Whilst some implications for supervisors and supervisees have been outlined, the overall implications for the profession also require attention, although these will be mentioned only briefly here. Key implications include the responsibilities for our professional body in examining its own structure, policies and procedures, and its own organizational processes which reinforce a Eurocentric bias in every aspect of clinical psychology. Clinical psychology training courses also need to re-vision the content and methods of training, to examine their own biases and institutional racism and to pay particular attention to the benefits and the abuses within supervision (clinical, academic and research supervision) in relation to cultural and racial oppression. Finally and inevitably, the content and nature of training for supervisors and the monitoring of supervisors and supervision have to be important challenges for the profession to embrace.

Chapter 8

Incorporating gender issues in clinical supervision

Maxine Dennis and Gill Aitken¹

In line with the Society's Equal Opportunities Statement and Policy all clinical psychologists should ensure that they maintain an up-to-date knowledge of issues regarding race and culture, gender and class and how such issues can impact on their day to day work as a member of the profession.

(DCP, 1999: Section 2, Principle 9)

Given the traditional and contemporary psychological ideologies about women and/or the patriarchal nature of the institutions in which they are practised, in what way should women relate to either the ideologies or the institutions?... Can female therapists 'help' female patients different from male therapists?

(Chesler, 1972:105)

Introduction

Throughout this book, there is implicit, if not always explicit, acknowledgement of differences in structural relations of privilege and power along the supervisor-supervisee dimension. In clinical psychology, as in other mental health and therapy trainings, the supervision process aims to enable supervisees to learn to bring together theory, techniques and interpersonal interventions:

Supervisors are vested with the power and responsibility, by their institutions and training programmes to evaluate, influence and judge trainees. They are also supposed to provide to the less skilled inexperienced and less knowledgeable student therapist the skill, knowledge, and personal awareness, to help the client in a professional and ethical manner.

(Carter, 1995:237–238)

In the context of the current chapter, we might want to consider how clinical supervision creates opportunities for a space and means of opening up different perspectives and dialogues which allow issues of diversity and power to be considered (McQueen, 2000). In our experience, training within clinical psychology is slowly moving towards providing awareness of how we develop and relate to one another from the (ad)vantage point of both our personal and various referent group memberships or identifications— as (trainee) clinical psychologists who are variously gendered, sexualized, racialized, and classed. The question of how we embody such (non)awareness of these identifications in our practice also requires us to be able to understand how this both reflects and informs the operation of power. However, the recognition or realization of how power relations are played out, and their differential effects, may be understood as too painful or too threatening to voice so that ‘that which is unspeakable cannot be challenged’, with the effect that dominant-subordinate relations are reproduced (Font *et al.*, 1998; Miller, 1986).

Within clinical psychology, it is mainly from the mid-90s that training programmes have systematically started to offer often limited ‘specialist’ one- or half-day modules or workshops in relation to diversity, whether that be gender, ‘race’ and/or sexuality. When explicitly incorporated into the curriculum, in our (and other trainers’ experiences) common questions raised by trainees revolve around the relevance of such an approach: ‘we now live in a more equal society’, or that ‘to notice gender, disability, or “race” is in itself discriminatory’, or that issues of inequality are not relevant to clinical psychology as ‘we treat everyone as an individual’ or ‘we work collaboratively’. At other times, trainees and supervisors want to know ‘how do we *do* gender in supervision?’ or ‘what set of skills/techniques do we need to learn?’ In part, we understand such responses in the context of how paralysing, or overwhelming it can be to us as individuals as we begin to personally and professionally become aware of the privileges and access to power resources we have. In part, we might understand responses to reflect the gender and culturally neutral approach of the dominant scientist-practitioner model of clinical psychology training in which the practitioner is positioned as a neutral, objective yet ‘expert’ participant whether in therapy or supervision encounters (Sayal-Bennett, 1991; Nadirshaw, 2000; Aitken, 2000b). Such observations are not specific to clinical psychology training (see e.g. Carter *et al.*, 1992).

Indeed, when we look at key texts cited in course documents outside of ‘specialist’ gender and diversity modules, or in the wider clinical psychology literature, there is little reference to gendered and racialized identifications unless as a demographic variable. Noticeably visible in their absence are gender-related issues in both therapy and clinical supervision in the UK clinical psychology literature. When preparing for this chapter, we found four texts which featured a collection of articles or chapters which explicitly explored and debated the gendered and power implications of clinical psychology as a profession or clinical psychologists as professionals: one book and three special journal

features/editions. Three at the beginning of the 1990s and one in 2000: an Open Forum in *Feminism & Psychology* entitled: 'Clinical Psychology Training: Training in Oppression' (Williams and Watson, 1991), *Gender Issues in Clinical Psychology* (Ussher and Nicolson, 1992), 'The Gender Issue' in *Clinical Psychology Forum* (Vetere and Gelsthorpe, 1994) and 'Women and Power' in *Changes* (McQueen, 2000).²

Here we aim to contribute in positive ways to the debates around why clinical psychology should be concerned with gender issues, and how gender issues can be thought about in supervision. We do not propose the use of a prescriptive model, or a 'recipe cook book' of techniques or strategies; rather, we draw on a range of resources to facilitate ways of thinking about and relating to these issues. Given the relative dearth of publications from within clinical psychology in the United Kingdom, we also draw on the work of wider feminist and anti-oppressive practitioners and therapists both from within and outside the UK to inform the development of thinking about gender issues within our own profession and to open up possibilities for conversations among and between ourselves.

The rest of this chapter is divided into eight main sections. In the first section, we briefly introduce ourselves (the authors) to provide the readers with some context of why we are interested in the topic of gender and power. In section two, we review some terms and definitions (around gender, power and empowerment) which are often used in working with diversity issues. This is to make more clear what we understand by these and to think about how we might need to support ourselves in preparing to reflect on and explore these issues. In the third and fourth sections, we outline a 'process' model of supervision as a framework to illustrate the complex web of relationships and contexts, which enter the supervisor-supervisee relationship, and provide some of the research evidence on the impact of wider social political contexts (section four), including clinical psychology developments (section five). We then focus on possible gender influences and effects on the process of supervision, including the supervisee-client and supervisee-supervisor relationships (section six). In section seven, we take this back out to implications for working with a client (as gendered). In the final section we discuss a case to work through, and questions we might ask ourselves.

About ourselves

Many feminists and anti-oppressive writers and practitioners argue that it is important to make more visible and transparent one's own commitments and positionings as ways to think about the power implications of what we practise (e.g. Hewson, 1999)

Gill

I have been working as a white-identified woman (trainee and qualified) clinical psychologist since 1993. In 2000, I negotiated a post explicitly as a clinical psychologist in women's services.

My interest and commitment to exploring issues of social inequalities reflect my understandings of my own gendered experiences in childhood (e.g. within a bi-European family, at school) and adulthood (e.g. first gaining work in clerical and secretarial fields). This developed through talking with others, and seeking out feminist and anti-oppressive writings. I initially entered higher education as a mature student to 'find a voice' and as a way to 'empower' myself. Entering clinical psychology training in the 1990s, I was also struck by the absence of reference to the social context of people's lives in descriptions and understandings of their presenting distress, or in the routes into clinical psychology services. Relatedly, there was little discussion about the possible differential gendered meanings and feelings of being referred to a particular service, with particular diagnoses, and in working with me as a woman psychologist and/or my possible feelings and attitudes about working with different women and men.

I understand a central aim of feminism to be to work towards social justice, but over the years I became aware that white (middle-class) feminists did not necessarily reflect or relate to the experiences of all women (hooks, 1981; Wilkinson and Kitzinger, 1996). I understand that 'white feminists must actively struggle to eliminate the structural racism from which we benefit' (Harding, 1986). Attempts to question the status quo always risk being constructed as 'too extreme' or as 'too emotive', and a person raising such issues risks problematization and marginalization or 'burn-out' (Holland, 1995; Sayal-Bennett, 1991). Resistance to changing the status quo often takes the focus away from the issues being raised (inequality, social injustice) to minimizing or trivializing the issues, or through forms of personal attack against the individual (s) (Aitken, 1996).

As I have continued to engage in reflective practice, I have moved from only focusing on the power of others (whom I constructed as dominant groups). I have become more aware of my own power resources, and power as relational. These include in my role as a supervisor (in relation to supervisees); as trainer (in relation to trainees); as clinician (in relation to client/patient), and as a white, woman professional who now has access to a range of economic resources (in relation to peers/clients). Rather than denying or necessarily experiencing my structural power as negative, I attempt to develop productive social power in relation with and in conjunction with another. In relation to both supervision (Hewson, 1999) and therapy (Aitken, 2000a), possible strategies include making more explicit power relations in encounters, identifying and negotiating how external constraints might need to be met, and maximizing choice in the context of such constraints.

Maxine

The question of how clinical teaching and supervisory practice address culture, racism and oppression have been of long-standing interest. Further, I am concerned about the provision of culturally appropriate clinical psychology and psychotherapy services.

As a manager of a primary care service, accessibility, quality and the provision of a service that adequately meets the needs of patients are central. Therefore, directly tackling issues of gender bias and factors that may hinder various communities, uptake of the service requires ongoing interrogation.

Much of my writing has focused on the impact of racism and oppression in therapy (Bennett and Dennis, 2000) and how these issues are addressed within supervision (Dennis, 1998). If we examine the literature it suggests that many black people do see the impact of racism as a more significant oppressive force than sexism (McKay, 1992). Equally the various strands of the white feminist liberation movement have been charged with being narrow and irrelevant to black women's lives. However, to separate being black from being a woman (man) does an injustice to a whole area of black people's existence and experience. The work of many theorists, for example Lorde (1984), Morrison (1992), hooks (1990, 1993), Collins (1990) amongst others, has had a great impact on my thinking and understanding.

Temperley (1984), for example, points to the ambivalence all of us feel towards the complementarity of the sexes. She states that it is easy to blame one sex or adopt an adversarial/rivalrous position which may eclipse the importance of sexual interdependence, union and creativity.

In my clinical work the aim is towards an openness and readiness to work with what the patient/client brings, in order to provide a container (Bion, 1959, 1962, 1970) which promotes some growth and understanding. An awareness of the socio-economic and political inequalities, together with the clients' /patients' connection with their community, is integral to my work. However, I continue to reflect on my practice and in so doing allow space for it to continue to evolve.

It is perhaps no surprise that Gill and myself chose to write this chapter together, for as McLean-Taylor *et al.* poignantly observe:

The persistence of racism, like the persistence of patriarchy, is a sobering historical and psychological reality. Patriarchy, as Gerda Lerner (1986) observes, has been another name for civilization. The 'race', class, and gender hierarchy, when re-imposed generation after generation, guarantees the continuation of this equation. As women of colour remind white women of their complicity and their privilege, so white women remind women of color that they have a common interest in breaking this cycle.

(McLean-Taylor *et al.*, 1994:212)

We hope that this joint chapter helps take us in some small way towards a greater understanding and appreciation of these interrelated issues within the practice of supervision.

Definition and concepts

Already in this chapter we have introduced terms and concepts of gender, power, and empowerment. Here we briefly consider some of the definitions available and consider what this means for our work as clinical psychologists. What we argue is that the particular definition(s) that we might draw on will both reflect and construct our practice in relation to therapy and supervisory encounters.

Gender

Often in the literature, 'gender' is used interchangeably with 'sex'. However, gender cannot be reduced to a single dimension such as genetic, genital, gonadal or hormonal sex. For some, the concept 'sex' is differentiated from 'gender', with the former being located in biological differences whereas the latter is as a social construct—whilst others contest that both sex and gender are social constructs rooted in social judgements and expectations. Gender has been variously and interrelatedly defined as

- the social characteristics of sex;
- a dynamic structural relation between women and men;
- a process through which social life is organized at the level of the individual, the family and society;
- the central feature is power.

A general assumption underpinning such definitions is of sets of dichotomized behaviours associated with femininity and masculinity (i.e. gendered differences or polarity around the categories of women and men). Some have argued that femininity is constructed to absorb everything defined as not masculine, and always to acquiesce in domination by the masculine; and gender is often considered a property of individuals and their behaviours, rather than also social structures and conceptual systems (Harding, 1986:34). Some authors prefer to talk about the politics of gender to highlight how power affects how women and men relate to each other and one another, and how gender is an integral dynamic of social orders (Lorber and Farrell, 1991). For example, it is argued that as we grow up socialization processes differentially affect boys and girls. That is, boys psychologically 'expand' and have increased cultural expectation about the development of an autonomous self and identity. By contrast, girls 'psychologically contract', with a sense of self developed in relation to the needs and desires of others (Larkin and Popaleni, 1994). This has been associated with men taking more instrumental roles (in external or public spheres) and women

being socialized into taking more expressive roles (in internal or domestic spheres). Whilst we question this separation of public/private spheres, it can be a starting point to explore gendered aspects of everyday life.

R.J.Green (1998) highlights ten traditional norms of masculinity, which are variously affected by age, 'race', ethnicity, and education, family and peers' ideas of gender. These norms include the suppression of emotional vulnerability, avoiding feminine behaviours and activities traditionally associated with the woman's role, primacy of the work role for power status and self-esteem, independence (thus avoiding or denying dependency on others), aggression to control others or means of conflict resolution, toughness/air of confidence in the face of adversity, pain or danger; striving for dominance, provider/protector for others in family, treating sexual partners as objects, homophobia (irrational fear or anger at gay men and lesbians, avoidance of emotional closeness and affection with other males):

a first step in creating change lies in an evolving consciousness of the straightjacket that gender norms and heterosexism impose... In this sense therapy becomes one vehicle for the construction of male identity. It challenges roles, it positions itself as commentator on structural aspects of class and culture that intersects with gender to create oppression. Our therapy must be culturally conscious and it must promote values in keeping with changing, positive values in keeping with changing, positive definitions for both men and women. These values would include a mandate for collaboration, partnership, and equality.

(Bepko *et al.*, 1998:79)

Font *et al.* (1998), in a therapy of liberation article, provide an expanded male and female role, which one might use in supervision to help both female and male clients think about masculinity and femininity. We explore this further in the clinical example presented on pp. 155–159.

A central question for us is what might be the possible implications for us as (trainee) clinical psychologists if we internalize or reject various genderrole stereotypes or attitudes, either in relation to self or to other women or men. Awareness of such gendered assumptions or premises may enable us as therapists/practitioners, or supervisors/supervisees, to attend to these issues in our constructions of self and others, and be alert to possible constructions by others and their possible impact or relevance to therapy and supervision encounters.

Power

Power as a concept has also been variously defined and has generated numerous typologies. The definitions that we are focusing on here include:

- Power is the ability to control ourselves and others (Leigh, 1984, cited in Ridley, 1995).
- Power (can be) an awareness, an understanding, a realization that you already have power, albeit power that the culture does not recognize (Kitzinger, 1991: 120).
- Power as positive, as the capacity to produce change (Mitchell, 1974; Taylor, 1994).

As defined above, power can be, and is often, located in the individual and as possessed by the individual. However, such a perspective ignores the relational aspects of power. Power enters our everyday discourses, often signifying the value of male behaviour and the devaluing of female behaviour. Organizationally, power has meant individual progress alongside the ability to limit, control and sometimes to destroy others' power (Miller, 1986). Whilst stereotypically women's power base is relational (Gilligan, 1982), including notions of taking care, being both supportive and facilitative of others, this form of power may be less readily seen or readily defined or legitimized within organizations. 'Relational power is not only about exercising power over others more effectively, but also about facilitating power in others' (Cassell and Walsh, 1993:113). This notion of relational power (both potentially oppressive and enabling) is the province of the chapter.

In considering the exercise of power in a supervisory context, the supervisor typically defines the relationship and is assumed to have a greater knowledge base, objectivity and status than the trainee, and as such can maximize or minimize the trainee's sense of powerlessness, which is present in the relationship. These feelings may be more evident at the beginning of training. The quality of the supervisory relationship can affect a client's feelings of powerlessness, which can be maximized or minimized depending on the power relationship set up by the therapeutic relationship. Clearly, this is not the full picture, as in being aware of the matrix of relationships which enter any interpersonal encounter we can start to be aware of how both the supervisee and the client may also have a powerful impact on the supervisory and therapeutic relationship respectively (see [Figure 8.1](#)).

In exploring power relations in supervisory encounters, Pinderhughes argues that a 'supervisor may use the helping role to reinforce... (his or her) own sense of competence by keeping subordinates in a one-down position' (1989:111). In this context, trainees are vulnerable to replicating aspects of harmful, or at the very least unhelpful, interactions with supervisors in a parallel process with clients, thereby extending the influence of an unhelpful supervisor onto clients.

In any hierarchical situation, the people in power typically define reality. Men have done this for women, parents for children, majority white people for black and minority ethnic people, mental health professionals (including psychologists) for clients/patients, and supervisors for trainees (Fernando, 1995; Nadirshaw, 1999; Pinderhughes, 1989; Ussher and Nicolson, 1992). As

(institutionally accredited) experts, power advantage includes enhanced credibility. The status of the supervisor means that it is often their word that is listened to rather than the trainee's, even in clear-cut differences of opinion, such as that concerning the lack of time available for supervision. If gender issues are not acknowledged as valid or legitimate areas of exploration by a supervisor, then how power relations are played out will have differential effects, possibly with a greater bearing within the supervisory relationship when the supervisee is training, and once qualified if the supervisor also has a managerial role to play.³

Empowerment

The concept of empowering ways of working has been particularly utilized by feminist researchers and practitioners in relation to women, and by professionals in relation to socially disadvantaged groups, including people diagnosed with severe mental health needs and learning disabilities. Three different definitions of empowerment are as follows:

- A person experiences herself as having a legitimate right to claim her voice and having expertise and a referent framework from which to act (Hewson, 1999).
- Empowerment can be felt momentarily or can be transformative when it is linked to a permanent shift in the distribution of social power (Yuval Davis, 1994).
- Empowerment involves rejecting the dimensions of knowledge, whether personal, cultural or institutional, that perpetuate objectification and dehumanization (Hill Collins, 1990).

Work around empowerment and empowering strategies typically reflects individualized approaches, which 'rely on developing in women this sense of personal agency...create in women a certain state of mind (feeling powerful, competent, worthy of esteem, able to make free choices and influence their world)' (Kitzinger, 1991:122). However, the lived reality of being able to make free choices and significantly influence the world may be more restrictive than we would like to think. As Kitzinger and others caution, this risks leaving the structural conditions unchanged and ignores the structural and social realities and conditions of many women's and members of minority groups' lives (see also Bell, 1995). From such positions (or based on such arguments), teaching the historic 'disempowered' to think positively, learn how to speak up and out, or how to be assertive are unlikely to change people's experience associated with being a member of socially disadvantaged groups.

Preparing ourselves for thinking about these issues

In western culture many men are trained to have a confident, selfadvertising presentation, which can earn expert power even when they

do not have relevant expertise. On the other hand, women are often trained to have a collaborative, self-effacing presentation which does not tend to earn expert power even when they have the expertise.

(Hewson, 1999:407)

Supervision is an opportunity to attend to pre-existing beliefs, stereotypes and perceptions which may impact on the ways we relate with and behave towards ourselves and others, as well as attending to more subtle aspects of gender in the (counter)transference. Killian (2001) posed a number of questions for supervisees and supervisors to ask themselves as a way to facilitate integrating gender and culture issues in supervision, which we have variously adapted. They are as follows:

Supervisee

- 1 How does your cultural self ('race', class, ethnicity, gender, professional identification, etc.) play out in the therapy room, in supervision?
- 2 How do you think your educational experiences affect your expectations of supervision in this training?
- 3 In which cultural context do you feel you have been practising your skills as a therapist? Which types of knowledge, skills are privileged?
- 4 How useful or effective would therapy be in general, or in this particular intervention, if sharing cultural similarities (e.g. gender, 'race', sexuality, class) with your client or your supervisor? What assumptions are underpinning notions of similarity?
- 5 How do assumed 'differences' in cultural context inform how you would set up therapy and supervisory encounters?

Supervisor

- 1 What is your knowledge of the ecosystems of culture, ethnicity, 'race', class, and gender, how do they relate to one's cultural self and affect perceptions of the world? When and how is this made explicit with supervisees?

- 2 What is your understanding of past and present relationships between your own culture and that of others? How is this communicated in supervisory encounters?

- 3 What is your understanding of how indirect and direct, covert and overt discriminatory practices may operate to marginalize and oppress members of particular social groups? Do you think such issues are relevant to clinical psychology?
- 4 What might facilitate or be a barrier to understand self and trainees as cultural and 'racial' beings?

To facilitate preparing ourselves to be able to 'speak about' these issues, supervisors and clinicians need to be familiar with some of the debates and research and publications (which may appear outside of mainstream texts and publications) on gender. These may include possible impact on clinical judgements of mental health, which are played out in the interaction of gender with 'race', class and age.

We would argue that it is the (ultimate) responsibility of supervisors to create the conditions for trainees actively to explore values and beliefs. This would include explicitly naming that as supervisors we welcome challenge to our own ideas, and that exploration of different viewpoints is a part of the learning and growth process for all (including a supervisor). As Killian's (2001) work highlights a holistic view of supervision, which incorporates cultural (and we would argue socio-political) contexts of any encounter, it is central to relate and connect supervisory with therapy processes, including power relations and interpretations.

One approach is for supervisor and trainee to name and discuss power imbalances during the initial placement contract. Clear boundaries, awareness of respective roles and responsibilities open up possibilities for a basis for a range of issues to be explored in non-condemnatory ways. This includes both 'visible' differences of 'race' and gender etc., which trainee and supervisor feel they have little choice about bringing to the encounter, and the potential more 'invisible' differences of sexuality and class, etc., which the individual may feel more able to choose. Any opportunity for self-reflection requires dialogue and the recognition that our learning is an ongoing process.

The supervisee's feeling towards and about the supervisor, how they are treated, whether conflict is addressed between them, and the encouragement to discuss things, can provide a parallel frame in deepening our understanding of our direct clinical work with clients. The enabling and containing aspect of the supervisory relationship is crucial. It may be that as supervisors we need to look at flexible formats for supervision in order to provide 'safe' spaces for supervision across gender (Milne and Oliver, 2000).

For example, in taking account of the 'female' relationship between work and power (indirect) and the male relationship (direct) within the psychology profession (a caring role) about equality and collaboration relations, there may be perceived tensions between power and 'perceived' position. Patel (1998), in

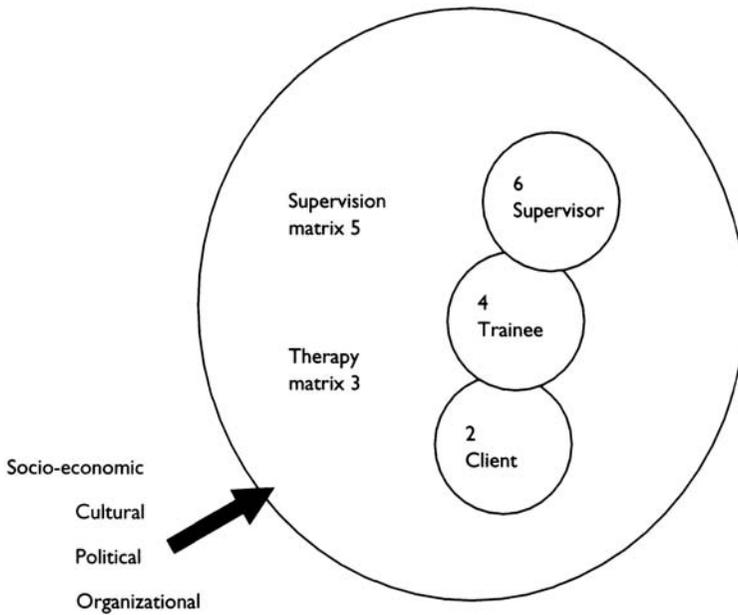


Figure 8.1 Process model of supervision

Source: Hawkins and Shohet (1989)

relation to 'race' and professionalism in 'black' (professional)— white (client) therapy encounters, highlighted the complexity of such issues. She noted that when occupying contradictory positions of 'perceived' subordinate (black-identified) group membership and 'dominant' (e.g. clinical psychologist), practitioners may find themselves drawing on strategies and tactics to reflect increased professional power to enhance credibility with a client expecting a dominant 'valued' ([sic]: white, identified therapist) (see also Aitken, 1998; Leary, 1997). This will have implications for supervision and issues that need to be addressed throughout placement and supervision experiences (see also McQueen, 2000).

Process model of supervision

We draw on a process model of supervision (Hawkins and Shohet, 1989) as a framework to visualize the richness and complexity of any supervision or therapy encounter. As indicated in Figure 8.1, we can identify a number of elements: client, trainee and supervisor, both as individuals and in various relations to one another (e.g. therapy matrix and supervision matrix). Such a model further makes explicit how any individual or encounter is necessarily embedded within and affected by (particular) socio-economic, political, cultural and organizational

contexts. *How* we understand the effects of the wider (social, organizational, professional) contexts on supervision and therapy will in part be dependent on our 'conscious' awareness of such issues.

As an example, we first consider the wider social context (as represented outside the circles). If as practitioners we adopt a consensus view of society (i.e. there is no conflict in wider society) then undertaking a gender-neutral approach to therapy will not be experienced as problematic or limited. That is, psychological distress is understood as reflective of individualized 'break down' which can be 'fixed' through individualized solutions, including psycho-educative solutions. This may involve the sharing of individualized techniques such as the learning of more adaptive cognitions, or behaviours, but which risk leaving the person as still unknowing about herself and her personal histories, connections and commonalities with others but which will inherently leave structural conditions unchanged. We might argue that such a societal view is the one into which we are socialized through clinical psychology training.

This is contrasted when holding a conflictual view of society, as one which is structured by social inequalities through which different individuals share commonalities (of exclusions and strengths) with others along dimensions of gender, 'race', class and the intersections of these. Such an approach necessitates the clinician and supervisor being aware of social inequalities and how such factors organize our existence *internally and externally*. That is, to hold a framework in which a person is understood as a social being and being aware of the ways in which institutionalized structures and systems of gender, ascribed 'race' and class are differently oppressive and constraining, both in the therapy encounter as well as any supervisory encounter.

In addressing issues within any therapy encounter, Sue Holland argues for a four-stepped 'social action' model. In this model the clinician is responsible for creating the conditions which go beyond an individualized 'fix' or curative approach. For example, for a woman being referred for depression, this would involve moving (but not imposing) the woman from patient (to be passively cured) to relating with another person (therapy) to explore meanings and how we relate to self and others. This can be developed by exploring options for the woman to link with others (e.g. group work) as a space to discover common histories to possibilities of a collective voice to work for change in our communities (i.e. social action) (Holland, 1992a: 73).

Within a process model framework we need to be aware that whether selfidentifying as woman or man, transgendered, lesbian, gay, bisexual or asexual, or as of black, white or mixed parentage, that growing up in Western society we have likely internalized powerful gendered and cultural messages about what is (un)acceptable and (de)valued just as have our women/men clients. We might ask ourselves to what extent do we make explicit to ourselves, or to our clients or in the supervisory context, our attitudes towards women and men, or what we consider as the normative limits of masculinity or femininity (see R.J.Green, 1998), and how comfortable does this fit with our ideas of ourselves as

professionals. Within supervision, it may feel that to raise such issues from a structurally less powerful position (supervisee) risks positioning ourselves in relation to the supervisor or to a psychologist as 'less than professional'.

As 'professional' men or women practitioners how do we experience sitting with a crying or angry man or woman client? How does it differ, if at all, if the client identifies as the same or other gender to us? What would be different if we, or they, also identified as gay or lesbian or heterosexual? Exploring within supervision should enable the beginning of the supervisee's own capacity for self-reflection, which Casement (1988) calls the internal supervisor, which is supported by the external supervisor pre- and post-qualification. At post-qualification one would expect a move towards more autonomous functioning.

Impact of wider social political context

In this section we present some background research findings, which have implications for supervision in connecting the external world (of out there) with the internal world (of psychology, of a supervisory relationship and of the individuals who come together). The specific knowledge base that we draw on will influence what is understood as significant and what is then validated.

The (everyday) material, social, psychological and political effects of the differential positions of men and women in UK society have been widely debated for decades. Research provides consistent evidence of differential effects, which seem to cut across cultural and class identifications. For example, in Bostock's (1997) review, differences are summarized under three broad headings.

Status and role expectations

Relative to men, women are accorded lower social status and more restrictive role expectations than men. This has been evidenced in the representation in structural positions of power in wider society, from the political sphere to the private and public sectors. For example, women are over-represented in heading up lone-parent families, looking after children, adults, older adults; as well as working at grass-roots level in the identified 'caring professions'.

Relating this to supervision, as practitioners, if discussing the needs of a male primary carer of children, we may be prone to idealize his role and work harder to offer greater practical support to him than we would a woman carer. Women who have harmed their children are more readily demonized, as they have transgressed both their mothering and caring roles.

Abuse and neglect experiences

Women are likely to have greater exposure to adverse emotional, physical and sexual abuse and neglect from childhood continuing into adulthood, with increased risk of social isolation.

Not only might this be reflected in the experiences of the women and men with whom we work, but also (as we are gendered) with our own experiences. How do we as men or women identify or un-identify with our clients, and with abuser/perpetrators and the abused/survivors? Do we even explore these issues within therapy encounters? What are the boundaries? If we hear about grooming and silencing strategies of male perpetrators, do we link this with our attempts to socialize our clients into our particular therapy approaches? What happens if we feel attracted to or feel hate towards our client? What happens if we become overt perpetrators, or we suspect a colleague or supervisor?

A salient reminder that as professionals we are not immune to reproducing such gendered inequalities can be found in the work of the Prevention of Professional Abuse Network (POPAN) (1994) and Garrett (1998, 1999). In a study of 171 cases studies of reported abuse by professionals in the National Health Service, men comprised 78 per cent of the perpetrators, of which 22 per cent and 51 per cent were known or suspected serial abusers. Of the survivors, 89 per cent were women and 15 per cent were trainees/workers in health care. In the reported cases, 12 per cent were psychologists (POPAN, 1994). In a 1988 survey of clinical psychologists (4–8 per cent) reported sexual contact with clients, with 35 per cent knowing of sexual contact between psychologists and clients (Garrett, 1998). This has clear relevance for supervisory encounters.

Access to societal resources

Women will have more limited access to economic, material and social resources. This is evidenced by figures which show that women are paid less than men, and that they form the majority living below the poverty line, being dependent on benefits, with implications for housing and contact with statutory agencies.

Failure of clients to attend for therapy is one example. As trainees, and supervisors, we are governed by narrow rules with pressures of waiting list times where failures to attend are often assumed to reflect a client's lack of motivation. What understanding do we have, and how do we support women with childcare issues who also have a restricted social support network and where our service may be one statutory appointment among many (social services, housing, general practitioners, etc.)? In supervision, do we discuss such issues? Do we consider such practical issues to be the province of clinical psychology? In supervision we have explored with trainees, how we can try to engage with a woman to explore possible conflicting needs. Given our earlier arguments about women's possible socialization to meet the needs of others, then it is important to explore how

being available to her children may be experienced as in opposition to a woman having a space to explore her (internal) needs. This can be done without the therapist taking up the position of a persecutory figure. Often client attrition can (privately) become a way to manage a waiting list, but without publicly rejecting a client.

Again, there are also gendered differences in access to societal resources within psychology as a profession. For example, in a review of grades in clinical psychology in 1988 men outnumbered women by 3:1 in the top grades (Ussher and Nicolson, 1992). Further, Ussher and Nicolson noted that women achieving success are often the fiercest advocates of gender neutrality (1992:14). This, they argue, may reflect the pervasiveness of gendered inequalities and the internalization of gendered assumptions. Within supervision we are mindful of the pressures on trainees (and supervisors) to take a gender-neutral perspective to meet the demands of the profession when 'core' competencies and the evaluation of trainee placements do not explicitly identify inequality or gender as an evaluation measure.

Drawing these threads together, the content and process of case formulation in supervision would need to be aware of the different frameworks in thinking about the ways men and women present distress. From a social inequalities perspective, women and men are differently socialized into subordinated and dominant positions respectively, and as part of the psychology of subordination it is argued that, for example, women are at risk of developing 'emotional/psychiatric disorder' or finding ways to exert control in indirect ways (e.g. use of alcohol, difficulties with eating and self-injury) to alleviate internal distress.

At one level we might argue that this is an extreme position to take, yet we see women over-represented in categories of affective related disorders (e.g. depression, anxiety, borderline personality disorder, affective psychoses), whereas men appear more often in the figures for substance misuse and personality disorders.

Debates have centred on whether or not men and women experience the same levels of distress, but that differences arise because of

- gender bias in assessment/referral/forms of interventions (under/overrepresentation *re* forms of mental health needs), and because
- women express distress differently.

Or whether men and women are predisposed to experiencing different levels/patterns of distress and that differences arise because of:

- social inequalities—internalization of negative stereotypes, for example; low self-esteem;
- social roles—marriage/forms of employment/carers/multiple roles;
- biological factors—hormonal, genetic;
- unconscious conflicts/internal object relations.

Our particular understanding of presenting distress, will impact on the way we talk about and open up therapeutic possibilities. The acknowledgement of inequalities is indicated in changes in legislation over the years. For example, although women comprise about 50 per cent of the total population numerically, women as a category can be considered a psychologically and economically oppressed or dominated group in that they have been routinely and legally discriminated against in society (e.g. Miller, 1976/1986; Ussher and Nicolson, 1992). Attempts to legislate out such discriminations in the UK are evident in the Equal Pay Acts of 1975, 1984, for example; in the Sex Discrimination Acts of 1975, 1986; in the Employment Protection Act, 1975; in the Race Relations Act, 1976; in the Race Relations (amendment) 2000; and in the Disability Act, as well as in BPS Guidelines such as the 'Equal Opportunities Statement' of 1994.

Clinical psychology developments

How aware are we as supervisors or trainees of the critiques of our profession. In our approaches to supervision we attempt to engage trainees with such literature and debates in ways which manage the tension between the trainee getting through the programme's requirements and the enabling of (de)stabilizing critical thinking rather than a passive acceptance of the mainstream status quo. This means that the supervisor has to move out of the position of ascribed expert and alongside the supervisee into a position of potential conflict when he or she may desire certainty.⁴

Over recent years, both in the United States and in the UK, the profession has been critiqued as a cultural mechanism which sustains the interests of those in power and which rarely challenges prevailing beliefs and stereotypes which affect thinking, diagnosis and selection for psychological work. Yet clinical psychology positions itself to 'achieve the alleviation of psychological distress and dysfunction and the promotion of psychological health and well being' (BPS, 1998a). Psychological theories, models and the research on which they are predicated have been critiqued for being partial, specifically reflecting white, middle-class, male and heterosexist assumptions and norms about what is normative and acceptable and for focusing on the individual as the site of both the problem and the solution. Such criticisms have emerged both from those outside the profession as well as within (Aitken, 1996; Fernando, 1995; Patel *et al.*, 2000; Nadirshaw, 2000; Prillettensky, 1989; Ussher, 1991; Ussher and Nicolson, 1992), and usually from those identifying with subordinated groups. Such theories and practices have been identified as excluding particular groups from accessing psychological services or for problematizing the individual as being 'deficient' when in services.

Yet given what we have argued about the gendered socialization of women and men in our society, there are a number of apparent paradoxes at work. According to available Division of Clinical Psychology figures, clinical psychology is now a predominantly female occupation. In 2001 women

comprised 64 per cent of the registered DCP members, compared with 57 per cent in 1989. This increased 'feminization' of clinical psychology looks to continue, since entry into the profession is predominantly by women who have consistently comprised 78–81 per cent of all successful applicants since 1995. In 2001, 367 of the 1,198 women applying gained acceptance to the 454 places available (compared with 87 of the 288 men applying). The interrelationship between gender and 'race' was not analysed—although from 1995 to 2001 8–9 per cent of all applicants have identified as (visible) minority ethnic categories. In 2001 the people of minority ethnic heritages comprised 7 per cent of all successful applicants.

We might expect that if women comprise the majority of workers, arguments about the adverse effects of gender bias operating within psychology will be countered. Further, given that women comprise the majority of clients as well as the majority of workers (both supervisors and supervisees) those structural inequalities would be mitigated. One explanation for the reproduction of inequalities is that women as a group, and men as a group, are not homogeneous, but inequalities intersect with class, 'race', sexuality, and professional dimensions. Further is the finding that few women (whether achieving ascribed professional status or in traditional roles) perceive or experience themselves as members of an oppressed group (Ussher and Nicolson, 1992). In part, this is understood as a possible reflection of internalization as an subordinated group—i.c. socialized into the normalcy of society, socialized into the dominant models of clinical psychology, engaged in denial of oppression, or identifying with the dominant group (psychology and male norms). Thus women and men reproduce the status quo, rather than bring about change to it. There is a parallel process and these issues are then seen as unimportant, split off and located in a few to examine or push for change. There is a need for changes to the structure of the profession (Nadirshaw, 2000). In supervision, a change in emphasis about what are considered valid topics for exploration may be a necessary step.

Gender in the supervisory relationship

A social movement that is transformative must break the isomorphism of power that it critiques.

(Almeida, 1998:2)

Returning to the process model of supervision, Hawkins and Shohet (1989) suggest that there are two main supervisory styles: (1) supervisors who attend to the therapy matrix via reports, written notes and tapes, and (2) those who attend via the 'here and now' of the supervisory process. In thinking through gender issues and the possible ramifications for supervision, in order for the second supervisory style (the here and now relationship), it would be necessary to

explore and discuss gender issues early in the supervisory relationship in order to be clear about what might belong to the client, supervisee, and the supervisor. These approaches to managing supervision are further divided into six modes of supervising. In brief:

- Reflection on the content of the session. The supervisee is helped to become more aware of what they are doing in the session with the client.
- Focusing on strategies and interventions. What interventions are made and why, reasons behind them, how they were made and the next step with the client (Davies, 1987).
- Focusing on the therapy process as a system that the two parties create together. This will include the conscious and unconscious interaction between the therapist and client (i.e. client's transference).
- Supervisee's counter-transference. What does the client stir up? Influences on the way a therapist views the client through their own belief and value system may include conscious prejudice, racism, sexism and other assumptions that colour the way we miss-see, miss-hear or miss-relate to the client (Kelvin, 1987).
- Supervisory relationship (the importance of this is addressed in earlier chapters of this volume).
- The supervisor's counter-transference. Here sudden changes and eruptions are used to examine the fantasy relationship between supervisor and client.

According to this model, good supervision must integrate all aspects and have some awareness of the developmental stage of the supervisee. At the beginning, the focus may be on the first two aspects, to facilitate holding an overview as they begin to look at what is actually happening rather than acting prematurely and speculating. The latter aspects become central as the supervisee becomes more sophisticated. Additionally, there are a number of tasks that need to be addressed. These include the nature of the work of the supervisee, style of their work, personality of supervisee, openness and trust established in the relationship; the personal exploration (e.g. therapy) is also important.⁵ From what we have argued throughout this chapter, gender issues can be integrated into all aspects of this work.

Linking back to the client

We wish to make a few points here—notably, that therapy is never a neutral space. A task is to make more visible or explicit how we negotiate power relations and develop trust, through shared understandings, transparency, collaboration and honesty. Tensions or 'ruptures' to a seemingly 'collaborative' alliance can be used as important resources and as a space to renegotiate power relations. If, at the minimum, visible or structural differences (e.g. 'race' and gender, professional-client, supervisor-supervisee) are acknowledged explicitly

early in the relationship, this may enable the client to come back in an in-depth way later when they feel more secure within the relationship.

The contexts of therapy (and supervision) of how the client accesses care and appropriate therapy, and whether the psychologist is seen as the 'acceptable' face of oppression, are going to be salient to issues around engagement and continued contact with the client. Clearly, social norms and cultural discourse impact on assessments (Harris *et al.*, 2001) and the social constructions of gender and power. These are significantly influenced by cultural ideologies, but are receptive to training (Leslie and Clossick, 1996).

In therapy, a good experience is important through us being committed and supportive to women/men with mental health needs; but commitment is not enough. We need to recognize the importance of early childhood and the socialization of women's and men's emotional development, and, for example, ongoing experiences of oppression and injustice. Individuals who are bound up in a struggle for survival may feel vulnerable to threats from within the external as well as their internal world and often do not have the emotional reserves/energy to bring about change. These may include resources from the outside in the form of care and other nurturing experiences so that energy can become self-generating.

If we relate this to supervision, containment of this complex matrix can be compounded without clear boundaries that allow for the emergence of trust and which can withstand, contain or work through tensions. A clear contract about the parameters of the supervision may enable a discussion about the supervisory relationship, something that needs to be on the agenda throughout the supervision.

The supervisor needs to be committed and will need to be cognizant of the effect interruptions (telephone calls) or cancelled supervision sessions due to planned or unplanned absences (crises) can have on establishing and maintaining a good working alliance. In order to provide a space that integrates new ways of working a supervisor may use their power to empower the trainee via sharing their knowledge (Wheeler *et al.*, 1986). The encouragement of respect by identifying the supervisee's competencies, affirming improvements and supporting individuality may enable progress and also form a basis from upon which constructive criticism can be heard. Tools for thinking about how to enable differences to be explored (not just visible differences) are presented in Figures 8.2 and 8.3: cycles of mistrust and trust, respectively.

We might ask of ourselves in clinical supervision whether the conditions are created that can enable the development of a creative cycle that can address difference and conflict.

Case study

The following scenario is an attempt to demonstrate how thinking about gender issues can enter therapy and supervisory contexts. In this example, we position

an older male supervisor with a young female trainee; the male client is a similar age to the trainee.

A client is referred for panic attacks⁶ and upon allocation was seen as a 'straightforward CBT referral'. During the initial assessment, the trainee (privately) felt she could have been friends with the client if they had met outside of therapy. The client was able to use the therapy to good effect, as seen by his self-reported reduction in the Beck's Anxiety Inventory (Beck *et al.*, 1988) scores and the trainee's observations.

The trainee looked forward to the sessions as she felt there was good rapport and the client appeared to make use of the therapy. Mid-point during therapy the client starts to wear excessive amounts of aftershave, paying the trainee a lot of compliments and requests self-disclosures regarding her social life. The trainee attempts to play down or ignores the comments about her clothing and attractiveness. Increasingly she becomes aware of how she is dressed over the course of the therapy sessions and of the different degrees of exposure of her body.

She attempts to bring this to supervision, by wondering whether the collaborative client-therapist relationship is breaking down. She explicitly names 'friendliness' as interfering with the homework and tasks within her clinical sessions. The supervisor focuses on providing strategies and techniques to orient the client back to the tasks of therapy. There is no explicit discussion around gendered issues, power or acknowledgement of the threat (awkwardness) the trainee is experiencing. The trainee does not feel able to bring these concerns to session again, and the supervisor does not raise the issue.

Nearing the end of therapy, the client says 'he has got something for her and he will give it to her in the last session'. She becomes increasingly worried regarding what the 'something' is. In fact he doesn't turn up for the last session. She is left with feelings of unease, but also relief. At the penultimate session, the client's symptoms have objectively improved.

The supervisor validates the fact that the client attended most of his sessions and that his BAI scores had been reduced. Referring to the vicious cycle of difference model in [Figure 8.2](#), the supervision example has followed a cycle of mistrust ([Figure 8.2](#)) rather than trust ([Figure 8.3](#)).

A man presenting with anxiety can set up the dynamic in a mixed-gender therapy for the woman trainee wishing to rescue a vulnerable male (see also Walker and Goldner, 1995). In our experience, this is often (but not always) different for a woman working with a woman referred for anger issues. In part, we understand that this is because such a referral would reflect a nonnormative expectation about acceptable women's behaviours, but it also challenges a woman practitioner's awareness and acceptance of anger within herself which might be different to a male practitioner's awareness.

The attempt to bring the (erotic) transference to supervision was named by the trainee wondering whether their collaborative relationship was breaking down. She explicitly named 'friendliness' as interfering with the homework and tasks

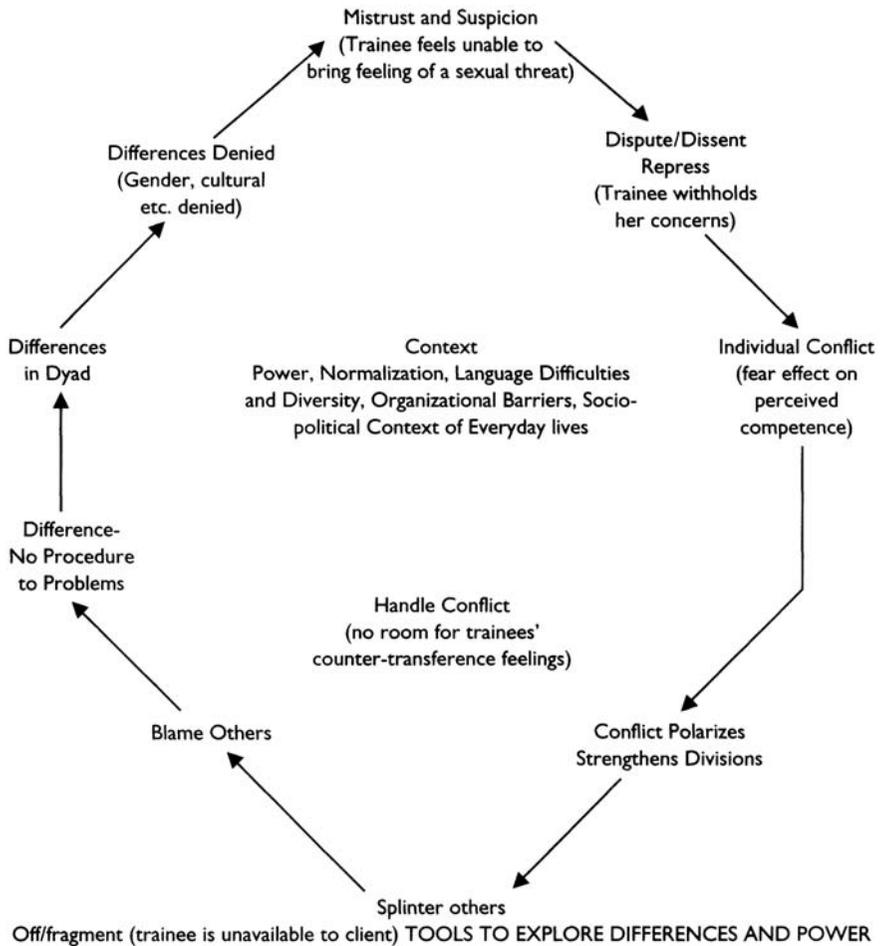


Figure 8.2 Cycle of mistrust

Source: Nadirshaw, Z. (in press) *Transcultural Clinical Supervision in Healthcare Practice*, London: Department of Health/University of Bradford.

within sessions. However, she privately experiences discomfort with the client, but in public is not able to frame this as she fears it would undermine her competency as a woman trainee. The supervisor's focus on technique and with no explicit discussion around gendered issues, power or acknowledging threat (awkwardness) to trainee experience, left the trainee feeling unable to bring this concern to session again. Without the space in supervision to explore these issues, the trainee attempts to play down or ignore her awkward feelings. However, these feelings direct her dress code, which she becomes increasingly aware of (a gendered response, being the object of desire and aware of how different clothing is relational to body exposure). Over time she starts to wear

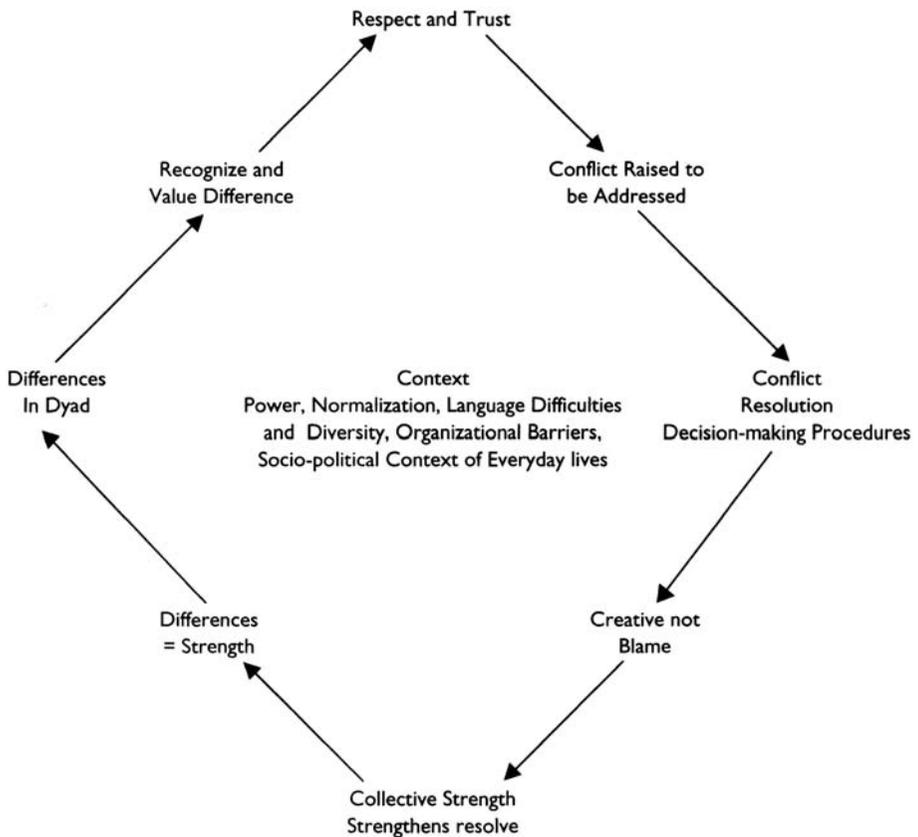


Figure 8.3 Cycle of trust

Source: Nadirshaw, Z. (in press) *Transcultural Clinical Supervision in Healthcare Practice*, London: Department of Health/University of Bradford.

trousers: a concrete solution to a tricky therapeutic encounter. She also has some feelings of guilt as she recalls when first meeting the client that if they had met outside of therapy they could have been friends.

Our approach would be to explore from the outset possible identifications and playing out of power relations with the client around age-related issues, sexualized attraction, as well as a wish to succeed as an effective practitioner. As supervisors we pay special attention to the language that the trainee brings to our encounter. Words, such as 'friendliness' would be explored in ways which would recognize possible sexualized presentation as a valid topic for supervision. This might be done through referring to male-female relations in general, literature that refers to erotic transference (Bollas, 1994) and counter-transference in same or mixed-gender therapy. From the scenario, the trainee experienced a blurring of boundaries that caused her to worry that her dress code/appearance was

provocative (women as causal of male desire)—but the supervisor, in not creating the opportunities, effectively silenced the trainee. On exploring the meaning and impact of requests for disclosures about personal information we are aware that some women trainees have experienced such requests by males as intrusive (violation of boundaries) and disabling whatever the stage of training, and more often experience such requests as attempts at connection when requested by women patients.

By making more explicit possible identificatory and power relations issues, this would enable an understanding of gendered perspectives as to why a client may be making comments in the context of gendered positions in wider society, which therapy encounters are not immune to. We aim to enable the trainee to be aware of how to speak with the client to pick up on his anxieties so that she can contain his vulnerability rather than it being reversed—that is, the client’s vulnerability has become turned around, and the trainee’s need to be looked after undermines her professional position and sense of competency as she feels her need is not legitimate and has not been validated in supervision.

When taking a gendered perspective, this should not be to the exclusion of wider diversity and similarity issues. In [Figure 8.2](#) we have added other examples of points of mistrust, and readers might want to think what could have been different at different points to create a cycle of trust.

We might ask that if the supervisor and supervisee were both women, would the trainee feel more able to bring this to the supervisor, or if all three participants were women would the comments on the part of the client engender different feelings or interpretations? How would this differ, if at all, if the trainee (or supervisor) was a self-identified ‘lesbian’ or ‘bisexual’? It is important not to portray a scenario of an ‘all-knowing’ supervisor without recognition of the supervisee within this relationship. What the supervisee brings to this relationship and how this affects her understanding and expression of the therapeutic encounter, as well as her readiness and willingness to use her supervision, has to be considered as an important part of the equation. In summary, both supervisor and supervisee are active participants in the supervisory relationship.

Trainees (later to become supervisors) will enter supervisory encounters with their own motivations for becoming a therapist or clinical psychologist. Just like the supervisor, the trainee may or may not have the privilege of a theoretical or experiential framework, which values the need to consider the impact of wider cultural context on therapeutic and supervisory encounters. We need to think through how to support and facilitate a learning environment in which the cultural context (of which we are all part) can be reflected upon. We suggest some examples of learning outcomes which may be usefully agreed at the beginning of a supervisee’s placement (see Appendix).

Clearly, learning within supervision is not a static process for the supervisee or the supervisor. Specific training for supervisors and ongoing training need to be integral parts of continued professional development.

We have used a CBT case, but note that therapy approaches which attend more to the process (e.g. exploratory therapy) may more readily lend themselves to attending to the issues raised as part of therapy. In saying that, whichever therapeutic approach is used it is possible to come up against conceptual vacuums which need to be explored within supervision. Supervision can help the supervisee to become aware and to address difficult issues in order that the patient/clients may make sense of the issues being addressed or confront issues within the therapy. This is in addition to the phases of the beginning, middle and ending of the therapeutic relationship, when focus may be placed on obvious differences as a distraction from the more general anxieties about therapeutic engagement, feelings of dependency, and concerns about separation and loss respectively.

Conclusion

To move away from the limiting idea of clinical psychology as a nonreflexive 'scientific' and 'objective' discipline and profession we must be seen proactively to encourage challenges to our established assumptions and practices, and to be prepared to question our assumed expertise in knowing what is necessarily 'best' for the client and/or researched. It is not simply a case of incorporating additive gender, 'race' or culture packages into our training programmes or clinical practice; rather, it demands a transformative process. Qualitative, feminist and/or anti-racist research approaches can play a vital role in enabling and empowering clinical psychology as a profession and a discipline to become aware of its own heritage and its relation to those groups it considers can benefit from clinical psychology theory and practice. We must remember that constructions of 'difference' may have specific and general effects for women and men, both within and outside of the therapy and supervisory encounters. A professional may attempt to minimize differences around structural relations of, for example, therapist and client. However, these can still (implicitly or explicitly) figure centrally in a therapy encounter, coexisting with (as well as independent of) other 'differences' in which gender, 'race' and/or class may figure. The socio-politico-historical context of clinical psychology and the cultural heritages of those training (in terms of 'race', gender, and/or class as exemplifiers of differences) need to be made explicit. Unless therapists and trainees are provided with the conditions in which to feel safe themselves (this does not mean unchallenged) to explore uncertainties, and the powerful feelings which emerge when dealing with issues relating to structural differences, how can we expect to be able to provide the conditions for a client to raise such issues without feeling vulnerable to further problematization, pathologization and/or exclusion by a professional. It may be that clinical psychology has to consider crossing disciplinary and/or professional boundaries in order to inform itself of alternative forms of analysis (see also Holland, 1995).

The capacity to tolerate self-reflection on our own personal and professional cultural heritages, and our role in perpetuating assumptions and practices which effectively disadvantage ‘others’, is central to changing dominant power relations as structured around ‘race’, gender and professionalism.

Appendix: learning outcomes

- 1 To be able to identify a range of issues about why psychologists should be concerned with gender, ‘race’, and culture and diversity.
- 2 Increased awareness and knowledge about how the unquestioning application of psychological theory and practice may mitigate against the provision of just and equitable services.
- 3 Increased awareness of how power relations are played out along dimensions of culture, professional, mental health and specific interactional contexts.
- 4 Increased recognition of the importance of our own personal, professional and institutional cultural heritages which necessarily enter all therapy and supervisory encounters.
- 5 Awareness of supervisors’ and trainees’ positions as being part of different systems in relation to client (acknowledging power relations), issues of client’s interests and limited confidentiality. To what extent are the foregoing made explicit with the client?

Notes

- 1 We would like to thank the clients, trainees and colleagues we have worked with over the years, who inform our thinking and practice. The views expressed here are personal and do not necessarily reflect those of our employing institutions.
- 2 In addition to such collections of articles, there are some published individual articles by British clinical psychologists—although we could find none relating specifically to clinical supervision.
- 3 For further reading around issues of power across different dimensions and contexts relevant to clinical psychology (professional, class, in therapy) see also Beckwith (1999), McQueen (2000) and Proctor (2001).

- 4 As supervisors we accept our authority, responsibility and accountability in relation to trainees, but we aim to challenge the view that we are sole bearers of expertise in particular areas. To accept the expert position prevents others from recognizing the necessary struggle which is part of the process of development.
- 5 Carroll (1996) uses a social role model to differentiate among the tasks of supervision. These include the learning relationship, pedagogical features, evaluation, monitoring of professional ethical issues, advisory role, consultancy role and to monitor administrative aspects.
- 6 A male patient diagnosed with panic attacks is a reversal of the usual picture where 70–95 per cent of anxiety-related disorders are diagnosed in women.

Chapter 9

Trainees' and supervisors' perceptions of supervision

Delia Cushway and Jacky Knibbs

Introduction

This chapter is concerned with perceptions about helpful and unhelpful aspects of supervision during clinical training, as seen through the eyes of both trainees and supervisors.

One author (Jacky) has been a supervisor for many years and has supervised more than a hundred trainees. The other author (Delia) has been involved in clinical psychology training and clinical supervision training, also for many years. But both of us can vividly remember being trainees and what our supervisors did or didn't do and how crucial that experience was to our future as psychological therapists.

Early research about trainee stress (Cushway, 1992) suggested that supervision was unique in that it ranked among the top five stressors, but it also ranked among the top five coping strategies. This seemed to indicate the power of supervision both to punish and to reward. Thus, when supervision goes wrong it can be a very negative experience for both supervisor and trainee alike. However, when supervision goes well it is experienced as a very powerful learning and sustaining experience.

It is important to remember that, while many trainees regard supervision as mainly for their benefit, its primary purpose is actually to safeguard the client. It therefore behoves us to explore how we can get the best out of supervision for the benefit of trainees and supervisors, but most of all for the clients we serve.

In the first part of this chapter we will explore what the literature tells us about helpful and unhelpful aspects of supervision. In the second part, we will report the results of recent studies we have carried out in which we compared supervisors' and trainees' perceptions of helpful and unhelpful aspects of supervision. Finally, we will explore the implications of these findings for the roles and responsibilities of trainees in the supervisory relationship.

Literature review

What is supervision?

There have been many definitions of supervision, as outlined by Scaife (2001a). Currently the most popular definition, and that adopted by Watkins (1997b) in his comprehensive handbook, is that of Bernard and Goodyear (1998) who define supervision as:

an intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services to the clients that she, he or they see(s), and serving as a gatekeeper for those who are to enter the particular profession.

(Bernard and Goodyear, 1998:6)

Milne and James (1999) remind us that, while recognition of the importance of supervision has increased recently for all NHS professions, supervision in clinical psychology generally, as well as in training, has reached a watershed because of demand outstripping supply. For these reasons alone, we need to be optimizing the quality and efficiency of the supervision we provide.

Even a cursory look at the literature shows us that most of the research on supervision has been carried out in the USA. Some notable British exceptions are the writing of Carroll (1996) and Wheeler and King (2001), both of whom are writing from a counselling perspective. A welcome recent addition to this literature has been Scaife's (2001a) book for mental health practitioners. Thus, most of the literature reviewed below is not directly written for, or about, British clinical psychologists. Nevertheless, we consider that many of the process issues in clinical supervision are relevant across therapy professions.

In this chapter we wish to consider helpful and unhelpful aspects of supervision as seen through the eyes of trainees and supervisors. So what does the literature tell us?

An early review by Carifio and Hess (1987), entitled 'Who Is the Ideal Supervisor?', summarized their attempt to answer this question in the following way:

Published literature suggests that high-functioning supervisors perform with high levels of empathy, respect, genuineness, flexibility, concern, investment, and openness. Good supervisors also appear to be knowledgeable, experienced, and concrete in their presentation. They use appropriate teaching, goal-setting, and feedback techniques during their supervisory interactions. Last, good supervisors appear to be

supportive and non-critical individuals who respect their supervisees and do not attempt to turn the supervisory experience into psychotherapy.

(Carifio and Hess, 1987:244)

While it does seem that these are all laudable qualities, this review doesn't highlight one important problem with perceptions of helpful aspects. This is that, even were all the reviewed studies to be methodologically sound, there is no demonstrated relationship between supervisee perceptions and outcome. Thus we do not know how any of these attributes or behaviours relate to performance as supervisee, let alone performance as therapist or client change. Nevertheless, there is much of importance to be gleaned from exploring supervisee and supervisor perceptions providing that we are realistic about what these actually tell us.

Qualities/characteristics of supervisors

Gender differences

Some studies (e.g. Alien *et al.*, 1986) have found no gender differences in the rated quality of supervision, but there is some evidence that male and female supervisors behave differently. Female supervisors have been perceived to be more effective (Putney *et al.*, 1992), less likely to structure the supervision session (Lichtenberg and Goodyear, 1996), and more likely to use minimal encouragers, whereas men used more self-enhancing and critical messages (Nelson *et al.*, 1996). Long *et al.* (1996) found that female supervisees perceive their supervisors to be more self-disclosing than do male supervisees.

Age and experience

There is some limited evidence that supervisors with more experience are rated more highly than inexperienced ones (e.g. Marikis *et al.*, 1985). In this study, experienced supervisors were more prepared to self-disclose and to give direct instructions than supervisors with no experience. Worthington (1984) found that more-experienced supervisors used humour more often than less-experienced supervisors. Neufeldt *et al.* (1997) comment that this is consistent with a finding that therapists lose their sense of humour during training but regain it after qualifying as they acquire experience (Skovholt and Ronnestad, 1992). It seems fortunate that it appears that one's sense of humour can return after training!

A study by Reeves *et al.* (1997) utilized the Supervisory Styles Index, which was devised by Long *et al.* (1996). This measure was developed to examine affiliative, non-directive, and self-disclosing supervisory styles within the supervisory relationship. Reeves *et al.* found that younger supervisors were less likely than older supervisors to decide what to discuss in supervision, or to insist

on supervisees' strict adherence to supervisor directives. In contrast with the Marikis findings, younger supervisors in this study felt more comfortable sharing personal experiences as a therapist with supervisees. Supervisors who were 50 and over were less likely to consider 'joining', an important part of the supervision process.

Trainee perceptions of supervisor competence

The Supervisor Rating Form (Heppner and Handley, 1981) was an early instrument designed to measure trainee perceptions of supervisors along the dimensions of expertness, trustworthiness, and attractiveness; the latter is defined as likeability by and compatibility with the supervisee. These authors, and others, found that these three variables were highly correlated with supervisee satisfaction, evaluations of supervisors, and supervisees' performance as rated by supervisors (Alien *et al.*, 1986; Dodenhoff, 1981; Carey *et al.*, 1988). The fact that when supervisees and supervisors like each other they rate each other favourably is hardly surprising. However, in their exhaustive review, Neufeldt *et al.* (1997) comment that in the Heppner and Handley (1981) study the supervisees' ratings of supervisors on the variables of attractiveness and trustworthiness were related to supervisors' ratings of supervisee performance and their willingness to supervise them again. Neufeldt *et al.* (1997) suggest that this calls into question the evaluations given by supervisors to trainees as legitimate outcome variables, particularly as Najavits and Strupp (1994) found that supervisors' evaluations of therapists were not correlated with those of outside observers or clients. Nevertheless, Heppner and Handley (1982) found that supervisors were also rated as more expert, trustworthy and attractive when they were perceived to be evaluating their supervisees.

Supervisor perceptions of trainee competence

One of the few British studies explored supervisors' ratings of clinical trainees' competence (Fordham *et al.*, 1990). Factor analysis revealed that the supervisors' judgements fell across two dimensions: one dimension relating to interpersonal skills, which accounted for most of the variance, and the other relating to organizational ability. The authors caution that it is not obvious that these judgements directly reflect the trainees' clinical performance. They suggest that the interpersonal skills dimension could be either an indication of the assumptions supervisors make about trainees judged good or bad on other criteria, or simply a reflection of supervisors' personal judgements of the trainees rather than a reflection of trainees' therapeutic ability at all. Clearly then, it appears that the issue of how well trainees and supervisors get on together may contaminate perceptions of the other's ability.

Summary of supervisor qualities/characteristics:

- There are limited findings in relation to gender and experience.
- Supervisors and supervisees who like each other rate the other favourably, but this may not be an accurate reflection of the other's ability

The supervisory working alliance

Some studies have focused on the importance of the relationship between the supervisor and supervisee. These suggest that the quality of the supervisory relationship will be an indicator of outcome in the same way that the working alliance in therapy has been shown to be a good predictor of psychotherapy outcome. Lambert (1980) reported that most authors agreed that appropriate levels of empathy, respect, genuineness, and concreteness, often called 'facilitative conditions' after Rogers (1961), are required in supervisorsupervisee interactions. Bordin (1983) extended the concept of the working alliance to supervision. A US study of graduates of clinical and counselling psychology doctorates found that supervisors who were rated high on providing the facilitative conditions were also those who were rated as contributing most to the graduates' therapeutic effectiveness.

In a more recent qualitative study, McNeill and Worthen (1996) explored good supervisory events and emphasized the importance of the supervisory relationship, which they considered was characterized by empathic attitude, a non-judgemental stance, a sense of being validated and affirmed, with encouragement given to explore and experiment. In a similarly conceived qualitative study of experienced supervisees, Weaks (2002), in a rare British study, confirmed that, without exception, all her participants judged the supervisory relationship to be of paramount importance. Weaks describes three 'core conditions' of the supervisory relationship as safety, equality and challenge.

The Supervisor Working Alliance Inventory (SWAI) developed by Efstation *et al.* (1990) has a supervisor version with three factors: client focus, rapport and identification, and a trainee version which has two factors: client focus and rapport. Webb and Wheeler (1998), in a recent British study, used the SWAI in a survey of 96 counsellors and found that there was a positive correlation between the quality of the supervisory working alliance, as measured by the perceived level of rapport experienced by the counsellor, and the extent of his or her disclosure in supervision. In this study, trainee counsellors were found to be significantly less able to disclose sensitive issues in supervision. The authors suggest that, in view of this finding, if a supervisee does not enjoy good rapport with their supervisor this may have significant implications for their clinical practice. This is particularly true for trainees, where an ability to disclose and discuss difficult issues with their supervisors is imperative for safe and ethical practice.

Summary of working alliance findings:

- There are suggestions that the quality of the supervisory relationship will be an indicator of supervisory outcome. (For further discussion see Chapters 2 and 3 of this volume.)
- The importance of the supervisory relationship has been confirmed by recent qualitative findings.
- Poor rapport in the supervisory relationship has implications for trainee disclosure and therefore clinical practice.

Supervisory style/behaviours

Helpful aspects of supervision

SURVEY FINDINGS

When supervisees are asked in surveys what they value in their supervisors, they generally want a positive supportive relationship with their supervisor alongside teaching and feedback that allows them to increase their competence. In an early study, Nelson (1978) found that a mixed group of trainees, including clinical psychology trainees, wanted supervisors to be competent practitioners who were willing to model therapeutic skills as well as to observe supervisees directly. While valuing supervisor activity, trainees also wanted their supervisors to be flexible, self-disclosing and congenial. This finding was supported in a study by Worthington and Roehlke (1979), who also found that trainees wanted structure and teaching in the context of a supportive relationship. Specifically, beginning trainees also wanted their supervisors to give didactic instruction as well as provide relevant literature. Although beginning therapists particularly request instruction, studies have been unable to detect differences in supervisor style according to level of supervisee development (Worthington, 1987; Krause and Alien, 1988). Neufeldt *et al.* (1997) suggest that in the more recent studies trainees express less of a desire for instruction and more of an emphasis on trainee personal development and self-understanding.

In Worthington and Roehlke's (1979) study of supervisee and supervisor ratings of helpful aspects, the authors point out that the behaviours that the supervisors believed to be important to good supervision were not always the same as those rated by supervisees. Specifically, supervisors seemed to perceive good supervision to be predominantly based on feedback, whereas beginning trainees valued direct teaching within the context of a supportive relationship, as outlined above, followed by encouragement to try out new skills. These authors comment that, although trainees often request positive and negative feedback, they can be threatened by evaluative feedback, particularly if negative. They suggest that trainees want to become self-confident by having supervisors disclose their own experiences, provide relevant literature and give feedback about strengths but not necessarily weaknesses. Nevertheless, two recent

qualitative studies have suggested that supervisees do want to be challenged. McNeill and Worthen (1996) and Weaks (2002) suggest that good supervision involves challenge in order to raise the supervisee's ability to perceive greater depth and complexity. As a consequence of effective challenge supervisees felt more confident to experiment with new ways of handling difficult situations. However, the latter study was carried out with experienced supervisees rather than trainees, who may feel less confident with challenge. These findings reinforce the importance of Kolb's (1984) model of experiential learning, aspects of which involve the setting of challenging tasks, self-assessment and facilitating awareness.

In the context of the perceived importance of the supervisory working alliance and the finding about trainees liking supervisors to disclose aspects of their own experience, Ladany and Lehrman-Waterman (1999) explored supervisor self-disclosure and its relationship to the supervisory working alliance using the SWAI. They found that the more supervisors made selfdisclosures, the stronger emotional bond trainees felt with their supervisors. Specifically, trainees perceived a stronger emotional bond with those supervisors who revealed counselling struggles, as opposed to neutral or personal counselling disclosures. McNeill and Worthen (1996) confirmed the helpfulness of supervisor self-disclosure, which they reported enabled tacit relabelling of mistakes as learning experiences and so reduced the need for supervisees to feel self-protective.

STUDIES BASED ON DIRECT OBSERVATION

A few studies have based their exploration of helpful aspects of supervision on direct observation rather than surveys. Friedlander and Ward (1984) developed the Supervisory Styles Inventory. In this study trainees used the trainee version to observe well-known supervisors with different orientations. They were able to distinguish between a highly task-oriented style of supervision that was endorsed by cognitive-behavioural supervisors and a highly interpersonal style that was more likely to be adopted by psychodynamic and humanistic supervisors. These authors also found that supervisory styles were related to trainees' level of experience in that supervisors were more task-oriented with beginning therapists and more 'interpersonally sensitive' with more experienced therapists.

Two studies by Shanfield *et al.* (1992, 1993) utilized the Psychotherapy Supervision Inventory devised by these authors to rate the styles of 34 supervisors in videotaped supervision sessions. In the first of these studies they found that raters reliably rated 'excellent supervisors' and that 72 per cent of the variance in rater-perceived excellence was accounted for by 'empathy', with 'focus on the therapist' accounting for an additional 5 per cent. In the later study Shanfield *et al.* found that supervisors with high ratings allowed the supervisee's story about the encounter with the client to develop. They consistently tracked the most immediate aspects of the supervisee's emotionally laden concerns. Further, most of the comments were directed towards helping the supervisee

further understand the client and remained specific to the material presented in the session. These authors conclude that 'the ability to track residents' concerns is at the center of supervisory activities rated as excellent. The resident provides data about what occurred and new knowledge is constructed in the supervisory interaction' (1993:1081).

QUALITATIVE STUDIES

Weaks (2002), in her qualitative study of experienced supervisees, reports individual difference in what supervisees are looking for in supervision. She identified four supervisee styles, which she named as affirmation seeking (seeking a warm and welcoming supervisory experience); perfect practice seeking (supervisees wanting confirmation that they were operating skilfully and ethically); knowledge seeking (supervisees continually searching for increased knowledge of themselves and their clients); and satisfaction seeking (dissatisfied supervisees who fantasized about the ideal supervisor).

Unhelpful aspects of supervision

There have been very few studies looking at what trainees find unhelpful about supervision. However, Rosenblatt and Mayer (1975) explored the complaints of social work students. Neufeldt *et al.* (1997) summarized the latter authors' findings in the following way:

What did they find objectionable in their supervisors? Supervisors who limited supervisees' autonomy; failed to provide adequate direction and clarity; or were cold, aloof, and/or hostile, contributed to students' stress. Trainees also objected to supervisors who acted as therapists and explored trainees' personal issues.

(Neufeldt *et al.*, 1997:515)

Watkins (1997b) has identified what he considers to be ineffective supervisor behaviours and suggested that they are lack of empathy, intolerance, being discouraging, defensiveness and lack of interest in supervisor training. A recent qualitative study by Magnuson *et al.* (2000a) used data from interviews with experienced supervisees to explore ineffective supervision practices. While this study examines views of post-qualified counsellors, we think that the general principles may still be relevant for clinical psychology trainees.

The data yielded six overarching principles of bad supervision, which encapsulated the behaviours described. The principles were:

- 1 Unbalanced, i.e. too much or too little of all elements of the supervision experience.

- 2 Developmentally inappropriate, i.e. non-responsive to changing developmental needs of supervisees.
- 3 Intolerant of differences, i.e. failing or unwilling to be flexible.
- 4 Poor model of professional/personal attributes, i.e. models what not to do as a supervisee or models unethical behaviour.
- 5 Untrained, i.e. unprepared to manage boundaries, difficult issues, or other interpersonal exchanges.
- 6 Professionally apathetic, i.e. lack of commitment or initiative for the profession, supervisee, and client.

Moreover, Magnuson *et al.* suggest that these overarching principles are found in three general spheres of activity. These are in the organizational/ administrative arena; in technical skills and in the relational sphere.

Summary of helpful and unhelpful aspects of supervision:

- Supervisees want a positive and supportive supervisory relationship.
- Beginners want specific didactic instruction, as well as feedback.
- Supervisors place less emphasis than trainees on instruction and more on feedback.
- Recent findings suggest that trainees do value challenge if it is offered sensitively.
- Trainees perceive supervisor self-disclosure as helpful.
- Supervisors are more task-oriented with beginning therapists and more relationship-focused with experienced supervisees.
- Supervisors were rated as 'excellent' if they stayed with the trainees' concerns in supervision.
- Preliminary evidence is emerging of different supervisee styles.
- So far there have been few studies on unhelpful aspects of supervision.

Research issues

Some problems have been highlighted with the research so far. The most important issue is that highlighted earlier in the chapter, which is that supervisory behaviours have generally not been assessed in terms of their impact on supervisee competence. We do not even have much information about the role that supervision plays in developing good therapy skills. Wampold and Hollo way (1997) suggest that in the general causal model, outcomes of supervision are found in changes in therapist characteristics. The goal of supervision is to produce a competent therapist delivering competent psychotherapy, which in turn will result in positive change for the client. These authors identify several classes of outcome. These range from reaction to supervision, to performance as supervisee, through therapist characteristics to performance as therapist, and finally to change in client. Clearly, most of the research so far has focused on the supervisee's reaction to supervision. While the emphasis on descriptive research

can be criticized, it can be seen from the possible outcomes listed above that supervision research is a very complex process.

The main reviewers of research in this field have agreed that there has been relatively little attention to testing existing supervisory theory (Ellis and Ladany, 1997; Neufeldt *et al.*, 1997). However, they differ in their opinion about other aspects of the research. Ellis and Ladany report that much of the research is poor quality, that there have been few replication studies and that there is a dearth of viable measures specific to clinical supervision. Neufeldt *et al.* have a somewhat more optimistic viewpoint. They consider that the research has evolved from descriptions based on supervisor and supervisee report to microanalytic accounts of supervision sessions. They also suggest that reliable scales designed for supervision do differentiate among supervisors on the basis of style and behaviour. However, all the reviewers agree that supervision research has a long way to go.

Summary of research issues:

- Supervision research is largely descriptive.
- Most studies have focused on supervisees' reaction to supervision with little attention paid to outcome.
- Reviewers of supervision research suggest that it is at an early stage.

In Britain there has been even less research, as highlighted earlier. We could identify only a very few published studies that have explored what the helpful and unhelpful aspects of supervision are from the point of view of the trainee and the supervisor. We cannot assume that the research from the US will travel into this different context. Thus we decided to carry out our own research for the purposes of this chapter.

Current research

We will report research findings from two sources in this chapter. First, we will report the results of an exercise carried out at a recent Supervisors' Workshop in the West Midlands of the UK; second, we will report the results of a recent survey, also carried out in the West Midlands, in which we compared trainees' and supervisors' perceptions of helpful and unhelpful supervision.

Supervisors' workshop exercise

At a recent residential supervision workshop, 33 trained clinical psychologists were invited to reflect on their own experiences of being trainees. Each of them was asked to think of three of their most helpful supervision experiences, and three of the most difficult or unhelpful aspects of being supervised. The results were all produced independently but, as can be seen from the data, there were a number of overlapping items.

Most helpful aspects of supervision

An initial attempt was made to group the responses obtained here about the best supervisory experiences according to the 13 factors identified by Herbert *et al.* (1995). In the analysis of results obtained using the supervision questionnaire (SQ-R), these authors had investigated three dimensions of supervision—satisfaction, supervisor competence, and the contribution of supervision to the improved ability of the supervisee. The 13-factor model proved to be too cumbersome for present purposes and inadequately reflected process issues. Similarly the dimension descriptors failed to capture the depth of the personal and professional development opportunities identified by our participants. In a very recent paper, Weaks (2002) uses qualitative methods to generate a series of themes of helpful supervisory experience as described by experienced counsellors. She identifies the three ‘core conditions’ for establishing an effective supervisory relationship as equality, safety and challenge. These seem to have a higher face validity in relation to the results here, although the ‘equality’ condition is perhaps under-represented in our sample, as we were inviting practitioners to reflect on their supervision experiences whilst inexperienced in the field. The two dimensions covered in Efstation *et al.*’s (1990) Working Alliance model—rapport and client focus—are also helpful categories here. The best fit for our results has been achieved by combining the overarching supervisory relationship descriptors ‘*rapport and safety*’, and the more specifically client-related professional development constructs ‘*client focus and challenge*’. The helpful aspects of supervision responses are therefore listed under these two major themes, each with a number of sub-headings:

HELPFUL ASPECTS OF SUPERVISION

1 *Rapport and safety*

- **Affirming and safe (27 items)**
e.g. being respectful of differences; honesty, feeling contained to admit difficulties
- **Emotional support (10 items)**
e.g. help to contain emotions and panic
- **Supervisor qualities (8 items)**
e.g. being warm, honest, with a good sense of humour
- **Supervisor's self-disclosure/normalizing (4 items)**
e.g. sharing/disclosure by supervisor
- **Feedback (3 items)**
e.g. spontaneous positive comments
- **Practicalities of supervision (2 items)**
e.g. available and regular
- **Endings (1 item)**

planning and preparation for ending the placement

2 *Client focus and challenge*

- **Challenge and direction (13 items)**
e.g. being challenged but with evidence
- **Introducing new ideas (9 items)**
e.g. stimulating new ideas, introducing different models
- **Reflection (7 items)**
e.g. giving space to reflect about clients
- **Client focused (6 items)**
e.g. talking through a case in detail
- **Therapeutic process (3 items)**
e.g. helping to explore counter-transference
- **Direct learning (3 items)**
e.g. being able to observe the supervisor working with clients
- **Theory-practice links (3 items)**
e.g. linking clinical work to theory and suggesting literature

TRAINING IMPLICATIONS

There are some practical implications of these findings for supervisor training. Feedback to supervisors about ‘rapport and safety’ needs of trainees, most specifically the perceived usefulness of supervisor self-disclosure, is explored in more detail by Ladany and Lehrman-Waterman (1999). The value for trainees of hearing about supervisors’ own learning experiences may not be immediately evident to new supervisors, and could be made explicit and rehearsed in supervisor training. Similarly, normalizing trainee concerns and difficulties is a potentially useful rehearsal topic. More obvious to supervisors will be the need for positive feedback and supervision planning from supervisors, but reiteration in supervisor training may help to enhance practice. The ‘client focus and challenge’ requirements may be role-played in supervisor training sessions—for example, introducing different models and making links between theory and practice. The usefulness of direct learning (i.e. observing supervisors working with clients) is often evaluated at mid/end placement and supervisors’ behaviour hopefully shaped up accordingly.

Most difficult/unhelpful aspects of supervision

It similarly seemed appropriate initially to map our qualitative responses in relation to unhelpful supervisory experiences, according to the six overarching principles flagged by Magnuson *et al.* (2000a). These poor supervision descriptors are, namely, ‘unbalanced’, ‘developmentally inappropriate’,

'intolerant of differences', 'poor model of personal and professional attributes', 'untrained' and 'professionally apathetic'. Most of the spontaneously generated items obtained from our group fitted quite neatly into these categories suggested by Magnuson, although it was notable that there were very few responses suggesting experiences of 'unbalanced' or 'apathetic' supervision. There were also two frequently identified groups of items which were not specifically mentioned in the Magnuson *et al.* paper, although arguably they could be seen as extensions of the categories listed by those authors. These were, firstly, problems with the practical boundaries of supervision, most notably, insufficient attention being paid to ring-fencing the supervision space. The second significant group of difficulties reflected hypercritical supervision. Again, these have been grouped for present purposes as an extension of the 'inflexible' category according to the Magnuson principles. Interestingly, this aspect of the supervisory experience, whilst clearly highly salient for our group of respondents, is not described by those authors. Thus the most difficult aspects of supervision reported by our respondents are presented below grouped according to Magnuson *et al.*'s (2000a) six overarching principles of poor supervision, with some further subdivisions.

UNHELPFUL ASPECTS OF SUPERVISION

1 *Unbalanced*—*too much/little of all elements of supervision experience (2 items)*

e.g. supervisor being too analytical

2 *Developmentally inappropriate*—*non-responsive to changing developmental needs of supervisees*

- **Not directive (8 items)**

e.g. being denied help and advice when needed

- **Not challenged (5 items)**

e.g. not being stretched or challenged enough

- **Prior experience ignored (4 items)**

e.g. undermining supervisee's experience

- **Too directive (11 items)**

e.g. always telling what to do and how to do it

3 *Intolerant of differences*—*failing or unwilling to be flexible*

- **Negative responses (13 items)**

e.g. unconstructive, personal, punitive criticism

- **Theoretical models (2 items)**

e.g. inflexible supervisor with regard to theoretical models

4 **Poor model of personal/professional attributes** *models what not to do as a supervisee or models unethical behaviour*

- **Practicalities of supervision (13 items)**
e.g. supervisions being cancelled, unreliable or rescheduled
- **External issues (7 items)**
e.g. supervisor being engrossed in own issues

5 **Untrained** *unprepared to manage boundaries, difficult issues or other interpersonal exchanges*

- **Supervisor qualities (6 items)**
e.g. supervisor being unable to admit to not knowing
- **Boundaries (7 items)**
e.g. supervisor shifting from supervision to therapy

6 **Professionally apathetic** *lack of commitment or initiative for the profession, supervisee and client*

- **Negative responses (4 items)**
e.g. dismissive

SUMMARY

The data seem to show a reasonable concordance with the existing literature outlined earlier in the chapter, particularly in respect of helpful factors in supervision. Broadly these fall into person-oriented aspects and task-oriented aspects. There is much less literature exploring unhelpful factors in supervision. Specifically it would be helpful to know if the clusters of good and bad aspects are separate and distinct or whether they are simply opposite ends of the same dimension; that is, does the converse of the helpful aspects fully represent what is understood by bad supervisory experience. In an effort to answer this question, as well as to explore the views of actual trainees, we carried out the following survey.

Supervision survey of trainees and supervisors

Participants

Supervisors and trainees from the West Midlands were asked to complete an anonymous postal survey in which they were asked to rate helpful and unhelpful aspects of supervision. Approximately one-third of all clinical psychology trainees and clinical psychology supervisors completed the survey. While it was

impossible to chase up non-respondents, due to the anonymous nature of the survey, the demographic characteristics collected did not suggest that the samples were particularly skewed. Ninety-seven supervisors, of whom 35 per cent were men, filled in the questionnaire. Over three-quarters of the sample reported that they did not subscribe to any particular model of supervision, while one-quarter subscribed to a named model of supervision. By far the greatest number of these latter respondents named the Hawkins

Table 9.1 Distribution of responding supervisors by placement offered and therapeutic orientation

<i>Type of placement offered</i>	<i>%</i>	<i>Therapeutic orientation</i>	<i>%</i>
Core learning disabilities	11	Eclectic and integrative	55
Core older adult	10	Cognitive-behavioural	27
Core child	20	Psychodynamic	10
Core adult	32	Other (includes systemic, Gestalt)	8
Specialist	26		

Table 9.2 Distribution of responding trainees by year of training, placement and placements completed

<i>Year of training</i>	<i>%</i>	<i>Current placement</i>	<i>%</i>	<i>Placements completed</i>	<i>%</i>
1	48	Core learning disability	17	Core learning disability	40
2	28	Core older adult	12	Core older adult	49
3	24	Core child	21	Core child	59
		Core adult	24	Core adult	78
		Specialist	17	Core specialist	24
		Parallel	9		

and Shohet (1989) process model of supervision. We think that this model is popular for several reasons. Firstly, it purports to be a process model that is neither tied to nor dependent on theoretical orientation. Secondly, supervisors in the West Midlands have been exposed to a lot of training utilizing this model, much of it actually run by Peter Hawkins!

Table 9.1 shows the distribution of placements offered and the therapeutic orientation of the responding supervisors. Fifty-eight trainees, 86 per cent women and 14 per cent men, responded to the survey. Table 9.2 shows the percentages of respondents in each year of training, the percentage of responding trainees in each type of placement and the percentage number of responding trainees who have completed the various placement types. It is noted that almost 50 per cent of the responses come from first-year trainees, while the third years had the lowest response rate. We speculated that first years are less resilient to difficult or unhelpful experiences and thus may be more motivated to fill in the questionnaires. Alternatively, it may be that second years and, more particularly,

third years are both busier as well as being more jaded by persistently being asked to fill in research questionnaires.

Measures

In this study we wanted to use existing measures wherever possible but, since they were all American, we found that a few wording changes were necessary in order to adapt them to a British clinical psychology training context.

The following measures were used with both supervisors and trainees:

- Worthington's (1984) Supervision Questionnaire Revised (SQR), has been used to assess the frequency of supervisory behaviours. However, we added a scale to explore degree of perceived helpfulness of the behaviour.
- The Supervisor Working Alliance Inventory (Efstation *et al.*, 1990).
- Since there are no scales exploring unhelpful as opposed to helpful behaviours, we devised a new scale 'The Supervisory Difficulties Questionnaire' (SDQ), derived from Magnuson *et al.* (2000a). Like the Supervision Questionnaire Revised, participants were also asked to rate the frequency as well as the degree of unhelpfulness of difficult supervisory behaviours.

Additionally trainees completed:

- The Supervision Questionnaire (Ladany *et al.*, 1996), which provided a measure of trainees' views about the quality and outcomes of supervision received.

Results

WHAT DO TRAINEES AND SUPERVISORS FIND HELPFUL?

Table 9.3 shows the top ten most helpful supervisor behaviours (taken from the 46-item SQR) for both supervisors and trainees ranked by degree of helpfulness. Perhaps what is most immediately obvious from this table is the striking degree of overlap between what the trainees consider to be important and what aspects the supervisors rate highly. While possibly not surprising, this similarity is certainly an encouraging finding. As the literature previously reviewed has found, what seems to be of paramount importance is establishing a good rapport and giving positive feedback to the trainee. It may be that unless a good rapport is established, little else of value can happen, or at the very least learning is hampered. Alongside a positive supportive relationship each group values teaching and feedback that allows the trainee to increase their competence and

confidence. There are slight differences between the groups. Supervisors seem to rate as important the holding and containing aspect of supervision a little more than the trainees, who value teaching and critical appraisal. Perhaps importantly and maybe not surprisingly, trainees also rate being able to observe their supervisor directly as more important than the supervisors. It should be remembered that the trainee group is skewed more towards the earlier part of training in that half the respondents were first-year trainees. Supervisor training could emphasize the importance of direct observation, particularly at earlier stages of trainee development. There may be a number of reasons, both legitimate and less appropriate, for avoiding observational experience

Table 9.3 Top ten most helpful supervisory behaviours for supervisors and trainees

<i>Rank</i>	<i>Trainee ranking of degree of helpfulness of supervisory behaviours</i>	<i>Supervisor ranking of degree of helpfulness of supervisory behaviours</i>
1	Establishing good rapport	Establishing good rapport
2	Giving appropriate positive feedback	Giving appropriate positive feedback
3	Giving appropriate feedback about less helpful behaviour	Supervisory session lasting at least one hour
4	Supervisory session lasting at least one hour	Helping trainee to establish self-confidence as an emerging therapist
5	Helping you to develop self-confidence as an emerging therapist	Establishing clear goals conjointly
6	Allowing you to observe, do joint work or listen to/watch tapes of supervisor working	Helping trainee to develop assessment skills
7	Providing relevant literature or references	Helping trainee to conceptualize cases and evolve a joint conceptualization
8	Suggesting alternative ways of intervening with clients	Consulting with trainee if emergencies emerge with clients
9	Helping you to experiment and discover your own unique style	Being available for consulting at times other than regular scheduled meetings
10	At least 45 minutes of each session is spent discussing clients or therapy	Giving appropriate feedback about less helpful behaviour

during placements, and these might be explored and challenged in supervisor training. Overall then, these ratings mirror the findings in the literature as well as confirming the qualitative findings from the supervisors' workshop. The groupings emerging there of 'rapport and safety' and 'client focus and challenge' could also encapsulate the ratings in [Table 9.3](#).

Summary of most important helpful supervisory behaviours:

- Significant overlap between trainees' and supervisors' ratings of most helpful supervisory behaviours.

- Survey results here are in line with previous research and our qualitative workshop findings.
- Establishing good rapport, and giving appropriate positive feedback ranked as top two most helpful behaviours by both groups.
- Supervisors rate holding/containing aspect of supervision slightly more highly than trainees.
- Trainees rate teaching, critical appraisal and direct observation of supervisor, more highly than supervisors.

Table 9.4 Rankings for the top ten most frequent helpful supervisory behaviours

<i>Rank</i>	<i>Trainee ranking of frequency of helpful supervisory behaviours</i>	<i>Supervisor ranking of frequency of helpful supervisory behaviours</i>
1	Supervisory session lasting at least one hour	Supervisory session lasting at least one hour
2	Giving direct suggestions when appropriate	Giving appropriate positive feedback
3	At least 45 minutes of each session is spent discussing clients or therapy	Reviewing goals with trainee at mid-placement
4	Evaluating you at mid-placement	Evaluating trainee at mid-placement
5	Reviewing your goals at mid-placement	Discussing experiences in placement in addition to client work
6	Giving appropriate positive feedback	Establishing clear goals conjointly
7	Establishing good rapport	Being available for consulting at times other than regular scheduled meetings
8	Helping you to develop self-confidence as an emerging therapist	Helping trainee to develop self confidence as an emerging therapist
9	The focus of most supervisory sessions is on the content of the therapy	Establishing good rapport
10	The focus of most supervision sessions is on understanding the clients' difficulties	Allowing trainee to observe, do joint work or listen to/watch tapes of supervisor working

Table 9.4 shows the trainee and supervisor rankings for the top ten most *frequent* helpful supervisory behaviours (taken from the 46-item SQR). The previous table showed the ratings for what trainees and supervisors considered to be important, whereas **Table 9.4** asked both groups to rate the frequency of helpful behaviours (i.e. what actually happens). Again the similarity between the ratings of the two groups is striking. Six of the behaviours appear in both lists. Clearly the ‘sanctity’ of the supervisory hour and the mid-placement reviews are valued. Given the BPS accreditation criteria, it is to be expected that these behaviours would appear as occurring frequently. Encouragingly, establishing good rapport, giving positive feedback and helping the trainee to develop self-confidence also appear again in both lists. Trainees clearly value the importance of client focus in the supervision sessions and also value being given direct suggestions. Supervisors

appear to think that they offer opportunities to be observed or do joint working, rather more than the trainees do. Generally it appears that supervisors want to discuss issues whereas trainees, at least in the early stages, value being told what to do. As suggested in the literature, there may be developmental differences according to level of experience. Stoltenburg *et al.* (1998) proposes four levels of trainee/professional development. Whilst developmental models of trainee progress remain to be fully evaluated, Stoltenburg's stages of development have high face validity, and link with the findings here. At level one, for example, the 'novice' is clearly reliant on tutors' directions and may be more concerned about personal performance, rather than being more focused on the needs of the client. The predominant concern at this stage with basic techniques has implications for supervisors being more structured and direct with instructions for trainees early in their training. Experienced supervisors may forget the earlier developmental need of trainees to be given explicit direction. It is reassuring and encouraging that, for the most part, both trainees and supervisors agree on what is important in supervision, as well the frequency of helpful behaviours.

Summary of most important helpful supervisory behaviours:

- Again, major overlap between trainees and supervisors' results (six items occurring in both 'top 10' ranks).
- Supervisory session lasting at least an hour flagged as most frequent by both groups.
- Other areas of overlap include mid-placement reviews, establishing good rapport, giving positive feedback and helping trainees' confidence.
- Some possible developmental discrepancies were highlighted, with less-experienced trainees valuing frequent direct suggestions more than supervisors.

WHAT DO TRAINEES AND SUPERVISORS FIND UNHELPFUL OR DIFFICULT?

Table 9.5 shows what supervisors and trainees regard as the top ten least helpful or most difficult supervisor behaviours (taken from the 46-item SDQ) and ranked for degree of unhelpfulness or difficulty. Again there is a great deal of correspondence between the ratings of supervisors and trainees. Seven of the items appear in both lists. There is a focus on unprofessional and incompetent behaviour, as well as lack of respect for boundaries. The trainees also consider lack of time in supervision, time interruptions, lack of feedback and apparent lack of supervisor training to be particularly unhelpful; supervisors rate giving negative criticism and giving the trainee too much non-client work to do as unhelpful.

Summary of most unhelpful/difficult supervisory behaviours:

- High level of agreement again between supervisors and trainees (seven items occur on both 'top 10' lists).
- Focus on unprofessional and incompetent behaviour and lack of respect for boundaries.
- Trainees emphasize unhelpfulness of lack of time in supervision, time interruptions, lack of feedback and apparent deficiencies in supervisor training.

Table 9.5 Supervisors' and trainees' ratings of the top ten least helpful supervisory behaviours

<i>Rank</i>	<i>Trainee ranking of degree of unhelpfulness of supervisory behaviours</i>	<i>Supervisor ranking of degree of unhelpfulness of supervisory behaviours</i>
1	I do not think that my supervisor is a competent practitioner	Unethical or illegal behaviour from supervisor
2	I don't get enough time from my supervisor for adequate supervision	Supervisor is an incompetent supervisor
3	I do not think that my supervisor is a competent supervisor	Supervisor is an incompetent practitioner
4	I think that my supervisor's behaviour in one or more situations is unethical or illegal	Supervisor doesn't care very much about the clients or the work
5	My supervisor just doesn't care very much about the clients or the work	Supervisor doesn't provide adequate time for supervision
6	I consider that my supervisor modelled unprofessional behaviour	Supervisor is personally intrusive
7	My supervisor does not respect the time and allows interruptions	Supervisor gives too much negative criticism to trainee
8	My supervisor seems untrained in supervision techniques	Supervisor models unprofessional behaviour to the trainee
9	I don't feel safe because I thought that my supervisor was personally intrusive	Supervisor is not a reliable professional resource
10	My supervisor gives me no feedback and I feel lost	Supervisor gives trainee too much other work to do

- Supervisors rate negative criticism and too much non-client work for trainees as particularly unhelpful.

Table 9.6 shows the top ten *most frequent* unhelpful supervisory behaviours reported by trainees in rank order. While the previous table attempted to explore what trainees and supervisors considered to be the most unhelpful or difficult behaviours, this table shows the *actual* unhelpful behaviours reported by trainees. Supervisors were not asked to rate this, as it was the trainee experiences that were thought to be the most pertinent.

The most frequent unhelpful aspects are somewhat different from the least helpful supervisory behaviours. This is encouraging in so far as trainees, for the most part, do not appear to be experiencing the kinds of unprofessional behaviour and incompetence listed in [Table 9.5](#). Trainees report that they would like more opportunities both to be observed and to observe. This mirrors the findings from the helpful behaviours regarding trainees' views about the importance of observation. Trainees clearly seem to regard direct observation, both ways, as more important than supervisors. Trainees also report feeling constrained about the evaluative nature of the supervisor's

Table 9.6 Top ten most frequent unhelpful supervisory behaviours reported by trainees

<i>Rank</i>	<i>Trainee ranking of frequency of unhelpful supervisory behaviours</i>
1	I am not given enough opportunities to be observed working by my supervisor
2	The criteria for evaluating my performance are not clear
3	I don't receive enough critical appraisal from my supervisor
4	I am not given enough opportunities to see my supervisor working
5	I feel constrained during supervision by the fact that my supervisor is also my evaluator
6	I have to cope with different styles of work and supervision from my supervisor compared to other supervisors
7	My supervisor concentrates on one/some aspects of the work to the exclusion of others
8	My supervisor doesn't give me enough guidance
9	I don't feel safe to discuss my professional weaknesses because I am not sure how I will be evaluated
10	My supervisor is not punctual and doesn't keep to time

role and unclear about the criteria for the evaluation of their performance. This finding may have implications for the 'assessment of competencies' debate, in that the definition and delineation of specific clinical competencies may allow for clearer and more transparent, as well as more objective evaluation criteria. However, trainees also report wanting more critical appraisal and direct guidance from supervision. Being given appropriate feedback about less helpful behaviour was also rated highly on the helpful behaviours list. This leads us to speculate about whether supervisors feel unskilled in challenging appropriately and are therefore reticent to give critical appraisal, since it can be taken as, and indeed sometimes is, negative criticism. Given the nature of the evaluative role of the supervisor, trainees can be acutely sensitive to anything that might be construed as negative criticism.

Summary of most frequently experienced unhelpful supervisory behaviours:

- Most difficult supervisory behaviours outlined earlier are not experienced frequently by trainees.

- High levels of overlap between present survey results and workshop feedback.
- Trainees would like more opportunities to observe and be observed.
- Evaluative nature of supervisory relationship and unclear evaluation criteria are frequently experienced as unhelpful by trainees.

There is considerable correspondence between these survey findings and the qualitative findings regarding unhelpful supervisory behaviours gathered from the supervisors' workshop. The top ten most unhelpful behaviours, shown in [Table 9.5](#), straddle Magnuson's (2000a) overarching themes. Most could be subsumed under the themes of 'poor model of personal and professional attributes', 'untrained', 'intolerant of differences' and 'developmentally inappropriate'. A few items could also be categorized as 'professionally apathetic' or 'unbalanced'. When considering the top ten most frequent unhelpful supervisory behaviours reported by trainees and shown in [Table 9.6](#), there is less correspondence with Magnuson's categories. Some of the items could be subsumed under the 'unbalanced' or 'developmentally inappropriate' category, and one item, relating to not keeping to time, would fit best under the 'poor model of personal/professional attributes'. However, several items relating to the difficulties of being supervised and evaluated by the same person do not fit easily into any category. It may be that this problem takes on added significance in clinical psychology training, where the consequences of failing a clinical placement are so serious.

SUPERVISION FACTORS

A preliminary factor analysis of the two trainee questionnaires asking about unhelpful and helpful supervisory behaviours suggested four factors. These are listed below with descriptive titles and some illustrative behaviours that load highly on each factor.

Factor 1: Supervisor disinterested and/or remote. Poor therapeutic focus on trainees and clients.

- 1 My supervisor just doesn't seem to care very much about the clients or the work.
- 2 My supervisor only seems concerned about service issues and seems insensitive to my professional and developmental needs.
- 3 My supervisor is inadequately prepared for supervision.
- 4 My supervisor gives me no feedback and I feel lost.

Factor 2: Supervisor incompetent and unprofessional.

- 1 I think that my supervisor's behaviour in one or more situations is unethical or illegal.

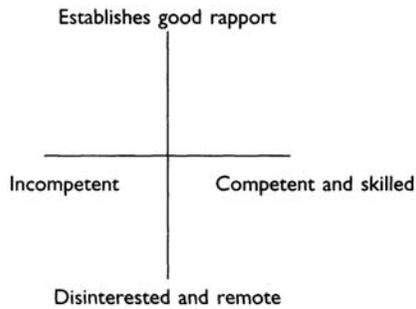


Figure 9.1 Proposed dimensions of supervisory behaviours

- 2 I think that my supervisor is not a competent practitioner.
- 3 I consider that my supervisor modelled unprofessional behaviour.
- 4 My supervisor imposes a personal agenda on our supervision sessions and only wants to talk about his/her issues.

Factor 3: Supervisor skilled and gives facilitative feedback.

- 1 My supervisor helps me to assess my own weaknesses.
- 2 My supervisor confronts me when appropriate.
- 3 My supervisor helps me to assess my own strengths.
- 4 My supervisor labels my behaviour as effective or ineffective rather than right or wrong.

Factor 4: Supervisor establishes good rapport and is approachable.

- 1 My supervisor establishes good rapport with me.
- 2 My supervisor uses humour in supervision sessions.
- 3 My supervisor makes it easy for me to give feedback about the supervisory process.
- 4 My supervisor is not too formal with me.

These factors are similar to the themes identified earlier from the workshop findings and we suggest that there might be two dimensions: a relationship construct and a professional competence dimension (see Figure 9.1).

Most of the supervision literature and the findings above emphasize the role of the supervisor and/or supervisory relationship, whilst there is relatively little emphasis on trainee responsibility for this process. Our final comments highlight the trainee's role.

Roles and responsibilities of trainees

Clearly within a developmental-relational model (Evans, 1998), the trainees' position will be an evolving and reciprocal one, but there are some useful indicators to trainees for maximizing their supervisory experiences. Inskipp and Proctor (1993) have produced a text on 'making the most of supervision' which is aimed at both supervisor and supervisee. It includes suggestions for the trainee to bring and share work 'readily and accessibly' with their supervisor, and to be both open to feedback and to provide feedback within supervision. Milne and Gracie (2001) have specifically addressed the role of the supervisee in a recent survey of supervision methods and trainee contributions. Collaborating in the supervision process was identified as the most significant theme. The authors indicate the importance of participating actively, sharing responsibility and operating as equals within the supervisory relationship. The results from our recent survey clearly highlight trainees' keenness for observational feedback (and supervisors' relative reluctance to prioritize this). Themes emerging from Milne and Gracie's work include an emphasis on the trainee taking responsibility for prompting supervisory activities such as observation, as well as preparing for supervision, feeding back to the supervisor and organizing (e.g. alternative supervision experiences). Together these are seen to constitute 'a healthy acceptance of an adult learner's responsibilities within a professional training programme'.

To summarize, trainees' responsibilities within supervision include:

- working on establishing a collaborative relationship
- presenting as an adult learner
- sharing responsibility for supervision
- being an active participant; maximizing the available supervision time
- clarifying needs within supervision
- being forthcoming in bringing work to supervision
- preparing; presenting work in an accessible way in supervision
- prompting supervisory activities (e.g. observation)
- being open to feedback from supervisor; self-monitoring and applying suggestions as appropriate
- offering feedback to supervisor
- arranging supplementary supervision experiences where required

Conclusions

The predominantly US literature we reviewed highlights the importance of the quality of the supervisory relationship and suggests that there may be developmental differences in the needs of trainees. Most of the research is descriptive and focuses on supervisees' reactions to supervision, with little attention paid to outcome. We found few studies on unhelpful aspects of

supervision. We concur with the reviewers who suggest that supervision research is at an early stage. Our research findings identify high levels of agreement between trainees' and supervisors' views of helpful and unhelpful aspects of supervision, with good concordance between qualitative and quantitative results. These give some useful pointers for supervisor training, particularly about the developmental needs of trainees and the importance of observational learning. The role of trainees in making their needs explicit to supervisors has been indicated.

There has been a recent burgeoning of supervision research studies and literature in Britain and evidence-based courses for supervisors are becoming established. Supervision needs in clinical psychology are now being comprehensively addressed with clear benefits for trainees as well as for the profession and the clients it serves.

Chapter 10

Therapy models and supervision in clinical psychology

Shane Matthews and Andy Treacher

Introduction

Our motivation in writing this chapter was clear to us from the start—we wanted to write a practical, yet well-grounded chapter which would hopefully be of value to most clinical psychology supervisors. The chapter can't be as practical as some manual-based supervision texts (e.g. Morrison, 1993), but we hope its pragmatism will be valuable to readers. In order to decide what to include and what to exclude we have been guided by two different considerations. Firstly, by the orientations readers of this chapter are likely to have. Secondly, by what we have found valuable ourselves in our attempts to develop a model of supervision.

Working to the first consideration is hazardous because of the lack of research. We therefore have to rely too heavily on the results of somewhat dated survey of clinical psychologists' therapeutic orientations by Norcross *et al.* (1992). We assume on the basis of this survey that the majority of clinical psychologists are likely to espouse one of four models—cognitive-behavioural, systemic, integrative/eclectic or psychodynamic/psychoanalytic. Readers may be interested to compare this typology with that described in [Chapter 2](#). Basing ourselves on the popularity of these four models we have elected to choose four supervision models which are hopefully congruent with the ideas that these approaches contain.

Having clarified which models we want to explore it is important to describe how we will do so—and point out the hazards of our approach too. Rather than reviewing all four models in depth we will adopt a more idiosyncratic approach. We will initially explore three models—psychodynamic, systemic and cognitive-behavioural therapy—but our exploration will be focused by the question of what we wish to take from these three models to create an integrated supervision approach that fits with our experience. From a scientist-practitioner point of view our strategy is clearly very problematic because we need to abandon any pretence that our approach is guided by research findings.

In an ideal world each of the models of therapy we've chosen would be paired with its respective model of supervision, and there would be a body of research

supporting the links between each of the pairings so that practitioners could feel secure that they were basing their supervisory practice on sound foundations.

Researchers have paid more attention to this issue recently. They have tended to use the notion of an educational pyramid to focus on the levels that need to be examined in order to link supervision to therapeutic outcome. Normally the pyramid is assumed to have three tiers—the supervisor at the top, the supervisee in the middle and the client at the bottom. According to a recent review by Milne and James (2000), studies focusing on the pyramid are quite numerous but they lack ‘empirical rigour’.

In order to emphasize this point they cite Binder (1993:304), who sums up the field as follows: ‘scientific investigations of the procedures used by psychotherapy supervisors and their efficacy are practically non-existent... studies that have attempted to assess the impact of supervision on trainee performance in actual therapy settings have had discouraging results’. According to Milne and James (2000) the Achilles’ heel of these studies is that there is insufficient focus on therapeutic efficacy.

It’s very creditable that Milne and James’s own paper has attempted to correct this weakness in the literature. Drawing on the important methodological advice of Ellis *et al.* (1996) they undertake a review which collates papers that address a more sophisticated educational pyramid—in addition to the three tiers we have already mentioned, a fourth tier is added in order to encompass an extra process which involves a consultant providing consultancy to the supervisor. Milne and James collate 28 papers relevant to this pyramid and are able to conclude that cognitive-behavioural supervision can be demonstrated to be effective.

Milne and James are cautious in interpreting the generalizability of the results of their study because the majority of the papers they reviewed described relatively straightforward skill-teaching interventions. Clinicians working with clients where the nature of the therapeutic work is more complex may well be highly sceptical of these findings, but nevertheless Milne and James have thrown down the gauntlet to all of us to validate our work in a similar way.

We would suggest that this highly rigorous approach may not be easily welcomed by us as clinical psychologists. As a profession we have learnt to espouse a scientist-practitioner model, but it is not at all clear that we actually adhere to the model. We may, perhaps, be able to claim that our work is more research-oriented than other health care professionals, but that does not mean we directly base our day-to-day practice on research findings (see Pilgrim and Treacher, 1992, [chapter 3](#) for further discussion of this issue). To illustrate this point it is important to record how we ourselves came to supervise in the way we do.

One of us (AT) became a clinical psychologist through the now extinct British Psychology Society Diploma in Clinical Psychology route—supervision was undertaken by three different supervisors: two clinical psychologists and a family therapist who had social work training. Each supervisor had a different style of supervision, but there was never any discussion of the model of supervision

adopted, its theoretical underpinnings or its possible research base. The other of us (SM) trained in clinical psychology at Plymouth. Supervision was received from five supervisors, but the experience was essentially the same. Later on both of us became clinical tutors and it was only the tasks associated with the role of being tutors (e.g. helping train supervisors) that forced us to examine our own weaknesses as supervisors. We then began to read the supervisory literature, with one of us (SM) completing a diploma in supervision which examined various supervisory models and approaches. Our goal was to explore which approach to supervision made sense to us. The choice we made was not influenced by the concept of the scientist-practitioner—to be honest it was the theoretical aspects of the approach that attracted us. Employing the model in our work then gave us anecdotal confirmation of its value, but there was never any question of being able to validate the model's efficacy by undertaking research within the paradigm advocated by Milne and James.

The model that we have been experimenting with for the last ten years or so is the well-known approach developed by Hawkins and Shohet (1989, 2000). The model is firmly based in the psychodynamic tradition and therefore may be off-putting to supervisors who adopt either a CBT or systemic approach. However, we believe that the model's great strength is its flexibility. We hope to illustrate this point in the final section of our chapter, but in order to (hopefully) make our chapter user-friendly we will explore the ideas we take from our three chosen models to flesh out our fourth (integrated) model.

Psychodynamic approach to supervision

Because of its important historical contribution to the development of supervision it is important to start our discussion with an exploration of the psychodynamic tradition. However, since neither of us have been specifically trained within this tradition it is important to clarify our approach. We value many of the ideas that come from the tradition and feel it is helpful for all integrated therapists to draw upon some psychodynamic ideas. This does not mean, however, that we are capable of undertaking psychodynamic psychotherapy. If we do undertake individual therapy then both of us tend to utilize systemic and CBT approaches but, at the same time, we will use aspects of the psychodynamic approach in order to reflect on what is happening, interactionally, between the client and ourselves.

Psychodynamic models have traditionally been expert-driven models involving considerable role confusion. Freud himself began to supervise groups of his disciples once his ideas had gained a following. His role within these groups had three facets—he taught, supervised and analysed (as Binder and Strupp, 1997, have pointed out). His approach led to the establishment of the well-known 'tripartite' model of training which involved didactic course work, the supervision of the treatment of several patients and (most importantly) the undertaking of a personal analysis. The core of the training was, of course, the

analysis—the theoretical assumption being that successful therapy could not be undertaken unless the would-be analyst was relatively free of neurotic conflicts. Clinical psychology as a discipline has not chosen to train its incumbents in this way, but nevertheless the profession is increasingly aware that it needs to respond to the challenge of psychodynamic ideas by trying to incorporate self-reflective ideas into training. Indeed we are aware of at least two of the doctoral training programmes (Oxford and Bristol) whose promotion of the reflective scientist-practitioner model has included support for some limited sessions of personal therapy for their trainees. Generally we feel that it would be unlikely for a trainee not to get a chance at some point in their training to begin to understand how their own personal history (and personality characteristics) influence their ability to be a clinical psychologist.

Our own approach to the psychodynamic tradition is frankly pragmatic. We are reassured that contemporary writers such as Frawley-O’Dea and Sarnat (2001) have created a model of supervision which has seriously modified the traditional approach. They have replaced the hierarchical expert supervisor with the highly self-reflective post-modern supervisor who takes co-constructionism to heart. Their model can build bridges to postmodern versions of family therapy, but it is less congruent with CBT models of supervision. We are still absorbing their ideas, which are, fortunately, highly compatible with Hawkins and Shohet’s (2000); but despite their great emphasis on the relational nature of the model there is a curious lack of emphasis on alliance building. They argue that it is still the openness and self-reflectivity of the supervisor that is crucial in creating the context for successful supervision. They do pay attention to contract making (which is essential to alliance building), but much to our surprise they do not make reference to it directly.

For us the idea of the therapeutic alliance between client and therapist is a very crucial one. We have built our approach on the work of Bordin (1979) and Dryden and Hunt (1985), who have summarized Bordin’s position as follows:

the therapeutic alliance is made up of three major components...the *bonds* refer to the quality of the relationship between the participants, the *goals* are the ends of the therapeutic journey while their *tasks* are the means for achieving these ends. Disruption to the therapeutic journey might occur because the ‘travellers’ (a) do not get on or have a relationship which is not conducive to the goals or task of therapy (weak or inappropriate bonding); (b) disagree on the journey’s end (nonagreement about goals); and/or (c) prefer different ways of reaching the therapeutic destination.

(Dryden and Hunt, 1985:123)

Bordin’s analysis has a pragmatic appeal to us as therapists, and as supervisors we have little difficulty in applying his idea of the alliance to the process of supervision. If we experiment by replacing the word ‘therapeutic’ by the word

'supervisory' then we seem to have the beginnings of a working blueprint for undertaking supervision.

There are, however, one or two elements missing from the blueprint. If we compare Bordin's alliance building with Hunt's (1976) own ideas about the alliance, then we achieve a more rounded understanding of what needs to be attended to. In defining what she means by the term 'supervisory alliance', Hunt offers us the following inventory: 'openness and clarity...[about]... the methods to be used...and why they are used, the style of supervision, the goals of supervision, the kind of relationship it is helped to achieve and the responsibilities of each partner in the supervisory relationship' (cited by Hawkins and Shoheit, 2000:28).

Hunt's list adds two new elements—responsibility and style. These are important dimensions, but we prefer Bordin's ordering of the tasks that face us. We believe that it is essential to concentrate initially on the emotional/relationship aspects of the alliance. As supervisors if we do not succeed in building a good-enough relationship with our trainees then there is a real danger that the tasks involved in supervision will not be completed so that the goals are never achieved. The crucial practical question is how to establish a working relationship. Both of us have family therapy backgrounds and are used to undertaking genograms with our trainees, albeit in a smallgroup situation (i.e. one trainer to two or three trainees). Sharing genograms one to one may seem intense. Nevertheless, if carefully undertaken, genograms can be very helpful to both participants, but a number of rules need to be observed. First, each genogram needs to be started as a narrative—'this is my personal story about me and my family. By all means ask questions about what I share and make supportive comments but I reserve the right to tell you what's off limits.' Second (and in order to prevent the supervisor becoming a therapist to the supervisee), the concluding phase of the genogram needs to explore two further series of questions. The supervisor needs to discuss their own genogram and explore linking questions, such as 'what are my strengths and weaknesses when working with my clients?' They also need to initiate conversations about how they themselves have developed their own reflections about their own genograms. For example, 'these are clients I feel most at ease with; these are the clients I feel least at ease with. Thinking through my genogram I am beginning to make sense of why this is so.' If the supervisee is willing the supervisors can then invite the supervisees to think about their clients and their genograms in the same way. The final part of the approach involves the supervisor initiating a discussion of how the two genograms set up interesting hypotheses about how the supervisor and the supervisee will be able to work together. Useful questions that can be asked are as follows: 'Looking at both our genograms can we work out how we think we will get along? Are there any possible instances which will help or hinder us?'

Spending supervisory time sharing genograms is also valuable because it gives the supervisee a chance to explore a whole series of questions that she can use in undertaking a genogram with a client or with a family. One of the best books for

developing this type of work is Wachtel and Wachtel's (1986) book *Family Dynamics in Individual Psychotherapy* (especially their [chapter 3](#)— 'Asking Questions that Review the Family System'). We have also found McGoldrick and Gerson's book *Genograms in Family Assessment* (1985) very useful, both to us and supervisees, because of its copious examples of genograms (including Freud's).

In order to demonstrate the value of undertaking genograms as an essential part of a supervision package, one of us (AT) can provide a very painful illustration of how a placement nearly failed because of an overenthusiastic approach which did not take relationship building seriously. I offered placements to two supervisees whose arrival was staggered because of timetable difficulties. The first to arrive was very keen but very inexperienced. We seemed to get on well but a month later we were joined by the second supervisee who was much more experienced and, to make matters worse, I had worked with her before in a different setting. The first supervisee found the transition from the twosome to the threesome very difficult, but fortunately had the courage to confront my lack of thoughtfulness in handling the situation. By chance the trainee's family background had painful echoes of our situation. The memory of the arrival of a younger sibling was dominated by a sense of parental abandonment. Fortunately, undertaking our genograms at this point of crisis was very helpful—we were able to understand better how we fitted together as a threesome and were able to begin to understand the strengths and weaknesses we brought to the situation. Fortunately, for me my supervisees were able to accept my mistake. Obviously my lack of forethought had created the supervisory context which had exacerbated the resonances between our newly formed supervisory system and the family systems we brought to the situation.

Our stress on relationship building reflects the fact that we both draw heavily on attachment theory ideas (e.g. Byng-Hall, 1995), but we believe our attachment to attachment theory is not naive. Supervisors, as attachment figures, are potentially ambivalent—inducing figures because of their dual role. Supervision, as defined in the strict sense by Bernard and Goodyear (1992), stresses the gatekeeping role of the supervisor who must be sure to examine the performance of the supervisee rigorously. The idea that the supervisor can be an examiner of the supervisee while at the same time forming a relatively close bond with them may, at first sight, seem an impossibility. Our experience contradicts this idea. Providing we use co-constructive methods in undertaking the task of examining the supervisee the two roles become compatible. Such an approach enables the supervisee to take on a great deal of responsibility for ensuring that the learning process during the placement is effective enough to achieve a graduating performance. The first step in establishing the coconstructivist approach is to negotiate a contract with the supervisee that clearly recognizes the responsibilities of both the supervisor and the supervisee. The crucial task the supervisor faces is to create a supervisory context that is

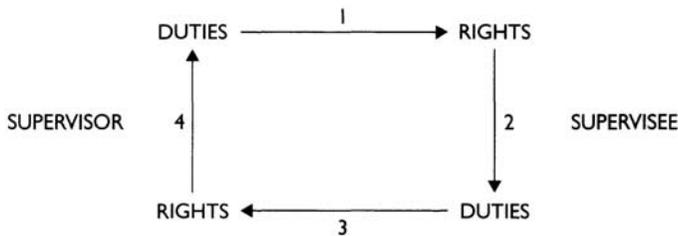


Figure 10.1 Supervisory interaction model

Source: Adapted from Scanzoni (1970)

good enough to enable the supervisee to enhance his/her performance sufficiently so that they can function well enough to pass the placement.

The supervisee's crucial challenge is to be able to respond to the supervisor's input in such a way that he/she feels secure enough to be open to the process, so that the supervisor can supervise appropriately. The rights and duties of the supervisor and the supervisee can be seen to interlock in Figure 10.1, which is based on a well-established model of marital interaction proposed by Scanzoni (1970), and which in our view fits many elements of the supervisory relationship.

This apparently crude exchange theory model works in the following way. If the supervisor sets the initial conditions for supervising effectively then the supervisee feels that he/she is being both well held and intellectually stimulated by the supervisor. Internally this prompts the supervisee to reciprocate by carrying out his/her duties diligently. In turn, this behaviour satisfies the rights of the supervisor; for example, one especially important duty of the supervisee is to be non-defensive in sharing the work he/she has undertaken so that the supervisor has valid information which can be utilized as the basis of supervision. Impression management by the trainee will disrupt this process, leading to the supervisor distrusting the supervisee and vice versa. Genuine reciprocity can be built provided four conditions are met:

- 1 A complex enough contract has been negotiated.
- 2 Ongoing evaluation is utilized (especially by the supervisor) so that genuine feedback can be obtained.
- 3 The initial relationship built between the supervisor and supervisee has been good enough to create a sufficient level of trust for openness, rather than defensiveness, to be currency of the exchange between the two participants.
- 4 Both participants are emotionally mature enough to handle the feedback they give each other effectively; lack of genuineness will deaden the feedback so that it is invalidated.

This final point takes us back to psychodynamic theorizing again. Traditionally psychodynamic supervision concentrated on exploring the transference and counter-transference between the therapist and patient. The supervisor remained opaque—the assumption being that the supervisor was somehow not part of the equation because they had been purified by their own analysis. (The ghost of Freud clearly looms here—he, as a supervisor, adopted a hierarchical position which did not invite examination.) Frawley-O’Dea and Sarnat’s (2001) co-constructivist model offers a very different approach, as this quotation from their book clearly illustrates:

When supervision goes well, it is alive, vibrant and vibrating, with the cognitive, linguistic, affective, somatic and relational responses of supervisee and supervisor to the patient *and to one another*. It is through the mutual regulation and renegotiation of the movement of supervision that more becomes possible within the potential space of supervision and, in turn, within the analytical work of the supervisee. Even when there is dissonance in one or both of the dyads, more becomes imaginable, sayable and playable for the supervisor, supervisee and patient as co-contributors to the supervisory matrix...There are, of course, potentially moments of dissonance or relational disjunction that, when named, processed and worked through, become precipitants to new understandings and/or heretofore unavailable narrative threads central to the supervised treatment, the supervisory relationship or both.

(Frawley-O’Dea and Sarnat, 2001:70; emphasis added)

This, we think, is a very valuable quotation for anybody interested in supervision. For ourselves we delete the word ‘analytical’ (because it is not relevant to us), but we can agree with all the other points made. Hawkins and Shohet’s model is particularly effective in offering practical ways of exploring disjunctions (as we will illustrate on pp. 200–206), but the psychodynamic thinking of Frawley-O’Dea and Sarnat is particularly valuable in prompting us to think about all aspects of the triangular space that is involved in therapy. Psychodynamic theorists no doubt find the concepts of transference and counter-transference useful in conceptualizing their work, but we personally find the concepts too limiting and too linear to be of direct value to us. As we understand it, the term ‘counter-transference’ is itself predicated on the assumption that transference has been created during therapy by the client projecting on to their therapist. Counter-transference is therefore a secondary process triggered in the therapist by the client’s active involvement in a transference relationship. This way of punctuating the process is perfectly valid from a theoretical point of view, but empirically we would assume that the process can happen in reverse; that is, a client can also be the object of a transference relationship created by their therapist. Counter-transference may well then be induced in the client, who may not be able to cope with the transference input from the therapist.

Our own way of conceptualizing these recondite processes is very different. We prefer to replace the ideas of transference and counter-transference with the broader and (perhaps) less theory-laden notion of unfinished business. We assume that all the participants in the pyramid (supervisor-supervisee-client) bring their own complex experiences to the encounters they participate in. The essential trust in both the dyads involved (supervisor-supervisee, supervisee-client) is to create narratives about these encounters which free all participants to be more reflective about what is happening to them as they work together.

As always, the devil is in the detail—how precisely is this storying to be achieved? Is the triadic structure sufficient to the task or is a fourth level—consultation—required in order to cope with the difficulties a supervisor may have in creating benign conditions which enable the whole system to function? This will be discussed in the final part of our chapter when we review our revision of the Hawkins and Shohet model. One of the model's great strengths is its ability to handle these issues practically and economically.

Systemic supervision

We are sure you will have already noticed that we have not been able to keep our comments neatly corralled by the framework we have utilized. In discussing the psychodynamic approach we have already talked about the significance of genograms, and a lot of our language and thinking owes a debt to narrative approaches (e.g. White and Epston, 1991), which are so fashionable amongst contemporary family therapists. These intrusions from the systemic and narrative camps reflect the fact that we are non-purist, integrationist theorists. Faced with exploring the contribution of systemic thinking we are, however, once again in a quandary about what to include and what to exclude.

Liddle *et al.*'s (1988) definitive tome on family therapy supervision inventories so many models that the task of selection seems impossible, but such is the fashionability of family therapy that many of the models reviewed are already (we suspect) redundant. The only visible tactic that we can realistically adopt is our usual pragmatic one of cherry-picking. We are prompted to select what has helped us most from the literature and from our own experience.

Fortunately for us our ideas correlate quite well with Liddle's own approach to supervision (Liddle *et al.*, 1997). He and his co-workers stress the importance of adopting a multidimensional approach to therapy (MDFT) so supervision, of necessity, has to be multidimensional too. This stance matches our own approach quite neatly, but it is noticeable that Liddle, before introducing his own model, explores some additional facets of supervision that he believes to be specifically important within the field of family therapy.

These include the person of the therapist, which we have discussed already in the chapter, and some of the research into family therapy supervision, which unfortunately is rather insubstantial and now somewhat dated. What we will

include are three further dimensions: (1) live supervision and videotape supervision, (2) thinking about family process, (3) using a lifespan framework.

Live supervision through a one-way screen (Montalvo, 1973) is a significant factor in training family therapy trainees and perhaps the most valuable form of supervision that either of us has encountered. But, of course, there can be a downside. If a supervisor is not good at relationship and trust building then live supervision can be experienced as aversive. So the use of joining techniques (e.g. sharing genograms as we have already established) is essential before exposing supervisees to the fish bowl atmosphere of the screen room with its one-way screen and video camera. It is important to stress, however, that there are user-friendly versions of these high-tech approaches, which can be used if supervisees are uncertain about the value of such methods. Former colleagues of one of us (AT), Donna Smith and Phil Kingston, pioneered an in-the-room version of supervision. This approach involves the supervisor (with or without team members) being present in the room with the supervisee and the family. There is an obvious danger of this approach becoming some form of co-therapy, but a structural rule helps prevent this from happening; that is, the supervisee invites the family members to communicate directly only with him or her and not with the supervisor who communicates directly only with the supervisee. This pattern of communication can feel strange when first used but the implementation of the structural rule means that the supervisor can maintain a so-called 'meta' position which enables her to retain an overview of what is happening. For a more detailed discussion of how live consultancy and live supervision work, see Smith and Kingston (1980) and Kingston and Smith (1983); see also Zarski *et al.* (1991) for a similar approach (which has been called the invisible mirror technique).

The use of the one-way screen for training purposes is quite a big topic in its own right, but it is important for us to point out that there is no need to use the screen in the usual hierarchical way (i.e. having the supervisor ringing the supervisee to communicate either the supervisor's ideas or the team's ideas, or both). A more supervisee-friendly approach encourages two-way communication—the supervisee can opt to ring the supervisor, asking for ideas or confirmation that the line of questioning being utilized is appropriate. The supervisor (after due negotiation with the supervisee) can also have the option of moving from the screen room to the interview room in order to offer ideas to the family and supervisee.

The reflecting team approach of Andersen (1987, 1990) is an idea that has had a huge impact in systemic work. This approach offers the family in therapy a chance to hear the reflecting team who have observed them either in the room or through a one-way screen. If a supervisee is involved initially as a member of the team then they can gradually develop their role in a clinic, without feeling over-exposed by taking on the role of therapist. The Andersen (1987) guidelines for participating in reflecting team work are very useful because they provide a structure for participation. Without this structure a supervisee (unless they had

considerable prior experience) could feel out of their depth, particularly if other team members are used to working with each other.

One of us (SM) uses reflecting teams in much of his work, and I am aware that being a member of a reflecting team has enabled involvement in a supervisee's direct work with families without having to supervise the work proactively. Reflecting-team work has an in-built structure which allows supervisory ideas to come to the surface within the reflecting team. Several supervisees have found that by giving them more space and less direct supervision they have been more effective in developing their skills.

Ideally when a supervisee is working with a supervisor trained in family therapy they should get a chance to experience a variety of working methods. Each approach can undoubtedly contribute to the development of the supervisee's work, but we personally feel the use of just one method is counterproductive. It is also important to remember that clinical psychologists often have to undertake family therapy solo (perhaps even home visiting) so they need to develop self-reliance rather than team dependence.

Videotape supervision is another important area of supervision which needs careful thought. Clinical psychology trainees vary in their experience of being audiotaped or videotaped for the purposes of supervision, so the 'threat' of being videotaped needs to be carefully handled. Very often the time constraints of traditional clinical psychology supervision militate against using such supervision effectively. There is, however, one way round this constraint that can work. If a supervisee is keen and values the approach then there is obviously a strong incentive for them to review their own tapes so that they can identify sections of the tape which they feel they need feedback about. To encourage this process, the supervisor can model one or two sessions of feedback, preferably by using a tape of their own work rather than the supervisee's. By providing a narrative about what they see on their own tape and stopping to illustrate the strengths and weaknesses of their own work, the supervisor can create an invitational framework which communicates 'I can critique my own work non-defensively, owning both when I'm working well and not so well.' When the supervisor reviews the supervisee's tapes then the prime role is to be supportive and identify skilful work. When needing to give more critical feedback negativism can be avoided by inviting the supervisee to be self-reviewing. A good opening gambit is to say 'I feel you're struggling here. Can you remember what you had in mind to do? With the benefit of hindsight can you think how you could have done this differently?'

Helping supervisees to understand family process (another of Liddle's dimensions) is something we also stress. Narrative approaches have tended to neglect this aspect of the development of therapeutic skills. Our approach (and hence our language) here will cause the purist narrative therapist difficulties. We find there are merits both in Tomm and Wright's (1979) inventory of family therapy skills and in Flemons *et al.*'s (1996) post-modern inventory. Introducing supervisees to these inventories, and then exploring with them through self-

evaluation which skills they feel they want to develop, can be very productive. Conceptual skills are perhaps the most difficult to develop, but this is where videotape reviewing, once again, comes into its own. It is one thing to conceptualize on the hop when you're interviewing a family; it is quite another to do it in the calm context of a video review with input from a supervisor and/or other team member. Clearly in the latter situation there is much more chance for learning to occur because the supervisee can adopt a far more observer/reflective mode which enables supervisees to take their time in trying to conceptualize what's happening.

Finally before moving on to our third model (CBT), it is worth briefly exploring the role that developmental models play in helping supervisees orientate to family therapy. We agree with Liddle that it is essential to help supervisees think within a life-span framework. Perhaps the best source of all for this approach is Carter and McGoldrick's (1999) book *The Expanded Family Life Cycle—Individual Family and Social Perspectives*. This is the third edition of a book which is something of a social document itself. Over the course of the twenty or so years since it was first published this book has been expanded and extensively rewritten in order to reflect the changing nature of American families. The impact of social and cultural changes (e.g. divorce), coupled with its very focused interest in gender, class and ethnicity, makes it essential reading for any supervisee who wants to develop systemic ideas which are contextually honed to be relevant to a caseload of families that come from diverse backgrounds. The first chapter of the book by Lerner (1999) is also particularly interesting from a supervisory point of view. He explores the interaction between the therapist's and client's life cycle stages, providing a useful checklist (see appendix at the end of this chapter) of interfacing dimensions between therapist and family. Asking a supervisee to use the checklist with at least one of their families is a realistic task to set, but the checklist is particularly valuable if a supervisee is in difficulties in working with a family and yet neither she nor her supervisor can identify why. As we will explore later on, the most comprehensive way of exploring the phenomenon involves using all the modes (or levels) of the Hawkins and Shohet model; nevertheless, using the checklist is usually productive and creates a number of points for further exploration during supervisory sessions.

Cognitive-behavioural therapy supervision

Although our basic orientation as therapists is systemic we are well aware of the value of CBT approaches and will often utilize CBT techniques in working with specific clients. Ricketts and Donohoe (2000) outline 'hallmarks of supervision within a cognitive behavioral approach', which include:

- emphasis on skills development;
- structured approach and goal orientation;

- considerable educative function;
- preference for live supervision (or use of video);
- skills practice demonstration (modelling by supervisor).

All these areas find a place within our integrative approach. We have also been interested in Padesky's (1996) ideas that there may be an 'advantage' in using CBT ideas to tackle personal difficulties before using them as a therapist, as it resonates with our espousal of a reflective approach.

While it is quite easy for us to integrate CBT work with systemic work when working with our own clients, it is not always so easy when we want to encourage supervisees to follow our lead. If we are primarily contracted by a supervisee to provide them with family therapy supervision in a family therapy clinic then it can look impossible to integrate CBT as well. However, one of us (AT) has devised the following pragmatic solution to the problem. Rather than expecting the supervisee to undertake the work I abandon my role as supervisor and become the therapist who undertakes the CBT work while the supervisee views my work from behind the screen. Normally I do CBT work with parents or partners—if the family is a lone-parent one then obviously I work just with that parent, if it's a two-parent family then I'm very keen to try and negotiate a contract to involve them both, despite the fact that one of them may (because they are exhibiting clear symptoms) appear to be in greater need of help. Involving both in the CBT work is much more productive because it keeps both involved and prevents therapy from becoming lopsided and over-focused on one individual.

Feedback from supervisees using this approach has been very positive. They are intrigued to see how an individual psychotherapy technique can be integrated into the work. In related training sessions they are introduced to CBT techniques (using the self-help book by Burns, 1980, as my main text so that they have the option of using the techniques themselves). This works well, particularly if the supervisees chose to work, for example, on performance anxieties which may be affecting their performance in the clinic. Obviously this approach has some risks of fudging the supervisor/therapist boundary, but because the work is undertaken in a group situation it is possible to maintain the boundary.

The more usual situation involving the integration of CBT ideas is when we are supervising individual trainees in our role as clinical psychology supervisors. Here the task is more straightforward because we are not confined by the structure of the training clinic. If we are going to undertake supervision of a case involving a lot of CBT work then we have modelled our approach on the structure outlined by Liese and Beck (1997) who advocate a supervisory session which has effectively seven steps to it:

- 1 Check-in.
- 2 Agenda setting.
- 3 Bridge from previous supervision setting.

- 4 Inquiry about the process and outcome of previously supervised therapy cases.
- 5 Review of any homework tasks set at the previous session.
- 6 Prioritization and discussion of agenda items.
- 7 Assignment of her homework.

Liese and Beck also advocate the use of (a) capsule summaries (to make sure the supervisor is not being garrulous and leaving the supervisee unfocused as a result of too many ideas explored), (b) feedback techniques (in order to evaluate the value of the supervision to the supervisee).

The rigour of Liese and Beck's approach is important to us, because as family therapy supervisors (who quite often use narrative approaches) we are aware of just how discursive our supervision can become. This may well be helpful creatively but it can leave supervisees under-focused and ill-prepared for their next session with a client. Asking for feedback *during* the supervisory session rather than (usually hurriedly) at the end of the supervision session is also salutary. The use of well-honed feedback questions enables the supervisee to evaluate the supervision there and then. Good feedback enables both sides to refine the supervision to make sure it's at least trying to deal with the most relevant areas. With a busy caseload, and perhaps only one hour to deal with a number of cases, it's essential that both partners are doing their best to ensure that the process is effective.

Liese and Beck's emphasis on agenda prioritization is also very important to us, and there is an obvious developmental aspect to this. The supervisee may well want to pay attention to all their current cases at the beginning of a placement (and the supervisor may well want to monitor progress too). By the middle of the placement there should, of course, be a maturing in the supervisee's abilities so that they will feel freed up to perhaps concentrate on one or two cases, knowing that other casework is at least proceeding on a good-enough basis. Clearly there is a possibility of a parallel process here—if the supervisor has modelled the use of feedback well in the supervisory sessions (and is encouraging her supervisee to utilize ongoing evaluation and feedback techniques when working with her clients) then the supervisee is in a good position to know which cases to bring to supervision and which can be held over.

Another strength of the Liese and Beck approach is their use of a Cognitive Therapy Adherence and Competence Scale (CTACS). This type of scale offers the possibility of being able to obtain accurate information about how a supervisee is progressing over a period of supervision. The scale has 25 items (rated 0–6) grouped under four headings: structure of the session, developing a collaborative therapeutic relationship, development and application of the core conceptualization, cognitive and behavioural techniques. The scale is (strictly) designed to be utilized by the supervisor when reviewing taperecorded sessions. This usage is obviously very appropriate, but the scale curiously doesn't include any items about the utilization of supervision itself. Liese and Beck's work has

prompted us to begin to develop a more comprehensive scale which does include items which explore supervisees' utilization of supervision.

Developing an integrative model

So far we have explored the ideas and techniques which we have absorbed from three major models of supervision. As a reader you may well be thinking that it's all very well to be eclectic, but being eclectic does not magically create an integrative approach. To create an integrative model we have had to adopt an alternative strategy. This strategy has involved looking at existing models of supervision, finding one that fits our approach reasonably well and then modifying it in order to incorporate ideas that we value but are missing from the model we have selected.

As we have already hinted, the model we chose was Hawkins and Shohet's (1989) process model. This model attracted us because its psychodynamic orientation meant that it contained many ideas that we have valued in supervision. Fortunately, because the model is process-oriented, we believe systemic and CBT ideas can be grafted on in a way that enhances the original model by giving it a new vitality. Hawkins and Shohet (2000) have themselves attempted to broaden their model by adding a seventh (contextual) model; however, we feel that their revision is not likely to be successful. In our opinion systemic, contextualizing ideas need to permeate all six modes of the approach rather than being confined to an additional mode.

As we began to utilize the original model in our own work and encourage supervisors to use the model, there was a potential problem. We were aware that the primarily psychodynamic language of the model did not fit with many of the supervisors we were working with. In response to this, a working group developed a brief document, using the broad ideas of the model and in particular the 'six modes' of supervision, but written in a less theory laden way. What became apparent was that the model, when given this more neutral framework, was attractive to supervisors and allowed them the flexibility to use ideas that were current in their practice within supervision. Typically many clinical psychology supervisors have developed their therapeutic skills either broadly in the traditions we have outlined or more specifically in areas such as cognitive analytic therapy, solutionfocused approaches, dialectical behaviour therapy, etc. Also, supervisors and supervisees (of whatever primary therapeutic orientation) were able to find a way of looking at the relationship aspects of supervision and estimating the role of unfinished business in influencing the therapeutic work being undertaken.

In the next section of the chapter we will explore each of the six modes in turn. We begin with Hawkins and Shohet's original description and include the more general description of the mode we use in parentheses. We go on to explain how we have chosen to modify each mode so that we can genuinely 'own' them at a conceptual level. We hope this owning is not an idiosyncratic process—we

suspect that in many ways we are typical integrative psychologists who seek to utilize CBT, systemic and psychodynamic ideas in providing useful reflections for anybody we supervise. Table 10.1 provides a summary of how we describe the modes in a less psychodynamic way and contains a list of key questions which we typically use when we are supervising using all six modes of the model.

Table 10.1 Supervision template

<i>Mode</i>	<i>Possible emphases for Clin. Psych.</i>
1 Thinking about the content	What is the client's social context? How do you understand the client's relationships with those around them? What are the issues that you are curious about in relation to your client?
2 Thinking about interventions	How was this intervention chosen? What are the stories around the intervention for the client(s) and therapist? Are there skills training issues?
3 Thinking about the clienttherapist relationship	What is the meaning of the relationship between the client and the therapist? Has the role of the therapist and way of working been adequately explained? How collaborative is the work with the client?
4 Thinking about emotional reactions or resonances for the supervisee	How does the supervisee's family pattern and background input on the work? What are the areas that the supervisee is willing to share? What are the supervisee's prejudices about these kinds of situations?
5 Thinking about the similarities between supervision and the therapy	Are there similar patterns within therapy and the supervision? Is the supervisory approach similar to the therapy?
6 Thinking about resonances for the supervisor	What is the impact on the supervisor? Has the supervisor access to supervision?

***Mode 1: Reflection on the content of the therapy session
(Thinking about content)***

Here discussions between supervisor and supervisee concentrate on 'the actual phenomena of the therapy session; how the clients presented themselves, what they chose to share, which area of their life they wanted to explore, and how this session's content might relate to content from previous sessions'.

Helping the supervisee to think about the phenomenological aspects of their client and their session enables us to maintain a stance of curiosity about what is happening, and this process in turn helps us to encourage our supervisees' curiosity (Cecchin *et al.*, 1993). Hawkins and Shohet (1989) describe a number of Gestalt-type approaches encouraging supervisees to think about such things as client presentations, speech, posture, movement, etc. These exercises are very valuable, but we also encourage our supervisees to think about their clients contextually (e.g. how they relate to their families, their communities and their culture).

Clinical psychologists are perhaps correctly criticized for being too focused on formulating and intervening. This can mean moving out of what most clinical psychologists would understand as the assessment phase very quickly. Our supervisory experience enables us to encourage supervisees to think about the relationship clients have with those around them and their social context. This reflective process helps us stop a 'closing down' process which prevents the supervisee from thinking about their client's unique situation. Some of Carter and McGoldrick's (1999) life-cycle ideas are generally very useful in helping this reflective process (as we have already mentioned), but it is an example relevant to supervising work with learning-disabled clients that comes most readily to mind.

A local supervisor described how she encouraged a supervisee to think about how an academically and socially successful younger sibling might influence the behaviour of a learning-disabled client with severe challenging behaviour. The supervisor asked the supervisee to draw on how the supervisee saw the relationship between different family members. Ultimately these exercises influenced the next stage of therapy—they encouraged a clearer discussion with the client and her parents about 'success' and family expectations.

***Mode 2: Exploration of the strategies and interventions used
by the therapist (Thinking about interventions)***

This involves discussions concerning 'the choice of intervention made by the therapist', when and why to use particular approaches and what alternatives might there be. Hawkins and Shohet (1989) emphasize that the main goal of this mode is 'to increase the therapist's choices and skill in interventions'.

This mode—the most pragmatic of all the six—is the mode which fits the scientist-practitioner approach best. If a supervisee has been successful in establishing a working alliance with their client then they will be able to garner a great deal of information about their client's predicament. Once more, this is best understood by most clinical psychologists as the assessment process. This information flow is useful to the supervisor who can begin to prompt the supervisee to begin to formulate her ideas about what is happening and to begin to think of possible interventions.

Our experience is that clinical psychology supervision often remains in this mode, and from a pragmatic point of view there is no reason to be concerned about this. If there is therapeutic movement, and ongoing evaluation reveals that change is occurring, then we would argue that good-enough therapy is taking place and there is no reason to complicate the therapy by seeking to widen our discourse about what is happening. From a training point of view it may, however, be important (as we've discussed earlier) to offer the supervisee very focused feedback (e.g. through reviewing videotapes or audiotapes). If CBT supervision is being utilized then Liese and Beck's format is particularly appropriate, but care needs to be taken to ensure that the supervisee is increasingly in the driving seat as far as formulating is concerned. If the supervisor is too expert then there is a danger of supervisor dependency being created.

If the therapy is not unfolding and 'stuckness' (Carpenter and Treacher, 1989) has been created then the Hawkins and Shohet model comes into its own (as we will illustrate as we consider the further modes), but it is important to think about other aspects of this mode of supervision. Our own therapeutic work is influenced by post-Milan ideas about interventive interviewing (e.g. Tomm, 1988). This approach assumes that the use of a whole range of questioning techniques creates different types of information flow between the therapist and family members. The questioning helps family members to think differently about what is happening to them; this process is therefore interventive because it may lead to change in behaviour as well.

This therapeutic approach is also useful in helping supervisees and supervisors to be more thoughtful about how they themselves have an impact on the clients they work with. For instance, what might be the meaning for both the client and the therapist of the kind of intervention that is being used? Has a client experienced something very similar before or something very different? Has the therapist worked in this way before?

Mode 3: Exploration of the therapy process and relationship (Thinking about the client-therapist relationship)

The suggestion here is that supervision pays particular attention to 'what was happening consciously and unconsciously in the therapy process; how the session started and finished...metaphors and images that emerged...changes in voice and posture'. They describe the main goal being 'insight and understanding of the dynamics of the therapy relationship'.

Our approach to this mode is simply to broaden its scope by asking our supervisees to think about their relationship with their client in the broadest terms. Initially, if we link this question to the therapeutic models we have considered, the answers might be very different. For the psychodynamic therapist it might be the key to the therapeutic endeavour. A systemic therapist might be wary of a relationship developing that is investing them with too much

expertise. A cognitive therapist might be more comfortable with this as long as there is a clear sense of collaboration between therapist and client.

However, as we established at the beginning of our chapter, we suspect that the majority of clinical psychologists are not working to a pure therapeutic model. We would nevertheless argue that whatever approach is used the therapist-client relationship is all-important. For example, Clarkson (1996) and others have argued that the quality of the relationship has much more impact on the client than the type of therapy being utilized. In our work with supervisors we have found that they are increasingly prepared to discuss the importance of the therapeutic relationship, but this willingness is often forgotten in supervisory situations because they feel the need to focus on the content issues that supervisees bring to sessions. Our advice is to respond to this pressure pragmatically—most supervisory time will be devoted to mode 2 issues, but a supervisor can encourage a supervisee to take an in-depth approach to at least some of their clients. This also fits with developmental notions within the supervisory relationship (Stoltenberg and Delworth, 1987), where it is suggested that this more ‘process’-oriented focus comes with trainee confidence and development. We are very keen to stress that we do not feel there is a hierarchy that places more value on the *process* focus of this and the following modes as opposed to the *content*-based modes 1 and 2. In our view each has value, and a challenge for a supervisor is to consider where an emphasis at any time might be.

Hawkins and Shohet offer some very useful playful ideas about how to explore the therapeutic relationship. They use a number of questions to prompt supervisees to think more reflectively. For example, how might you name a film of the therapeutic relationship, and what actors would you get to play yourself and your client?

Another focus around the client and therapist relationship is an exploration of the pattern that might be emerging in the therapeutic work and whether that might be helpful or constraining. Useful questions in supervision might be: How might your client respond if you asked them if a session or part of a session was addressing the right issues? Might your client think there are things you avoid asking them about that may be helpful?

These kinds of questions, if used skilfully, will help the supervisee to take a much more wide-angled approach to their work. It helps them move beyond problem-solving towards a more reflective way of thinking about therapy. The clinical work emerges far more as an encounter between two human beings who both bring a great deal of prior experience to the encounter. This way of thinking opens up deeper issues, which are more explicitly explored by mode 4 supervision.

***Mode 4: Focus on the therapist's counter transference
(Thinking about emotional reactions or resonances for the
supervisee)***

In this mode the supervisor looks at 'whatever is still being carried by the therapist, both consciously and unconsciously, from the therapy session and the client'. They describe different types of transference such as the 'personal material of the therapist', and the 'transferential role that the therapist has been allocated into by the client'.

When supervising in this mode we ask our supervisees to think about any emotional reactions or resonances that they experience while working with the client they have in therapy. We prefer this broader framing rather than using the stricter concept of counter-transference. One reason for doing this, as we have discussed earlier, is to make the supervision model fit with as many supervisors as possible. Another is because, as some supervisors who have trained psychodynamically have reminded us, the notions of transference and counter-transference are complex and are understood and misunderstood in a variety of ways.

Our approach, of necessity, assumes that a comprehensive supervision contract has been negotiated and that the supervisee is willing to explore supervisory issues relevant to this mode. The genogram work we would have undertaken at the beginning of the placement now becomes relevant again because there is an opportunity to help the supervisee explore her own family patterns in relation to the patterns explored in the client's life. Within this mode it is also possible to explore the value system that the supervisee brings to their work. A major influence for one of us (SM), has been Cecchin *et al.*'s (1993) discussion of therapist values. He argues that since we all have prejudices and loyalty to certain ideas, a key skill (particularly for a beginning therapist) is to develop some irreverence to all beliefs about therapy, including their own and those of their supervisor. While this approach may be a little idiosyncratic for some tastes, it does focus attention on how the responses we have to situations we find ourselves in with clients are filtered by our own experiences. There is also a further important question for the supervisee that needs to be explored: To what extent should the supervisee's emotional responses be shared with the client? Different therapeutic models will answer this question very differently. Interestingly, the more recent systemic models of Hoffman (1993) and White (1995) describe the use of 'self' as a possible appropriate therapeutic strategy within the context of the development of a more collaborative approach.

Mode 5: Focus on the here-and-now process as a mirror or parallel of the there-and-then process (Thinking about similarities between supervision and therapy)

The focus here is the relationship between supervisor and supervisee and what happens in the supervision sessions 'in order to explore how it might be unconsciously playing out or paralleling the hidden dynamics of the therapy session'. The example they give is how if a client was acting in a 'passive-aggressive' manner, the same pattern may be unconsciously present in supervision.

Thinking about similarities between supervision, and therapy and in particular the notion of a parallel process between these two, has been described by Hawkins and Shohet and others. According to McNeill and Worthen (1989: 330) parallel process occurs 'when certain vestiges of the relationship between a supervisee and his or her client appear in supervision'. While doing further training in supervision, one of us (SM) was struck by the attention paid to this by therapists with a psychodynamic or humanistic background. Alongside transference there was a sense of it being at the heart of the supervision. For many clinical psychologists this does not necessarily fit their view of supervision. However, our experience of working with supervisors has taught us that this idea can be very useful, particularly when exploring 'stuck' situations. For example, the idea of a supervisee mirroring a client by blocking all ideas for change ('yes, but') rings a bell for a lot of supervisors.

A possibly more accessible notion is that patterns in therapy can be repeated in supervision and it can be helpful to consider how both might be changed. The link between this and a parallel process is very strong, but the feedback we have had is that thinking about patterns is more concrete and meaningful to therapists who do not work in a psychodynamic way. Another useful question here is whether or not the supervision offered is coherent with the therapeutic approach being offered by the supervisee. Certainly there is some research evidence (e.g. Neufeldt *et al.*, 1997) that supervisees rate supervisors more highly if there is a shared therapeutic orientation. From a systemic viewpoint, key questions that need to be asked are whether ideas about expertise and how change occurs are consistent within the two domains (therapy and supervision). For many clinical psychologists there is also the important and appropriate caveat that they would not want to seek to turn supervision sessions into therapy sessions. Again this connects with our earlier comments on boundaries and the negotiation of clear contracts.

Mode 6: Focus on the supervisor's counter-transference (Thinking about resonances for the supervisor)

The supervisor 'primarily pays attention to their own here-and-now experience in the supervision...and...uses these responses to provide reflective illumination

for the therapist'. They make the point that unconscious ideas may 'emerge in the thoughts, feelings and images of the supervisor'.

We prefer to use the term 'resonances for the supervisor' rather than focusing once again on counter-transference. At a practical level it is asking a lot of a supervisor to be consistently in touch with what is happening to them while the supervision takes place. Careful note-taking during supervisory sessions can help, but ideally a supervisor needs to be working with a consultant or participating in a supportive peer supervision group.

Our systemic approach is generally helpful in supporting supervisors as they seek to clarify what is happening when they supervise. The use of genograms (as discussed earlier in the chapter) can be an essential tool for anybody who wants to keep checking how they are influenced by the complex processes that are involved in supervision. Second-order cybernetic ideas (summarized by Dallos and Draper, 2000) are also highly relevant to this mode. These ideas challenge the notion that a therapist can be entirely objective or detached. By engaging in either the therapeutic or supervisory process we become part of the process we are trying to observe. Our ideas and beliefs obviously influence the overall process but we are also influenced by the process in a reciprocal fashion.

Summary

We set out to produce something that may have practical value when considering therapeutic models and their link with supervision. In relating something of our collaborative work with our colleagues in the South West of England of modifying Hawkins and Shohet's valuable supervision model, we hope there are connections for readers both as potential supervisees and potential supervisors.

We are convinced that the model is heuristic—it has certainly influenced the way that we supervise, and the experience of sharing it with other supervisors has been rewarding. What has been attractive to us is that supervisors can be encouraged to explore these ideas and to use the aspects that connect most to their practice. As a model we have seen it used concretely and explicitly with supervisor and supervisee working through each mode sequentially, or as a background template where supervisors have more elegantly incorporated some of the modes into their supervisory sessions. While not all clinical psychologists will take to this as a model, they do seem to respond to the challenge it carries with it of being prepared to look more closely at the way they themselves supervise.

A final point needs to be made. Supervision has been neglected as a topic within clinical psychology training. A survey in the North West of England by Gabbay *et al.* (1999) suggested that a significant number of clinical psychologists (over 40 per cent of a 40 per cent response rate) felt that the supervision they received could be improved. A recent survey in the South West with over 165 supervisor replies (by SM) revealed that over 60 per cent of respondents had received no training at all in this area. However, the same survey also revealed that a

majority of supervisors do want training in supervision and that receipt of training is correlated significantly with having taken on more supervisees. Our experience in working with supervisors has been extremely positive because it has reflected this desire to engage with the complexity of supervision as a topic and to raise supervisory standards.

As a profession we need to take the next steps by setting up supervision courses utilizing the type of heuristic model offered by Hawkins and Shohet and encouraging supervisors to form support groups so that their interest in supervision can be supervised. It should be that the NHS agenda of expanding training numbers and clinical governance will provide support for this as supervision increasingly becomes understood as a key component of any clinician's work.

Appendix: Adaptation of Lerner's list of the interfacing dimensions between therapist and family

Multigenerational history

Unresolved emotional issues with significant others

Other family patterns and legacies

Sibling position

Family life cycle

Age

Current life events

Health/disabilities*

Culture

Gender

Race

Class

Ethnicity

Sexual orientation

Religion

Politics

Community, work system, friendship circle

* Added by us (AT/SM)

Chapter 11

Conclusions and future perspectives

Ian Fleming and Linda Steen

This book has attempted to provide an overview of the issues directly relevant to supervision within the profession of clinical psychology. This has been achieved through contributions both by leading figures in the field of clinical psychology training in the UK and by experienced clinicians and supervisors, covering the most up-to-date practice and research.

As acknowledged in [Chapter 1](#), the book would have been slimmer if the literature on supervision from counselling and psychotherapy had been excluded. Chapters by Sue Wheeler, Helen Beinart, and Delia Cushway and Jacky Knibbs discussed the relative paucity of research dedicated both to supervision within clinical psychology and to supervisory practice in the UK, and the questions remain: how much of the literature is transferable to clinical psychology and what are the particular issues for clinical psychology in the UK? Is it the case, as suggested by Delia Cushway and Jacky Knibbs in [Chapter 9](#), that many of the process issues in clinical supervision have relevance across therapy professions?

Lawton and Feltham (2000), cited in [Chapter 3](#) of this book, suggest a distinction between supervision in counselling and supervision in clinical psychology, the former being more process-focused and the latter more goal-oriented. Whilst much is still unknown about the practice of supervision within clinical psychology, this view would certainly concord with our experience, both as clinicians and as trainers; the work of clinical psychologists often involves setting goals and demonstrating outcomes.

In this chapter we will review the main themes of the book and consider the future issues for supervision within clinical psychology. The extent to which the existing literature can be generalized to supervisory practice within clinical psychology in the UK will be considered throughout.

Is there an accepted model of supervision within clinical psychology?

One suggestion within this book is that there is no clear model of supervision within clinical psychology. Indeed, as noted in [Chapter 1](#), the BPS, DCP *Policy Guidelines on Supervision in the Practice of Clinical Psychology* explicitly state

'there is no one model or style of supervision that will apply to all clinical psychologists' (BPS, 2003:2). In Delia Cushway and Jacky Knibbs's survey of clinical psychology supervisors and trainees described in [Chapter 9](#), over three-quarters of the sample of supervisors reported that they did not subscribe to any particular model of supervision; the majority of those who did subscribe to a model cited Hawkins and Shohet's (1989) process model of supervision. In [Chapter 10](#), Shane Matthews and Andy Treacher review different models and suggest that there may well be a discrepancy between chosen therapeutic models and those adopted by supervisors for supervision. If this is the case, and there is a lack of empirical evidence concerning clinical psychology supervisors, this contradicts the conclusions from the general literature that supervisors tend to rely on their therapeutic approach in supervisory practice. As Hawkins and Shohet (2000:59) point out, 'one's style as a supervisor is affected by the style of one's practitioner work'.

Kadushin has suggested that this may be ameliorated by training: 'Lacking training in teaching but possessing clinical skills, the temptation for the clinician-turned-supervisor is to utilize the preferred clinical approach in teaching' (1992: 157).

However, if these comments are accurate, what is it about supervisory practice that training needs to modify? Furthermore, what are the particular skills that supervisor training needs to develop and emphasize?

Pre- and post-qualification supervision

A great deal of the general supervision literature considers both pre- and post-qualification supervision (referred to by Page and Wosket, 1994, as *trainee and practitioner* respectively). The emphasis within this book has been on the former, which reflects the relative absence of empirical descriptions of and attention to post-qualification supervision in clinical psychology to date. Thus in some books, considerable discussion is given over to the issues involved when qualified in selecting and working effectively with a supervisor. In particular the myriad interpersonal aspects are attended to, as are the service and organizational contexts in which the supervision is occurring and the potential discrepancies in therapeutic stances between supervisee and supervisor. Clearly the latter can be seen as having greater salience where both parties have equal professional status than in pre-qualification supervision where the greater experience of the supervisor is conflated with greater power (Holloway, 1995).

Fleming and Steen ([Chapter 1](#)) drew attention to the relatively short history of supervision within clinical psychology training in the UK. The parallel volume about supervision after qualification would be a very thin book indeed. As will be discussed below, as continuing professional development for clinical psychologists is becoming recognized as increasingly important and necessary, so too is the notion of post-qualification supervision.

As an empirically based profession, how does clinical psychology address issues of effectiveness and evaluation?

Clinical psychology as a profession prides itself on its abilities both to carry out research and to transform its practice through the assimilation of research. One of the commonly found core statements of the profession refers to its members as scientist-practitioners (DCP, 2001b). How does this perception measure up to the practice of supervision and supervisor training?

Although there have been masterly reviews of effectiveness (e.g. Ellis and Ladany, 1997) which have drawn rather pessimistic conclusions about the effectiveness of supervision, there are alternative conclusions that can be drawn.

From a more selective review of the literature we do know what is effective in supervision, and we have models (e.g. Kolb's experiential learning cycle) and some empirical knowledge to support it (Milne and James, 2002). We can learn from the evidence in order to develop effective practice. In addition we can learn from the staff training and management literature about the important factors for introducing and maintaining change in behaviour.

Ellis *et al.*'s (1996) review can be used to identify what good research about supervision would look like. The available knowledge could supply the content for supervision training, and it is of interest to ask, although elements feature in the programmes of training put on for supervisors (Chapter 5), why this is not in place? Similarly, with regard to evaluative tools: if elements of experiential learning skills form the content of supervisor training, then why not use the Supervisory Skills Survey (Fleming *et al.*, 1996) as an instrument to evaluate change resulting from the training (Chapter 5)?

Supervision has been more developed over a longer period of time in counselling and psychotherapy. Given that these traditions have placed a greater value on anecdotal evidence and personal experience, this may be reflected in the research. The greater scientific rigour claimed by clinical psychology may make the profession well placed to carry out research into the important factors hypothesized to play an active part in supervisory effectiveness. From descriptions of research contained in the current book, both quantitative and qualitative research methodologies would appear to be useful; Helen Beinart (Chapter 3), for example, described her research that used both quantitative methodology and grounded theory.

In view of the multitude of variables that would need to be under experimental control, it may be that seeking resulting changes in supervisee behaviour or client outcome are not legitimate goals of supervision or supervisor training. As several of the contributors have outlined (e.g. Chapters 6 and 9), there are a range of classes of outcome of both supervision and supervisor training. For supervision, for example, these include the supervisee's reaction to supervision, performance as a supervisee, therapist characteristics and change in client. In supervisor training, there is the added element of change in supervisor's behaviour, knowledge and attitude as a result of the training.

Is insisting on improvements in therapeutic outcomes a legitimate goal of supervisor training or are we seeking an unjustifiable holy grail that makes research almost impossible to carry out?

Different therapeutic models would of course consider outcomes differently. Many schools would consider inadequate any goal that did not include consideration of the client, arguing that the parallel process or mirroring requires that the client cannot but be a feature of the supervisor-supervisee dyadic relationship (see, for example, Hawkins and Shohet, 2000).

What are the future issues for supervision within clinical psychology?

Accreditation of supervision within pre-qualification training

Several of the contributors have raised the issue of accreditation of supervisors. Sue Wheeler (Chapter 2), for example, outlined the accreditation process for supervisors within the British Association for Counselling and Psychotherapy. In Chapter 4, Turpin *et al.* described a model of accreditation of training units. In the wider clinical psychology literature, too, the issue of placement accreditation has been under discussion for some time (Milne *et al.*, 2001).

The possibilities of introducing accreditation for supervisors were discussed in some detail in Chapter 5. The discussion placed accreditation within a logical context framed by demands for quality assurance and supervisor training. Although the training of supervisors, with its relevance to those supervisors' CPD, could clearly be seen as a legitimate activity of *pre-qualification* training programmes for clinical psychologists, there remains a question of its extension to an evaluative and arguably managerial activity in relation to *qualified* clinical psychologists. There might well be a concern that any extension of evaluative training from those entering the profession to those well established within it may be a crossing of the Rubicon for clinical psychology training programmes and programme staff. Clinical tutors may have legitimacy in organizing voluntary training for supervisors, but will this extend to a role of accreditation with the accompanying professional attributes and rewards?

Any hesitation about the role of the programme staff in accrediting fellow professionals might be compounded by a pragmatic concern about placement availability and supervisor numbers (Chapter 4). Hesitation about the introduction of accreditation may be linked to real concerns that the introduction of any additional 'hurdles' might (at least in the short term) exacerbate the problems caused by the shortage of training placements. Clinical psychology training programmes report that their placement planning arrangements could become critical if very small numbers of supervisors decided that they could not supervise because of new requirements for training or accreditation. It will be important in future to reconcile these issues of 'quality control' and to ensure a

maximum number of supervisors who are able to offer supervision and placements on a continual basis. Interestingly, it is the authors' impression that this has become less of a concern over time: in Manchester we gain the impression that more newly 'qualified' cohorts of supervisors expect quality issues to be attended to. The culture of qualification bestowing 'independent professional practitioner' status upon one without a need for direction and governance is becoming historical.

The relationship between supervision, CPD and accreditation

The benefits to the profession of linking supervision with CPD and emphasizing it as a core activity are clear. Such a development could make it easier to introduce mandatory arrangements for receiving (and providing) supervision, thus easing the barriers to the expansion of training and the growth of the profession.

At the time of writing no clear arrangements have been organized to equate supervision activity and training with CPD requirements. To date it has been suggested that attendance at supervisor training events could constitute a second level of CPD, with supervision as a core activity. It would be relatively simple for supervisors to keep a logbook of their experience and of their training, especially if they provided training placements for more than one clinical psychology programme. This would acknowledge that currently supervisor training is not standardized and that training is not a prerequisite to supervising. As discussed in [Chapter 5](#), more direction about the content and methods of supervisor training and linking this to standards would be helpful, if not necessary, for the introduction of an accreditation scheme, and there is no reason to suggest that this would not be welcomed by clinical psychologists in general.

Improving supervisory practice: learning from other professions

At the time of writing, there are very few detailed descriptions of the supervisory practice of clinical psychologists. Cushway and Knibbs's research ([Chapter 9](#)) highlighted the elements of supervision found to be helpful and unhelpful by trainees and supervisors and, in doing so, gave some very helpful pointers for good supervisory practice. Matthews and Treacher ([Chapter 10](#)) described their approach to supervision in some detail, thus giving the reader a flavour of their supervisory practice. More work is needed if we are to obtain an accurate view of what happens in clinical psychology supervision.

From a review of the general supervision literature, there is some consensus on what good supervision involves; two themes that emerge as being central to good supervisory practice are the establishment of a good supervisory relationship and, related to this, the negotiation of a clear supervisory contract.

Supervisory relationship

The importance and, indeed, centrality of establishing a good supervisory relationship has been highlighted in several of the chapters. In [Chapter 2](#), for example, Sue Wheeler cited research evidence in support of this assertion and pointed to the finding that uncertainty about supervisory expectations can affect relationship dynamics (Ladany and Friedlander, 1995). She also described her own work (Webb and Wheeler, 1998) which found there to be a correlation between quality of the working alliance and the extent of supervisees' self-disclosure in supervision. This seems to be particularly pertinent to the situation in clinical psychology training, where supervisors often rely on trainees' self-reports of their work rather than direct observation (see [Chapter 6](#)).

In a survey of clinical psychology trainees and supervisors conducted specifically for the writing of their chapter, Delia Cushway and Jacky Knibbs ([Chapter 9](#)) found that 'establishing a good rapport' was rated by both parties to be the most helpful aspect of supervision.

Helen Beinart ([Chapter 3](#)) described Holloway's (1995) SAS model of supervision, which sees the supervisory relationship as 'the container of dynamic process' (p. 41). She then went on to describe her own research in which supervisees (both trainee and newly qualified clinical psychologists) were asked specifically about their experience of supervisory relationships and the factors that had contributed to their effectiveness as clinical psychologists. This led her to develop her own model of the supervisory relationship, which is described in [Chapter 3](#).

Given the acknowledged importance of the supervisory relationship, it is relevant to consider the extent to which this is attended to in supervision within clinical psychology.

In the context of pre-qualification supervision, the BPS (1995a) *Guidelines on Clinical Supervision* acknowledge the importance of establishing a good supervisory relationship, as is evidenced in the following statement: 'the care taken in the early stages to build up a good relationship will enhance the quality of the clinical supervision' (BPS, 1995a: section 7.1). No specific guidance is given, however, on how this should be achieved.

Supervision contract

In the general supervision literature, establishing a supervision contract is seen as a way in which the parameters of the supervisory relationship can be negotiated at the outset and regularly reviewed. Several writers have highlighted this. Inskipp and Proctor (1989), for example, see the contract as being 'critical to establishing a way of being together in the supervisory relationship' (cited in Holloway, 1995:52). As well as covering the practicalities of the supervision, such as frequency of meetings, evaluative aspects, etc., the contract should enable both parties to express their expectations, hopes and fears about the

supervision and the relationship. In Chapters 7 and 8 of this book, Nimisha Patel and Maxine Dennis and Gill Aitken pointed to the central role of the contracting process in addressing power imbalances. Whilst it is expected that the supervisor will initiate the contract, the supervisee will have an equal part to play in this process (for further discussion of the role of the supervisee, see Chapter 9 of this book).

In Chapter 5 it was noted that some clinical psychology programmes organize training events for supervisors on supervision contracts. Little is known, however, about the types of supervisory contract used within clinical psychology.

For pre-qualification supervision, the guidance from the BPS is as follows:

The general aims of the placement should normally be agreed within the first two weeks of the placement and a clinical contract should be written. Attention should be paid in the clinical contract to the range of opportunities available in the placement, and to the needs, interests and previous experience of the trainee...

(BPS, 1995a: section 4.1)

As can be seen from the above statement, whilst there is a clear recognition of the need for a contract at the start of placement, the expectation is that this will be concerned with the practical aspects of the placement rather than with the supervisory relationship.

If we are to take seriously the research findings about the crucial role that the supervisory relationship plays in determining the course of supervision, it would seem that there is a clear need for clinical psychologists to follow the lead of others, notably counsellors and psychotherapists, who advocate the explicit discussion of these issues at the start of any new supervision arrangement.

As mentioned earlier, in addition to a placement contract the Manchester clinical psychology programme recently introduced the idea of drawing up a psychological contract (Schein, 1980) with the recommendation that trainees and supervisors explicitly address their worst fears and wildest hopes, and what each expects from the other. From our discussions with colleagues on other training programmes we know that we are not alone in this practice, although the exact extent to which other clinical psychology programmes require similar contracts is not known.

As stated earlier, little is known currently about the practice of postqualification supervision in clinical psychology, and this includes the issue of supervision contracts. In the absence of any guidelines for post-qualification supervision it is possible that this aspect of supervision could be neglected. Different models of supervision (peer group, one-to-one, managerial) will require different factors to be considered in the process of negotiating the contract (Hawkins and Shohet, 2000). For example, it might be important to consider the organization and the professional context within which the

supervision is taking place; this is likely to be all the more important in inter-professional supervision.

Improving supervisor training

One hindrance to the development of more universal training of supervisors has been that many mental health professionals apparently have believed that to be an effective therapist is the primary pre-requisite to being a good supervisor.

(Bernard and Goodyear, 1998:5)

In relation to the above statement, as discussed in [Chapter 6](#), whilst there are some transferable skills that therapists can use in their supervisory practice—for example, the ability to establish a good working relationship and empathic listening—the goals of supervision are very different to those of psychotherapy and require different skills. It is suggested that one of the purposes of supervisor training should be to alert new supervisors to the ways in which supervision and therapy are similar and different.

In [Chapters 5 and 6](#) of this book, research was reported upon which gave a clear picture of both current and suggested practice for supervisor training within clinical psychology. It was seen that training is currently being provided by clinical psychology training programmes on an increasingly systematic basis. Whilst this research provides a very good starting point from which to further develop supervisor training, it was acknowledged that there is much that is still unknown about both the content and the effectiveness of supervisor training. Supervisor training will be considered in more detail later in this chapter, and suggestions made for the future.

Addressing issues of diversity

Culture and ‘race’

In [Chapter 7](#), Nimisha Patel made clear and substantial points about issues of power within supervision. She proposed that supervision has a responsibility to challenge inequalities in power and identifies strategies for doing so. Holloway (1995), too, in *Clinical Supervision: A Systems Approach*, examines the interaction of power and supervision to the interpersonal identity of a supervisory relationship. Such an explicit position is not central to the ideology of British clinical psychology, however, and it is interesting to consider what may be needed to shift the professional culture so that this viewpoint can be accepted and adopted. Where within the mainstream clinical psychology literature, for example, would supervisors find legitimacy for exploring the social political and historical factors that she identifies as important? In Manchester we have

experience of leading training workshops for supervisors that provide an introduction to these themes (see [Chapter 5](#)), and there appears to be a lower application rate for this workshop compared to other supervisor training events. It may be significant that until 2002 the only workshop cancelled because of inadequate interest was one around this theme. Anecdotal comments from a senior colleague in the training arena suggest that our experience is not unique.

Again, with respect to the ‘legitimacy’ of this area within clinical psychology, the Manchester Clin.Psy.D. programme has developed teaching about issues of political and interpersonal power for some years and implemented a requirement for social context to be demonstrated in examinable work. The experience has not been uniformly successful (Fleming and Burton, 2001) and there still appears to be a need within clinical psychology to assert the issues described by Nimisha Patel.

How does the situation in clinical psychology compare with that in related professions? As mentioned earlier in the book ([Chapter 1](#)), Carroll (1996) admonishes counselling and psychotherapy texts in the UK for their ignorance of issues of culture in supervision.

One imagines that the situation has changed in the interim period. In the second edition of their text on supervision, for example, Hawkins and Shoheit include a chapter on working with difference, ‘in order to correct a major omission in the first edition, that of looking at how differences, including race, class, gender etc. inform and affect the supervisory relationship’ (2000: xviii).

The importance of training in diversity for supervisors is supported by the research carried out with clinical psychology trainees in South Africa by Kleintjes and Swartz (1996). This demonstrated the difficulties faced by supervisees (trainee clinical psychologists) in discussing issues of culture and diversity if their supervisors had not done so.

Gender

Maxine Dennis and Gill Aitken ([Chapter 8](#)) addressed the issues of how gender acts upon the supervision process.

On the Manchester clinical psychology programme, training both for supervisors and trainees attends to some of the issues identified by the authors, but not in the depth or complexity suggested by the authors.

Aitken and Dennis refer to ways in which both parties to the supervisory process can begin to address power imbalances related to gender. It is our experience that the use of ‘psychological contracts’ (Schein, 1980) in which expectations and ‘non-specific’ factors involved in supervision are identified and negotiated has been helpful in drawing the attention of both parties to these issues and the ways in which they affect supervision.

The authors refer to the lack of diversity among clinical psychologists, and the profession’s lack of representation of the different cultures within the general population. This is of increasing concern to those responsible for training, and

the Group of Trainers in Clinical Psychology (GTiCP) directly addressed this issue at its 2002 annual conference. At the time of writing, work arising from the conference is ongoing and these issues are likely to remain at the top of the profession's agenda for the foreseeable future.

Post-qualification supervision

[S]ince post-qualification professional supervision is a woefully underresearched area, it is not easy to cite well documented examples of good practice to follow or prescribe established standards that might inform local audit procedures. It is therefore politic to incorporate some element of careful appraisal of both process and outcome when evaluating initiatives in continuing supervision for qualified clinical psychologists, both to improve the service for participants and to provide feedback for the host organisation.

(DCP, 2001a:9)

As has been mentioned previously, it is only relatively recently that the BPS has recommended that all qualified clinical psychologists should receive supervision as an essential part of good practice and professional development. At the time of writing, we know very little about the practice of postqualification supervision within clinical psychology. Whilst there are some data to suggest that supervision is regarded as an important, if not essential, part of post-qualification practice for many clinical psychologists (e.g. Golding, 2003; Lavender and Thompson, 2000), it is known that a substantial percentage of clinical psychologists do not receive supervision (Gabbay *et al.*, 1999). The exact reasons for this are unclear but there is some evidence to suggest that they include both personal and organizational factors (Gabbay *et al.*, 1999).

There are several issues that need to be addressed with regard to supervision for qualified clinical psychologists. These include a consideration of both the functions and models of post-qualification supervision and the process of choosing a supervisor.

Writing from a social work perspective, Kadushin (1992) identifies three main functions or roles of supervision, namely educative, supportive and managerial. These functions would seem to fit very well with the expectations of pre-qualification supervision and we, along with colleagues from other training programmes, often use them as a starting point for supervisor training. It is interesting to reflect on the extent to which these functions are explicitly acknowledged in post-qualification supervision, where the evaluative or managerial aspect may be less pronounced, although just as important. Here, as elsewhere, the need for an explicit supervision contract would appear to be essential.

In [Chapter 1](#) we alluded to the fact that traditional one-to-one models of supervision may be neither appropriate nor possible in post-qualification supervision. We do not have a clear picture of current supervisory arrangements for qualified clinical psychologists, although in our experience it seems that one-to-one and peer group supervision are the most commonly used models. In a national survey of supervision practice of therapists who were accredited through the British Association for Behavioural and Cognitive Psychotherapies (BABCP), Townend *et al.* (2002) found a range of supervisory arrangements including individual supervision with the same person, group supervision with a nominated chairperson, group peer supervision, pair peer supervision, and extending to supervision via telephone and e-mail. The BABCP is a multidisciplinary organization, comprising, amongst others, nurses, clinical psychologists, counsellors, psychiatrists and social workers, and the sample was relatively small so it is not possible to draw any conclusions about the practice of clinical psychologists. Nonetheless, it is useful to consider the extent to which this range of supervision arrangements could be applied to clinical psychology supervisory practice.

As was mentioned earlier in this chapter, in much of the general literature on supervision, consideration is given to the factors involved in selecting a supervisor (e.g. Hawkins and Shohet, 2000). We suspect that the issues may be different for clinical psychologists working within the NHS. Whilst there is little known about clinical psychologists' supervision arrangements currently, organizational constraints are likely to be influential, and the question remains: to what extent can and do clinical psychologists *choose* their supervisor(s) and supervision arrangements?

With regard to choice of supervisor, the BPS, DCP *Professional Practice Guidelines* state:

If no clinical psychologist is available with the necessary expertise and skill to provide specialist supervision for key aspects of work, clinical psychologists should seek supervision from an appropriately qualified psychologist in a neighbouring authority or from a related discipline.

(BPS, 1995b: section 1.2.2)

This leads to a consideration of *who* provides supervision for clinical psychologists. As implied in the above statement, the expectation is that the supervisor will be someone working in the same service as the supervisee. Interestingly, in Sue Wheeler's ([Chapter 2](#)) survey of experts, there were mixed views expressed as to whether or not the supervisor should work in and have knowledge of the service context. With regard to professional relationship, in our experience it is not unusual for a person's line manager to also provide supervision. In some professions, however (for example, counselling psychology), there is an explicit expectation that 'the supervisory relationship is clearly distinguished from any line-management responsibilities' (BPS, 2001d:8).

Given what is known about non-disclosure in supervision (see [Chapter 2](#) for a full discussion of this), it would appear that choice of supervisor is an important issue and one that needs to be balanced with the constraints of the work context.

Recognizing that post-qualification supervision is a relatively new concept for clinical psychologists, and referring back to the BPS statement cited at the start of this section, we should be mindful of the need to evaluate supervisory practice on a regular basis.

Multi-professional training

As mentioned in several of the chapters of this book, the concepts of shared learning and multi-professional training are being accorded prominence within the NHS and the education of health professionals. As noted in [Chapter 4](#) of this book, for example, at the undergraduate level ‘several innovative schemes are being established to support inter-professional learning across medical, allied health care professions and social work education’.

With regard to supervision within clinical psychology, during prequalification training, to date, there has been a general expectation that clinical psychology trainees will ‘normally be supervised by a clinical psychologist’ (BPS, 1995a: section 1.1). At the time of writing, however, there is a move towards recognizing that the supervision of specific aspects of a trainee’s work could be provided by ‘an appropriately qualified and experienced member of another profession’ (BPS, 2002a: section 8.2, p. 14). With regard to post-qualification supervision, the concept of interprofessional working and training has particular relevance, as clinical psychologists both provide supervision for and receive supervision from members of other professions.

Sue Wheeler, in [Chapter 2](#) of this book, described the generic supervisor training courses that attract members from a range of professional groups (including clinical psychologists); as mentioned in [Chapters 5](#) and [6](#), however, to date the supervisor training provided by clinical psychology programmes has not tended to be organized on a multidisciplinary basis.

In view of the aforementioned developments within both the NHS and the profession, it will be interesting and important to gain a clearer picture of the ways in which this aspect of multi-professional training develops in clinical psychology.

What should clinical psychologists do next?

Carry out research in order to evaluate both supervision and supervisor training

Bernard and Goodyear (1992) make the point that the first research into supervision was carried out as recently as 1958. Since then, there has been a

mushrooming in research, and Ellis *et al.*, in a review published in 1996, referred to 32 empirically based studies of supervision.

Nonetheless, one of the main themes in much of the general literature on clinical supervision, and one that has been highlighted in most of the chapters in this book, is the need for more research in the area.

Whilst acknowledging the importance of supervision and training in the psychotherapies, for example, one of the concluding comments in Roth and Fonagy's (1996) review of psychotherapeutic interventions is:

[T]here is relatively little research on the impact of these processes, particularly in a form that examines the progress made by individual therapists over time... A longitudinal rather than a cross-sectional methodology might be more useful for assessing the impact of training and supervision on the development of and outcomes from, clinical practice.

(Roth and Fonagy, 1996:376)

There are a number of important and pressing areas for research. These include identifying the particular skills necessary for effective supervision in clinical psychology, evaluating the most effective means of training supervisors, and identifying whether clinical psychologists can use different models in supervision to those used predominantly in their clinical work.

In relation to supervisor training, Ian Fleming (Chapter 5) reported that the forms of evaluation used by the majority of training programmes are currently quite limited; he concluded by stating that more research into supervisor training is needed. In a similar vein, David Green concluded his chapter by stating: 'There is probably enough professional consensus and research expertise within the clinical psychology training community in the UK to mount largescale and more formally evaluated programmes than have as yet been reported.' It is to be hoped that the profession will rise to this challenge,

***Consider the most important tasks for supervision within
clinical psychology, both pre-qualification and post-
qualification***

In Chapter 1, it was noted that within clinical psychology there has not been much explicit discussion of supervisory tasks to date. Similarly, as reported in Chapter 5, whilst there was found to be agreement amongst clinical psychology trainers about the content of supervisor training, it was acknowledged that this did not necessarily shed any light on whether there was agreement about supervisory tasks and skills.

In the general literature on supervision, there is a good deal of agreement about the functions and tasks of supervision; as was mentioned in Chapters 1 and 2, Carroll (1996) describes seven main tasks of supervision and, in general, these accord with other writers' descriptions.

With regard to pre-qualification supervision, there is some evidence both from the data presented in [Chapter 5](#) and from the wider clinical psychology literature, that many, if not all, of these tasks are seen as having relevance to clinical psychology supervision. As stated earlier, however, there is a need to discover more about both the perceived functions and the practice of post-qualification supervision within clinical psychology and, in doing so, to find out whether, and if so in what ways, the tasks are different to those of pre-qualification supervision.

***Consider the material that should be included in training for
clinical psychology supervisors***

Sue Wheeler concluded her chapter by stating: 'There is now a vast literature on supervision that can be consulted when a training programme for supervisors is planned.' Similarly, as reported in [Chapter 5](#), Carroll (1996) describes six elements of a 'model curriculum' for training supervisors. Unsurprisingly, perhaps, given that much of the content of clinical psychology supervisor training derives from work carried out in counselling and other professions, there is a good deal of agreement between the content of supervisor training currently provided by clinical psychology training programmes and that suggested in the wider supervision literature. As discussed previously, however, there is an urgent need for more research in this area.

What we do know about good practice in supervisor training is that the way in which the training is delivered is very important. Milne and Howard (2000), amongst others, remind us that good supervisor training should mirror the process of supervision and contain a mixture of symbolic, iconic and enactive methods (Milne and James, 1999). Thus, advocating the use of Kolb's (1984) model of experiential learning in supervision, Milne and Howard (2000) suggest that supervisor training should enable participants to work round the learning cycle themselves. Sue Wheeler ([Chapter 2](#)) makes the same point when she states that good teaching should mirror the model of supervision; 'didactic teaching will reinforce the idea that supervision is a didactic experience'. It is not known how many training programmes refer to Kolb's model in their supervisor training, but we do know ([Chapter 5](#)) that programmes use more than just didactic teaching.

Much of the literature on supervisor training has focused solely on training provided to supervisors. As noted in the Introduction and in several of the ensuing chapters, however, there is a growing recognition that any discussion of supervisor training also needs to consider the training provided for supervisees. The literature suggests that by training supervisees they will be empowered to use the supervisory relationship in order to maximize their opportunities for learning in supervision (Inskipp, 1999). Training should help supervisees both to make the best use of supervision and to recognize their rights and responsibilities.

In [Chapter 6](#), David Green described an initiative within nursing in which supervisees are provided with training in supervision.

Within clinical psychology, Graham Turpin, Joyce Scaife and Peter Rajan ([Chapter 4](#)) suggested that clinical psychology training programmes could introduce training in supervision as a core skill throughout the three years of training. The recently revised accreditation criteria (2002) certainly pave the way for this by having as one of the objectives for clinical psychology training:

Using supervision to reflect on practice, and making appropriate use of feedback received.

(BPS, 2002a:B.1.3.7)

Whilst we know that many clinical psychology programmes do already provide this type of training within the curriculum, there is no systematic information about this.

Delia Cushway and Jacky Knibbs concluded their chapter by listing trainees' roles and responsibilities in supervision, and these could certainly be used as a starting point for training supervisees. In [Chapter 5](#) it was reported that there have been some initiatives for jointly training supervisors and trainees; this would seem to be an ideal way of emphasizing that supervision is a joint venture.

In [Chapters 1](#) and [5](#) we referred to the support and spirit of collaboration that can be found within the Group of Trainers in Clinical Psychology (GTiCP), the body within the British Psychological Society that comprises and represents the interests of those involved in clinical psychology training. Members of the GTiCP already share some supervisor training materials and resources; it is not uncommon, for example, for clinical psychology programmes to invite trainers from other programme teams to deliver supervisor training. The survey reported upon in [Chapter 5](#) is a first attempt at gaining a view of supervisor training for clinical psychology supervisors in the UK. It is likely this will lead to further collaboration and sharing of resources in the future.

Finally, much of the discussion about content of supervisor training to date has focused on pre-qualification supervision. Whether, and the extent to which, the needs of post-qualification supervisors are different is unknown at the time of writing. If the links between CPD, supervision and accreditation become formalized in the ways suggested earlier in this chapter, these issues will need to be examined in more detail.

Develop a professional structure through which quality of supervision can be monitored

Becoming a supervisor constitutes a milestone in a person's career since it is the primary validation of one's clinical experience. Recognition of this requires supervising to be seen as a critical element of CPD. This presentation of the importance of supervising may appear exaggerated. We would argue that it is

not; the appearance is because historically the profession of clinical psychology has not awarded the role and practice of supervision the training and support that it is due. The profession is in a position to change this situation, possibly in the ways suggested previously.

Consider research supervision

Whilst this book has focused exclusively on supervision of clinical work, any discussion of supervision within both clinical psychology in general and clinical psychology training in particular would not be complete without mention of research supervision.

For many qualified clinical psychologists, working either in clinical or academic settings, research is a key aspect of their work. Within the profession, supervision for research work is now seen as being just as important as supervision for clinical work, as is reflected in the following statement taken from the DCP Guidelines for CPD when referring to post-qualification supervision: ‘an opportunity to reflect systematically on one’s practice is a useful discipline and applies to all aspects of a clinical psychologist’s work, e.g. research, consultancy, teaching, administration’ (DCP, 2001a:9).

In clinical psychology training, research plays a large part. In addition to trainees undertaking a series of clinical placements throughout the three years (as outlined in [Chapter 4](#)), there is a requirement for them to carry out both a small-scale project within a clinical placement setting and an independent (‘large-scale’) research project under supervision.

With regard to the ‘large-scale’ research project, the work usually begins in the second year and extends to the end of training. In general, trainees are able to choose both the area of research they want to pursue and the research supervisor (s) who will oversee this aspect of their training. Research supervisors are usually clinical psychologists who are chosen by trainees for their expertise in the particular field under study. It is interesting to consider how trainees make their decisions about their area of research and, in particular, whether the choice of research supervisor is guided by the supervisor’s reputation as a supervisor or as a researcher.

Whilst there exist BPS *Guidelines on Clinical Supervision* (1995a) which specify minimum standards for certain aspects of placement (clinical) supervision during training—such as the need to draw up a placement contract, opportunities for trainees and supervisors to observe each other’s clinical work and amount of time spent in supervision whilst on placement—until recently there has been no equivalent guidance from the BPS about the requirements for research supervision.

This situation has changed slightly, however, with the introduction of the revised *Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology* in which the following reference is made to research supervision:

Each trainee must have a research supervisor who is competent in research supervision... There should be a research agreement between supervisor and trainee that covers matters such as a schedule of regular supervision meetings and progress reviews, written feedback on drafts and a timetable for the project.

(BPS, 2002a: section 10.8)

This is the first time any formal guidance has been issued about both the practicalities of research supervision (e.g. the need for a research agreement) and the competence of the supervisor. The latter begs the question what skills and knowledge are needed to be a competent research supervisor? Many of the clinical psychologists who offer research supervision are the same people who provide clinical supervision on placements and it is interesting to reflect on whether or not the tasks of both types of supervision are similar and transferable.

That research supervision is considered important within clinical psychology training is reflected in the findings of the recent survey of supervisor training provided by clinical psychology training programmes, reported in [Chapter 5](#), which indicate that nine of the 27 clinical training programmes that responded to the survey offer training in supervising research. As acknowledged in [Chapter 5](#), the exact content of this training is unknown, which makes it difficult to draw any conclusions and to know whether the focus of these events is on the practicalities and requirements of the research or on the research supervision itself. This is clearly an area that would benefit from further examination.

Interestingly, in the wider academic arena too, there is an increasing acknowledgment of the importance of high-quality supervision for postgraduate research. The Quality Assurance Agency for Higher Education (QAA) recommend that in addition to having recognized subject expertise, supervisors 'should have the necessary skills and experience to monitor, support and direct research students' work' (1999: section 9B). Leading on from this, the QAA recommend that institutions should consider the 'provision of training for supervisors' (*ibid.*).

With this recommendation in mind, the Training and Accreditation Programme for Postgraduate Supervisors (TAPPS, 2002) was set up as a three-year pilot scheme through the Biotechnology and Biological Sciences Research Council (BBSRC). The aim of TAPPS is to provide improved training, recognition and support for postgraduate research supervisors by encouraging them to gain accreditation for their skills against set criteria. To gain accreditation, supervisors have to submit a portfolio of evidence demonstrating competence in the essential areas of postgraduate supervision.

The aforementioned developments are particularly interesting in view of the earlier discussion about accreditation of clinical supervisors.

***Decide whether pre-qualification training programmes
should have responsibility for post-qualification supervision***

The increasing recognition of the importance of post-qualification supervision within clinical psychology has been discussed in several places throughout the book. At present, training for pre-qualification supervision is provided by clinical psychology training programmes. One question remaining at present is to what extent should the training required for post-qualification supervision be provided by pre-qualification programmes?

There is a wealth of knowledge and expertise about supervision amongst clinical psychology trainers, and it could be argued therefore that they would be ideally placed to provide the training. As mentioned in [Chapter 5](#), however, there would be significant resource implications; at present, the majority of programmes do not have a designated budget for pre-qualification supervisor training.

As reported in [Chapter 5](#), there are currently a small number of clinical psychology programmes that have responsibility for both pre-qualification training and CPD, which includes training of post-qualification supervisors. It will be interesting to monitor the extent to which this practice becomes more widespread in the future.

***Consider whether there is a role for mentorship within
clinical psychology***

The concept of mentorship is one that is developing in the field of education; less has been written about mentoring in clinical professions within the NHS to date. One exception to this is in nursing, where mentoring exists within the training of student nurses. Described by Butterworth and Faugier (1992:11) as ‘an experienced professional nurturing and guiding the novice’, the mentor is a qualified and experienced nurse whose role is to facilitate, guide and support the student in learning new skills, behaviour and attitudes. It is worthy of note that the concept of clinical supervision for qualified staff is relatively new in most areas of nursing, and it is interesting to reflect on the similarities and differences between mentoring and supervision (Fowler, 1998).

Within clinical psychology, a ‘mentor scheme’ for newly qualified clinical psychologists has been in existence in the north-west of England since 1991 (Verduyn *et al.*, 1994). The scheme was introduced as a way of systematizing the training needs of recently qualified clinical psychologists at a time when it had been established that not all newly qualified clinical psychologists were receiving supervision. It was envisaged that the mentor would be an experienced clinical psychologist whose role would be ‘to work collaboratively with the recently qualified psychologist to develop a training plan’ during the first three years of the ‘mentee’s’ post-qualification practice (Verduyn *et al.*, 1994); mentoring was seen as being complementary to, rather

than an alternative to, supervision. Since its introduction the mentor scheme has continued to flourish, and both authors have had experience of acting as mentors. From our experience, there are some similarities between mentoring and supervising: the need to establish and define the parameters of a supportive mentoring relationship, to set objectives and review them regularly, and to seek and receive feedback on the process. In contrast to supervision, however, whilst the mentor is, by definition, a more senior member of the profession, the relationship has less of a managerial feel than it does in prequalification supervision and the explicit evaluative component is removed. Whether there is a role for mentoring within clinical psychology remains to be seen. At the time of writing, more information is needed about both the extent to which the practice of mentoring exists elsewhere within clinical psychology and the role and functions of mentoring within this context.

Linked to the concept of mentoring is the idea of ‘supervision for supervisors’. As discussed in [Chapter 5](#), in our experience new supervisors in particular frequently state that they would like to receive supervision for their supervisory practice. Whilst this could occur within the context of their clinical supervision, we are aware that this does not happen very often. Milne and James (2002) describe a consultancy model for supervisor training and it would be interesting to consider whether such a model would serve the purpose described above and whether there is a role for programme team staff to provide this support.

Concluding comments

It would seem that British supervision is in a healthy, forward-moving state, characterised by rootedness in practice. There can be little doubt about the richness of supervision work taking place within counselling training as well as in the supervision of seasoned counsellors. Furthermore, British supervision is well on its way to providing excellent training for supervisors.

(Carroll, 1996:21)

To what extent does Carroll’s assertion apply to clinical psychology supervision? Throughout this book, one of the consistent themes has been that whilst we are beginning to gain an idea of the practice of supervision and supervisor training in clinical psychology in the UK, more research is needed to help us to develop a clearer picture.

These are exciting and challenging times for both clinical psychology as a profession and clinical psychology training. As has been discussed throughout the book, the profession has grown rapidly in recent years and is continuing to expand. Both receiving and providing supervision are becoming recognized as important parts of a clinical psychologist’s work and are certainly high on the agendas of newly qualified clinical psychologists, whose choice of job is

influenced, to some extent, by whether they will have access to supervision (Lavender and Thompson, 2000).

Much has changed in the 20 years since we both qualified, when there were no clear guidelines for pre-qualification supervision, and post-qualification supervision was sporadic, at best, and was usually only received when feeling 'stuck' with clinical work. Supervision now has a high profile within the profession, and the challenge that faces us is to learn from the supervision literature from other professions and to continue to carry out more research in order to 'develop more flexible and efficient methods of supervision' (Milne and James, 1999:36).

In doing so, we need to remain mindful of the following, written from the viewpoint of counselling psychology, where post-qualification supervision has been mandatory for some time:

Clinical supervision costs money, it has become increasingly mandatory for many, there is no convincing empirical evidence that it 'works', yet it seems to have few opponents.

(Davy, 2002:229)

With this in mind, some of the challenges that face us include: how to ensure good practice in supervision and to avoid 'supervision for supervision's sake' in post-qualification supervision; how to make supervising more attractive for those clinical psychologists who currently do not supervise or attend supervisor training; how to manage the resource implications of increasing and competing supervisory demands—supervision of assistant psychologists (Knight, 2002), other professionals, trainee clinical psychologists and peers.

Whilst remaining mindful of the need for more research evidence and more sharing of information, the contributions in this book have shown that there already exists a great deal of knowledge and expertise within the profession.

We are at an exciting stage in which both the methods used to develop supervisory practice and the content of supervision are ready to enter new territory...

(Milne and James, 1999:36)

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